

## Multi-State Learning Collaborative for Performance and Capacity Assessment or Accreditation of Public Health Departments (MLC)

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Many states have made innovative leaps towards implementing performance and capacity assessment or accreditation programs of their public health departments. The MLC is an initiative that convenes five of these states to study key components of the state-based assessment / accreditation programs. The project is funded by The Robert Wood Johnson Foundation and managed by the National Network of Public Health Institutes and the Public Health Leadership Society.

### GOAL OF THE MLC

To foster the continued development of existing innovative assessment programs and widely disseminate their lessons learned to strengthen the effectiveness of governmental public health agencies.

### THE MLC WILL

- Address state identified needs for enhancement of current assessment/accreditation activities
- Foster peer exchange and collaboration among the participating states
- Share best practices and lessons learned with the public health practice community
- Provide data and information to inform the Exploring Accreditation Project

### ACTIVITIES

- Internal and National Conferences & Teleconferences
- Site Visits to the Participating States
- Peer Networking & Technical Support
- Interactive Website to Foster Exchange & Collaboration
- Research and Evaluation
- Enhancement Projects

### THE PARTICIPATING STATES

Five states were selected to participate in the MLC from a field of 18 applicants. The participating states are: Illinois, Michigan, Missouri, North Carolina, and Washington.

### COMMON THEMES

The assessment/accreditation programs in the participating states share many common characteristics:

- Public health institutes are involved in four out of the five participating states
- Heavy reliance on self assessment
- Similar periodicity for review process (3-5 years)
- Development of state specific standards
- Foundation from previous work: Core Functions, APEXPH, NPHPSP, MAPP, Turning Point Performance Management Collaborative and the Operational Definition

### STATE ENHANCEMENT PROJECTS

Some of the deliverables that will be accomplished by the state enhancement projects include:

- Transition from Certification to Accreditation (Illinois)
- Accreditation Readiness Tool (North Carolina)
- Digital Library of Accreditation Documents (Michigan)
- Social Marketing Campaign (Missouri)
- Fund for Public Health Improvement (North Carolina)
- Evaluate Standards (Washington)

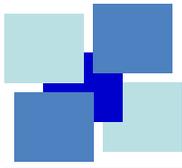
### FOR MORE INFORMATION

Visit the MLC website at:

[www.nnphi.org/multistatelearningcollaborative.htm](http://www.nnphi.org/multistatelearningcollaborative.htm)

Or Contact:

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## Arizona

### OVERVIEW

Arizona is one of the 17 states with a decentralized public health system. Because a decentralized system relies on the initiative of individual health departments, it is a challenge to initiate and maintain a performance assessment or accreditation process and ensure uniformity throughout the state.

### PERFORMANCE ASSESSMENT ACTIVITIES

The Arizona Public Health System is interested in the implementation of the National Public Health Performance Standards Program. However, at this time, public health performance assessments conducted in Arizona have been county and tribal specific:

#### **Apache County**

In the fall of 2002, the Apache County Health Department began a community-wide process to improve community health. One of the first steps was to bring together formal and informal leaders to initiate a strategic planning process to implement MAPP. As part of this process, the National Public Health Performance Standards (NPHPSP) Local Instrument was completed in 2003. As a result of these processes, the Apache County Health Department has implemented a number of workforce and program enhancements.

#### **Coconino County**

In 2002, the Coconino County Health Department began a process to examine public health competencies. Its goal was to develop a county-wide public health system assessment plan in order to evaluate the feasibility of establishing a public health tax district. In January 2005, the Coconino began a comprehensive strategic planning process using the MAPP model. The public health system assessment was completed in October 2005, using the NPHPSP tool. Coconino County is concentrating other MAPP assessments on the individual communities within the county. A strategic plan will be finalized by the end of 2006.

#### **Mohave County**

The Mohave County Health Department has not implemented performance assessment activities at this time. Due to resource demands inherent in the process, the department has been reluctant to move forward without technical support and guidance.

#### **Yavapai County**

The Yavapai County Health Department has completed a Model Public Health Act analysis of state and local public health laws as they impact disease outbreaks, public nuisances, and bio-terrorism in 2005. A flowchart tool outlining public health legal powers and duties was produced. This tool can be used for staff training, guidance in the field, and strategic planning.

#### **Navajo Nation**

The Navajo Nation has implemented both the NPHPSP Local Performance Assessment as well as the State Assessment at the tribal level to assess the 10 Essential Public Health Services.

#### **Arizona Department of Health Services (ADHS)**

The ADHS is active in the Association of State and Territorial Health Officials (ASTHO), supports the National Association of County and City Health Officials (NACCHO), and is interested in the National Public Health Performance Standards Program. Staff have recently participated in National Public Health Performance Standards Program training workshops. The Department is hopeful that existing affiliations with the 15 Arizona Counties, the 22 Arizona Tribes, and the numerous public health stakeholders will allow the Department to integrate the National Public Health Performance Standards and the State Public Health System Performance Assessment instrument into its existing strategic planning program and improve public health practice through the establishment of statewide public health standards.

### GOVERNANCE

In Coconino County, the County Board of Health has proved oversight to the County Health Department in the implementation of the NPHPSP assessment process.

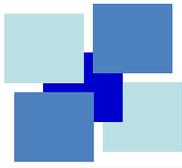
The Apache County program was overseen by the MAPP Core Committee, which included the Apache County Health Department Director, the Health Educator, the Bio-terrorism Logistics Coordinator, and the Bio-terrorism Program Coordinator.

### COSTS

A challenge for local health departments, particularly smaller departments, has been to find adequate resources and support to conduct performance assessment activities. However, despite these challenges, two relatively small county health departments that each serve a large geographical region (Apache County and Coconino County) have self-financed public health systems performance assessments. Apache County used some bio-terrorism funds to initiate the process, but has since self-funded it. The Coconino County process has been entirely self-funded.

### ASSESSMENT RESULTS

The Apache County used the results of its NPHPSP to begin a quality improvement process. As part of its effort to improve community partnerships, the department developed and initiated a community partner satisfaction survey. To improve its workforce capacity, the department has made two additional hires: a veterinarian with biostatistics and epidemiology qualifications and a Registered Nurse epidemiologist.



## HISTORY

Connecticut has a long history of preferring local, independent control in governmental and administrative functions. As a result, the established public health infrastructure is a complex system involving state, public, private, and voluntary entities.

Connecticut has 88 local health departments; forty-nine of the LHDs have full-time health directors, and 39 have part-time directors. All local health departments must comply with state statutes related to the administration of their health department, and also local ordinances that pertain to their specific geographical and municipal district. The significant variations in local health departments' capacities and resources perpetuate challenges to ensuring equitable and uniform statewide public health services.

### ***The Connecticut Association of Directors of Health***

The Connecticut Association of Directors of Health, Inc. (CADH) is a non-profit organization that represents local health departments and districts in Connecticut. Strengthening and assuring the efficient and effective delivery of public health services throughout the state is a prime goal of the organization and its members. Towards this end, CADH has driven public health advocacy initiatives since its inception several decades ago, with a solid record of influencing public policy on a host of critical issues.

As an organization dedicated to building Connecticut's public health infrastructure, CADH has committed significant focus and resources on the incorporation of public health practice standards. Preliminary work in this area started seven years ago when CADH established a Standards Committee to focus on developing public health practice standards that assure accountability, reliability, and consistency as well as pave the way for future accreditation of local public health departments.

### ***CADH Accreditation Committee***

In 2005, CADH established an Accreditation Committee to research existing state/local accreditation programs to further inform Connecticut's process. A survey of established state accreditation programs provided insight into other states' lessons learned, as well as recommendations and successful approaches that will facilitate statewide voluntary accreditation in CT.

## PERFORMANCE ASSESSMENT

CADH's early work included the review and modification of the 10 Essential Public Health Services to better reflect the realities of Connecticut's departments and overall public health system. Ultimately, CADH embraced the National Public Health Performance Standards Program (NPHPSP) as a mechanism to assess current systems.

In 2002, CADH secured a CDC Public Health Prevention Specialist to coordinate the pilot-testing of the NPHPSP local assessment instrument with local health departments. In 2004, CADH, in conjunction with NACCHO and CDC, kicked off the NPHPSP assessment process statewide, establishing a volunteer performance assessment program for the first time in Connecticut. As of August, 2005, nearly 50% of full-time health departments have completed the CDC NPHPSP Assessment.

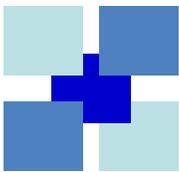
In addition to the NPHPSP Assessment, many health departments throughout the state have conducted community health assessments, strategic planning, and quality improvement efforts. However, there has been no common approach and little consistency relative to these efforts.

## CAPACITY BUILDING EFFORTS

In response to the Legislative Program Review and Investigations Committee report (2004) the Commissioner of DPH initiated a "Transition Program" for municipalities with a part-time director of health to build emergency response capacity by joining and/or forming health districts. The Department offered financial incentives to municipalities with a part-time Director of Health to participate in this program.

There have also been significant efforts focused on building the capacity of the public health workforce. Both CADH and DPH have been working collaboratively with community partners such as the Connecticut Partnership for Workforce Development, the two Centers of Excellence representing the 32 acute hospitals statewide, the Connecticut Association of Public Health Nurses, the Connecticut Environmental Health Association, and state universities to advance a public health workforce training program grounded in core public health competencies. Another mechanism that has been implemented is a web-based learning management system that promotes public health training opportunities and tracks participation in education and training activities.

Connecticut hopes to advance its capacity building efforts and a voluntary accreditation program. Key activities will be continued engagement of partners and formation of task force; development of standards and/or measures specific to the governmental health agencies that will provide foundation for accreditation system and develop incentives and framework for piloting and implementation.



## Florida

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### HISTORY

The Florida Department of Health (DOH) has a long history of utilizing performance management and quality improvement practices and, as a result, has seen significant health improvements. The state attributes these changes to a movement away from quality assurance (QA) to a more comprehensive performance improvement process. In the late 1980's, the DOH reorganized its QA review system for county health departments. At that time the system was process oriented and did not necessarily rely on evidenced-based standards.

### Timeline of Key Assessment Activities

- In 1992, Florida adopted the Assessment Protocol for Excellence in Public Health (APEX) model to link community health status indicators (outcomes) with public health programs (processes) at both the state and local level.
- In 1998, the state began promoting the use of the Florida Sterling Criteria for organizational excellence. The criteria covers seven categories including leadership, strategic planning, customer market focus, measurement analysis and knowledge management, human resource focus, process management, and organizational performance results.
- In 1999, Florida piloted the National Public Health Performance Standards (NPHPS) State Assessment Tool. In 2004-2005, the NPHPS state assessment tool was repeated and involved all sixty-seven (67) county health departments.

### PROCESS

#### ***CHD Performance Improvement Process***

The Quality Improvement (QI) system was led by Central Office Program staff who conducted reviews for county health departments (CHD) every three to five years. In 2000, the DOH included the use of Peer Reviewers. Peer Reviewers have become an essential part of the Quality Improvement teams that review Florida's 67 county health departments. Some major steps in the process include:

- Local CHD conducted self-assessment.
- DOH Central Office Programs conducted a desk audit and, at times, followed with a CHD on-site visit.
- QI Central Office staff extensively reviewed CHD and program submitted information and conducted on-site systems review at CHD over a period of 3-5 days.
- The QI Central Office staff completed a report documenting the performance improvement issues and agreements, and provided the report to the CHD.
- CHDs provided a six-month follow-up report of progress.

#### ***Redesigning the CHD Performance Improvement Process***

In 2004, Florida began redesigning the QI process to develop a resource tool and enhance the measurement system that would help CHDs to assess performance and manage their improvement efforts on a continuous basis.

A QI Advisory Council, consisting of county health department representatives including business managers, administrators/directors, nurses, and Peer Reviewers; Central Office Program staff; and public health experts put together a CHD self-assessment tool or Performance Report Card.

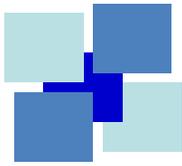
In August 2005, the Pilot Performance Improvement Process was deployed to twenty (20) selected CHDs. Central Office Programs contributed supporting evidence and comments regarding the data entered into the Performance Report Card and completed their analysis in December 2005.

Statewide strengths and opportunities were identified based on data collected from the report card, surveys, technical assistance requests, and other sources. QI Advisory Council members were polled and identified performance improvement process and strategic planning as opportunities for improvement for the statewide action plan. Workgroups are meeting to develop an action plan by May 2006. Undertaking these challenges from a statewide perspective will provide an opportunity for CHDs to develop improvement plans specific to their CHD; ensure that issues are addressed with consistency in CHDs; and save dollars and resources for the organization.

Between January and April 2006, Performance Consultants facilitated providing technical assistance to the twenty pilot CHDs based on needs determined from the Performance Report Card and surveys as well as other data sources including results from the NPHPS and Community Needs Assessments. A tabulation of the most requested technical assistance areas among these pilot counties were clinic flow, strategic planning, development of a medical records review system, process management/mapping, and training and information linked to human resources.

An evaluation of the Performance Improvement Process has been completed. This information will be shared with the QI Advisory Council at upcoming meetings as they revise the process, including the Performance Report Card.

The revised process will be completed by July 2006 and plans are to deploy the Performance Improvement Process to all 67 CHDs in Fall/Winter 2006.



# Illinois Local Health Department Certification Process

## HISTORY

The Illinois Department of Public Health convened an inclusive strategic planning process in the late 1980s that resulted in the 1990 report, *The Road to Better Health For All of Illinois*, a plan that called for implementation of a number of initiatives to build local health department capacity. Key among those recommendations was the need to conduct needs assessments describing local public health needs and to develop standards enabling local health jurisdictions to be responsive to identified community health needs. In 1993, under the auspices of the Project Health implementation plan, a new local health department certification program was launched, the purpose of which was "to assure quality public health services are delivered to Illinois citizens."<sup>1</sup> Established in the Illinois Administrative Code, the program requires that certified local health departments carry out the core public health functions of assessment, policy development and assurance by meeting specified practice standards. The adoption of the core functions and practice standards in 1993 represented a groundbreaking shift away from the traditional model of requiring that LHDs implement specific categorical programs to a focus on the functional role of a health department in the community.

## PROCESS

- Local Health Departments (LHD) conduct Illinois Project for Local Assessment of Needs (IPLAN) process
- IDPH reviews IPLAN submission for substantial compliance with Code
- IDPH Director grants a five year certification to the LHD upon approval of the IPLAN and self-affirmation of compliance with all practice standards.

## GOVERNANCE

The Illinois Department of Public Health governs the certification process via the following activities:

- Development and enhancement of the IPLAN data system
- Training and technical assistance
- Review of IPLAN submissions for substantial compliance with the administrative rules (every 5 years) and provision of follow-up technical assistance

## STANDARDS:

LHDs must meet the following set of agency-based public health practice standards:

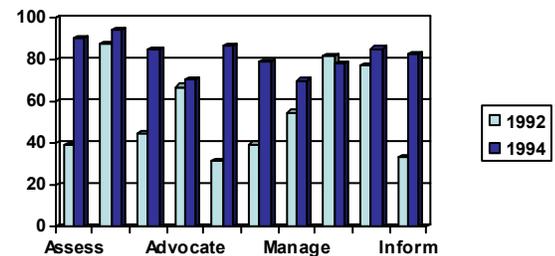
- Assess community health needs
- Investigate hazards within the community
- Analyze identified health needs for their determinants
- Advocate and build constituencies for public health
- Prioritize among identified community health needs
- Develop policies and plans to respond to priority needs
- Manage resources and organizational structures
- Implement programs and services to respond to priority needs
- Evaluate programs and services
- Inform and educate the community

## COSTS/FINANCES:

- PHHS Block Grant for state program - - \$250,000 annually since 1993
- Local activities to maintain certification status: Local sources of funding, IL Local Health Protection Grant (recipients are certified local health departments)

## EVALUATION:

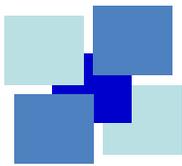
Research conducted at the University of Illinois at Chicago shows that the IPLAN has led to improved performance of core public health functions.



## ENHANCEMENT PROJECT- Illinois Accreditation Development Project

- Design an accreditation framework that would transition the IL local public health certification program into a more performance-based program
- Contribute to the knowledge base and participate in national dialogue through the MLC

<sup>1</sup> Title 77: Public Health, Chapter 1: Department of Public Health, Subchapter H: Local Health Departments. Part 600: Certified Local Health Department Code. Section 600.100: Statement of Purpose. <http://www.ilga.gov/commission/jcar/admincode/077/07700600sections.html>



## HISTORY

The Kansas Public Health System is a highly decentralized system consisting of one primary state agency—The Kansas Health Department (KDHE)—and 99 local health departments serving all 105 counties of Kansas. Sixty-eight of the 105 counties have a very low population density and are classified as either rural or frontier counties. Many of the rural and frontier counties historically have provided a limited range of services due to a small staff. The goal of performance measurement in Kansas is to not accept lower standards in rural areas, but rather to modify the structure of the delivery system so that all Kansas citizens, regardless of location, have access to full public health services.

In the late 1990s, the Kansas Health Foundation awarded the Kansas Association of Local Health Departments (KALHD) a grant to develop program standards through a group process involving local health departments and the Kansas Department of Health and Environment.

When the National Public Health Performance Standards (NPHPS) were developed by the CDC and its partners, KALHD decided to embrace these national standards as the goal and reference point, rather than developing separate standards for Kansas.

## PROCESS

Because of the challenges presented in Kansas, the establishment of an assessment and performance measures system had to be preceded by efforts to establish a stronger, regionalized structure. A portion of local funds from the 2002 CDC Bio-Terrorism grant offered incentives for local health departments to establish regional partnerships with other local health departments. Inter-local agreements were approved by the County Commission of each participating county and filed through the Office of the Attorney General. Currently 103 of the 105 counties in Kansas are a member of one of 15 public health regions. Kansas' efforts in performance management are built upon this regional structure.

Concurrent with regionalization, another strategy for improving local capacity and promoting standardization throughout the state has been used in the last few years. This strategy involved public health departments working jointly through the Kansas Association of Local Health Departments to develop common business practices, policies and procedures that incorporate strong local input and buy-in with best practices. In this way, the 15 regions are evolving into units with the capacity to make important, cohesive decisions affecting the provision of public health services across the state.

*Track and Trend* is a performance management tool used to develop and improve the standardization and regionalization of the local public health system across Kansas. The system utilizes the 10 EPHS and the NPHPS as its framework.

During the first stage of the project, the Kansas Health Institute (KHI) analyzed three selected essential services and an advisory group of representatives from KALHD, KDHE, KHI and the KU School of Medicine was convened to identify key performance indicators specific to each of these essential services.

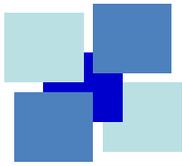
The *Track and Trend* project includes the construction of a series of “digital dashboards” available to all Kansas public health departments through a secure Web site. *Track and Trend* allows the user to view each region's status and historical trends relative to a particular key performance indicator. A large amount of information is condensed into a consistent format that quickly conveys progress made across Kansas towards key performance indicators. As a management tool, *Track and Trend* helps to communicate the goals in building public health capacity within Kansas communities. Each region can view their status, monitor progress in building capacity, and identify areas for additional focus.

## COSTS

Public health in Kansas has been historically underfunded. The strategy adopted in Kansas for implementing the national standards has been to use them as a framework for building capacity as other resources become available. Using the NPHPS as a central framework helps integrate a variety of efforts funded through categorical grants. Costs for two regional capacity assessments performed in 2002 and 2003 totaled \$165,000. Costs associated with developing the performance measures and dashboards are in excess of \$77,000.

## EVALUATION

To evaluate current efforts, KALHD conducted a two-year, statewide capacity assessment using CDC's “Public Health Preparedness and Response Capacity Inventory.” Assessments were conducted in 2002 and again in 2003 to track improvements made over the course of the year. The assessments were analyzed by KHI, who aggregated the data by the 15 public health regions. Each public health region received an individualized report, which provided a gap analysis showing each of them how they and other regions fared in relation to state-wide averages, and where additional efforts were needed in their region. The capacity assessments were used as baseline data for accountability and planning for additional capacity development.



# Michigan Local Public Health Accreditation Program

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## HISTORY

The State of Michigan has a mature, organized, and institutionalized local public health accreditation program. The timeline begins with the establishment of the Public Health Code in 1978, followed by the state/local development of Minimum Program Requirements (MPRs) in 1980. During 1989, with state technical assistance, local health departments used the Assessment Protocol for Excellence in Public Health (APEXPH) tool as a means to assess and enhance the core capacities. During 1989 – 1992, Established Committees One and Two (comprising state/local public health leaders) recommended pursuing accreditation. These early collaborative efforts defined the attributes of a local health department and served as the basis for the Michigan Local Public Health Accreditation Program.

The mission of this living program is to assure and enhance the quality of local public health in Michigan by identifying and promoting the implementation of public health standards for local public health departments and evaluating and accrediting local health departments on their ability to meet these standards. The Program's goals are to assist in continuous quality improvement; assure a uniform set of standards that define public health; assure a process by which the state can ensure local level capacity to address core functions; and provide a mechanism for accountability.

## PROCESS

The Accreditation Program assesses the ability of a local health department to meet minimum administrative capacity requirements. The Accreditation Program also conducts performance reviews for contractual local public health operations services and some categorical grant funded services provided by a local health department. The review process requires a team of approximately 50 state-agency reviewers, of which about 15 are used for each on-site review. The review cycle is 3 years.

Steps to Accreditation:

1. Self Assessment; 2. On-site Review; and
3. Corrective Plans of Action

Accreditation Status Options:

Accredited with Commendation; Accredited; and Not Accredited

Michigan has reviewed each local health department twice. All 45 local health departments are currently accredited.

## COSTS/FINANCES:

The MDCH currently allocates \$220,000 (via contract to the Michigan Public Health Institute) for performance of day-to-day operations of the program. Since the inception of the program, approximately \$1,935,000 of

## COSTS/FINANCES continued:

state funding has been dedicated. LHDs and State Departments incur significant in-kind costs.

## GOVERNANCE

The governing authority for the MLPHAP is the Michigan Department of Community Health (MDCH). Three state agencies comprise the accrediting body:

- Michigan Department of Community Health
- Michigan Department of Agriculture
- Michigan Department of Environmental Quality

An Accreditation Commission maintained by the Michigan Public Health Institute serves as the advisory body for Michigan's Accreditation Program.

## STANDARDS:

The state health department is responsible for establishing minimum standards of scope, quality, and administration for the delivery of required and allowable services as set forth under the Public Health Code. The current model is based on Minimum Program Requirements (MPRs)

- MPRs are constructed through a formal process (Policy 8000)
- MPRs must be based in law, rule, department policy or accepted professional standards
- 221 indicators

## EVALUATION:

Accreditation Quality Improvement Process (AQIP)

- 2003 marked the beginning of a formal Quality Improvement Process
- Locally-driven workgroup convened by MDCH to provide direction (all partners represented)
- Workgroup developed survey to obtain understanding of what/how to improve
- AQIP produced 44 recommendations

## ENHANCEMENT PROJECT-

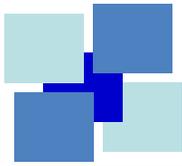
Michigan's MLC enhancement project has two goals that work toward continued success:

I. Enhance Michigan's Accreditation Program

- Objective 1: Assess opportunities for enhancement to current approach
- Objective 2: Draft voluntary component to enhance current approach
- Objective 3: Develop tools to enhance reviewer team and local health department interface
- Objective 4: Develop a model for ongoing awareness, education, and training of local governing entities

II. Contribute to an interactive learning environment for accreditation

- Objective 5: Establish an evolving digital library of Michigan accreditation information
- Objective 6: Develop a model to establish a best practices information exchange



# Minnesota

## HISTORY

In 2001, a state-local working group was charged with developing a long-range strategic plan to define a statewide public health infrastructure that would be most effective in improving the health of the public. A survey conducted during the strategic planning process suggested that some form of standards and statewide uniformity in local public health functions would greatly simplify efforts to describe the system and its benefits to the Legislature, local elected officials, and citizens.

The recommendations of the strategic planning process led directly to the development of *six areas of public health responsibility* and the *essential local public health activities* that now form the basis of Minnesota's Local Public Health Planning and Performance Measurement Process. Several national initiatives including HHS Public Health in America (essential services), NPHPSP, NACCHO Operational Definition of a Local Health Department also informed the development of this process.

In 2003, modifications were made to the Local Public Health Act (the 1976 law that established Minnesota's local public health system) to reflect the improvements that resulted from the strategic planning process.

## STANDARDS AND PROCESS

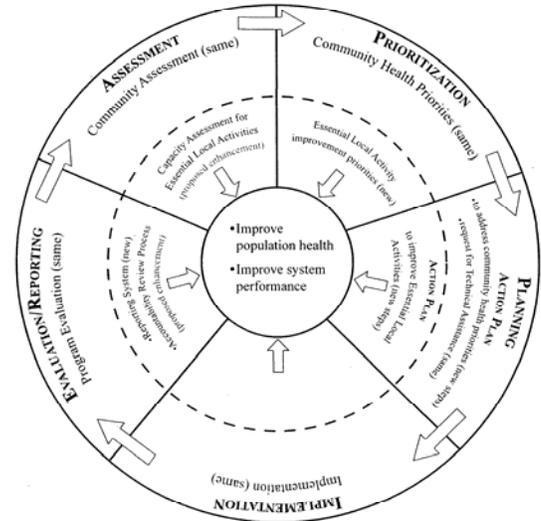
The Local Public Health Planning and Performance Measurement Process (see diagram) is based on *six areas of public health responsibility* and a set of *essential local public health activities* that support each of the six areas. The six areas of public health responsibility are:

- Assure an adequate local public health infrastructure
- Promote healthy communities and healthy behaviors
- Prevent the spread of infectious disease
- Protect against environmental health hazards
- Prepare for and respond to disasters, and assist communities in recovery
- Assure the quality and accessibility of health services

The essential local public health activities for each of these areas define what public health services should be available throughout the state. Local public health departments report annually on a set of performance measures, as well as financial, staffing and statistical data. Tools are currently being developed to help local health departments identify and address priorities for improvement, with consultation from MDH. The Local Public Health Act sets up an accountability framework that stresses quality improvement over time.

## Minnesota's Local Public Health

### Planning and Performance Measurement Process



## GOVERNANCE

Governance of Minnesota's Local Public Health Planning and Performance Measurement Reporting System occurs through the partnership of the Minnesota Department of Health (MDH) and local governments. Standards and guidelines are developed jointly, as are reporting requirements and recommendations for accountability.

## KEY PARTNER ORGANIZATIONS AND ROLES

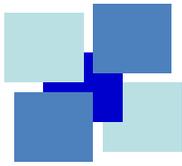
- The MDH Office of Public Health Practice (OPHP)
- Local public health departments and the Local Public Health Association
- The State Community Health Services Advisory Committee (consisting of 1 representative of each of MN's 53 Community Health Boards)

## COSTS/FINANCES:

The primary cost of MN's Local Public Health Planning and Performance Measurement Process is derived from staff time at the MDH and local health departments. The first phases of this work were partially supported by the RVJ Foundation's Turning Point Program. MDH offers a state subsidy for local public health operations.

## EVALUATION

All local health departments recently reported on the performance measures as well as financial, staffing and statistical data. Those data provide a baseline from which to evaluate future efforts, as well as serve as an additional pilot test to identify needed refinements to the measures. Additionally, statewide outcomes have been established for each of the six areas of public health responsibility to be tracked at a statewide level by the MDH.



# Missouri Voluntary Accreditation Program of Local Public Health Agencies

## HISTORY

The Missouri Voluntary Accreditation Program of Local Public Health Agencies is administered by the Missouri Institute for Community Health (MICH). The following are milestones of Missouri's accreditation program:

1981-1999-Model standards for LPHAs defined & objectives identified.

2000-2001-Accreditation model established based on core functions & 10 essential services

2001-The self-assessment tool was developed and piloted & guidance document for the model was developed

2002-Missouri Institute for Community Health becomes a 501(c)3 agency & publishes the accreditation standards.

The goals of the accreditation program are to:

- To serve as a measure of accountability to the governing bodies & other funding sources
- To provide state & local elected officials a model of public health capacity
- To encourage Missouri's LPHAs to remain current with public health practice & science

## PROCESS

The Voluntary Accreditation process has four steps:

1. Application for accreditation
2. LPHA self-assessment
3. MICH review of LPHA
4. MICH accreditation decision

Local Public Health Agencies select the type of accreditation that they wish to apply for:

- Primary Accreditation - 23 Standards/Criteria
- Advanced Accreditation - 33 Standards/Criteria
- Comprehensive Accreditation - 39 Standards/Criteria

## GOVERNANCE

MICH is a 501(C)3 agency:

- 95 member Advisory Council
- 13 member Board of Directors
- 9 member Accreditation Council

The Accreditation council also has two subcommittees:

- Standards Review Committee
- Qualifications and Training Review Committee

## STANDARDS

The accreditation program is based on three sections of standards

- Performance Standards - What do you do?
- Workforce Core Staff Requirements, Qualifications, and Competencies - Who does it?
- Physical Facilities and Administrative Services - Where do you do it?

## COSTS/FINANCES:

Local Public Health Agencies pay application and accreditation fees based on the type of accreditation that they are applying for as described in the table below.

		<b>Accreditation Fees</b>
Primary	\$450	\$1,500
Advanced	\$700	\$2,250
Comprehensive	\$900	\$3,500

Additional funding for the program includes:

- Heartland Center for Public Health Preparedness & Workforce provides \$70,600
- Accreditation Fees provides \$28,000
- RWJF Multi-State Learning Collaborative
- MDHSS provided start-up funds to assist in the development of the standards and program

## EVALUATION

In 2004 MICH commissioned an extensive three phase evaluation of the Accreditation Program based on process and impact findings. Evaluating not only the LPHA performance, but MICH as an organization at every phase

- Phase 1- Self Assessment Process
- Phase 2- On-Site Review Process
- Phase 3- One-year Review Process

## ENHANCEMENT PROJECT-

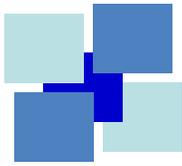
### Intended Outcomes

- Enhance accreditation model through integration of evaluation findings
- Publish a monograph related to evidence-based public health
- Implement social marketing campaign to increase number of LPHAs participating in voluntary accreditation program

### Key Action Steps

- Maintain competency levels of existing on-site reviewers
- Update existing standards & staff competencies
- Continue 3 phase evaluation process of LPHAs and on-site reviewers
- Use the CDCynergy model to create the social marketing plan for the accreditation program
- Implement social marketing strategy
- Work to sustain the program by meeting with legislators, foundations and other potential funders

<sup>1</sup> Paid only once with initial application unless there is a break in accreditation status.



# New Hampshire

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## HISTORY

The New Hampshire Department of Health and Human Services, Division of Public Health Services (DPHS) and the Community Health Institute (CHI), the state's designated Public Health Institute, possess a strong foundation in performance management.

New Hampshire is a state with a decentralized public health structure, health services are delivered through an array of community-based agencies. Beginning in 2001, the DPHS integrated performance measures into contracts with its community health providers. Performance measures were selected based on national performance indicators such as Healthy People 2010, HEDIS measures, federal grant requirements, and national authoritative bodies such as the American Diabetes Association and the American Academy of Pediatrics.

While the work on performance-based contracting proceeded, the DPHS and the CHI began the process of formalizing a mechanism for local public health system assessment and improvement. Four community public health partnerships were funded to develop models for improving local public health. By summer 2005, 14 partnerships—now collectively known as the New Hampshire Public Health Network (PHN)—had been established. All 14 PHNs have completed an assessment of the local public health infrastructure utilizing the National Public Health Performance Standards (NPHPS), Local Public Health System Assessment. In 2004, as part of a reorganization of the DPHS, a new Bureau of Policy and Performance Management was created to continually assess and improve the performance of programs and services. New Hampshire conducted the State Public Health System Assessment for the NPHPS in October 2005. An advisory committee has been formed to review the scores from the state assessment and plan next steps.

## USE OF ASSESSMENT DATA

Although the majority of DPHS programs utilize performance measures to assess their own programs as well as the programs of its contractors, the programs are in varying forms of sophistication in how the data are evaluated and utilized for performance enhancement.

At the local level, each of the 14 PHNs have completed a local public health systems assessment using the NPHSP-Local Public Health Assessment Instrument as a contract requirement. Each of the networks is also required to develop a Public Health Improvement Plan (PHIP) based on the results of the assessment. The PHIPs outline goals, objectives, activities, responsible organizations, timeline, and evaluation measures for each activity included in the plan. Of the 14, 11 have completed the PHIP development process.

## STANDARDS

DPHS uses 31 performance measures that were defined by the state to assess the performance of contractors. In addition, the state and local NPHPS assessment tools have been implemented.

## KEY PARTNERS

### **New Hampshire Performance Management Collaborative:**

This collaborative is comprised of community agency directors, performance improvement staff primarily from community health centers, staff persons from DPHS utilizing performance measures in their programs, and the CHI

**Public Health Improvement Team (PHIT):** The PHIT is an internal performance improvement committee for DPHS.

**Community Health Institute:** CHI has been a key partner with the planning and implementation of the PHN. CHI has also been contracted by the State of New Hampshire to provide technical assistance and training to the PHN.

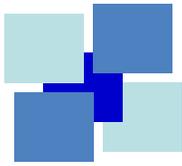
## COSTS

Using a combination of general and federal funds, DPHS commits \$114,073 specifically towards salaries for staff members that manage the DPHS performance management efforts. All additional DPHS staff members dedicate a portion of their staff time to performance management activities. Exact costs for staff time have not been determined.

CHI also commits staff and associated resources in their role as technical assistance provider to the PHN partners. Staff costs for performance assessment work via other technical assistance tasks have not been specifically tracked.

## EVALUATION

In June 2005, in collaboration with the New Hampshire Performance Management Collaborative, the DPHS published **Improving the Public's Health in New Hampshire: A Performance Management Approach**. This publication reports on New Hampshire's progress on 11 selected measures.



## HISTORY AND OVERVIEW

New Jersey's local public health structure consists of more than 560 local boards of health and 115 local health departments (16 county, 7 regional, 50 municipal, and 41 multi-municipal) responsible for directly providing or contracting for public health services.

State law mandates that the New Jersey Department of Health and Senior Services (NJDHSS) shall prescribe "recognized public health activities [and] minimum standards of performance." Local boards of health are responsible for maintaining programs that meet these activities and standards of performance.

In 2003, the *Public Health Practice Standards of Performance*, which are the direct regulatory descendent of the *Minimum Standards of Performance* – first promulgated in 1969 – were adopted by the state Public Health Council.

The purpose of the Public Health Practice Standards of Performance is to:

- Establish standards of performance for public health that comply with state law
- Assure the provision of an array of public health services to all citizens of New Jersey
- Designate activities required of all local boards of health that build capacity and encourage a systems approach to local public health
- Encourage cooperation among local health departments and their governmental and community partners
- Align local public health performance with the Ten Essential Public Health Services and the National Public Health Performance Standards Program (NPHPSP)
- Build local public health systems that are reliable and cost effective
- Ensure the assessment of local health departments organizational capacity as well as local boards of health, health departments, and local public health system performance
- Develop and implement outcomes-based improvement plans
- Implement and evaluate those plans to ensure increased longevity and quality of life for New Jersey residents.

## PROCESS

Overseen by the Department's Division of Local Public Health Practice and Regional Systems Development, each local health department is required to complete 2 performance and capacity assessments:

- An annual Local Health Evaluation Report provides a self-evaluation and includes an immediate analysis report and score on several core activity areas and overall performance.

- Every 3 years, each local health department is required to complete the *New Jersey Enhanced Assessment Protocol of Excellence* in Public Health, which builds on the national APEX instrument, the Ten Essential Public Health Services, NPHPSP Model Community Standards, Essential Elements of Bioterrorism Preparedness, *Healthy New Jersey 2010*, and Public Health Practice Standards.

One hundred and fifty local boards of health completed the NPHPSP Local Public Health Governance Performance Assessment Instrument. In addition, all local health departments are implementing the Mobilizing for Action through Planning and Partnerships (MAPP) and its component assessment, such as the NPHPSP Local Public Health System Performance Assessment.

## GOVERNANCE

The NJDHSS established governance processes at both the statewide and local levels. A Public Health Practice Standards Implementation Advisory Group (PSIAG) provides guidance on statewide policy for standards implementation, best practices, and performance improvement. At the local level, the Governmental Public Health Partnerships (GPHPs) are responsible for guiding the development of a local public health system and assuring performance assessment and improvement.

## PARTNERS

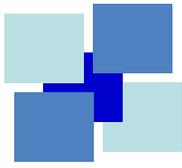
- NJDHSS, Division of Local Public Health Practice and Regional Systems Development
- UMDNJ School of Public Health
- The NJ Health Officers
- The NJ Association of County Health Officers
- The NJ Local Boards of Health Association
- The NJ Public Health Association

## COSTS

- \$575,000 for the operation of the Performance Improvement and Development Program established within the NJDHSS (10% state funding; 90% federal funding)
- \$730,000 for 3 Memoranda of Understanding developed for the implementation of the *New Jersey Enhanced APEX*, the NPHPSP, and the development of the *New Jersey Public Health Continuous Quality Improvement* process and resource manual.

## EVALUATION

All of the performance program activities described have been implemented within the last year or are at the beginning stages of implementation. As such, New Jersey has not yet had the opportunity to formally evaluate the findings of the assessment or the overall performance assessment program.



### **HISTORY**

New York State's public health system consists of a large number of public, private and voluntary organizations including state and local government agencies, health care providers and insurers, and community organizations. The New York State Department of Health (DOH) and 58 local health departments (LHDs) have the primary responsibility to promote and protect the health of the public. The mission of the Department is "to protect and promote the health of New Yorkers through prevention, science and the assurance of quality health care delivery."

In the early 1980s, New York State illustrated its continued commitment to strengthening public health service delivery and its partnership with the New York Association of County Health Officials (NYSACHO) and the LHDs by implementing systematic improvements in local public health assessment, planning, performance monitoring, and state aid reimbursement. The program was codified in Article 6 of the State's Public Health Law and is referred to as the *Article 6 Program*. The Program mandates an Annual Performance Report (APR) from LHDs related to codified standards and provides state reimbursement for local health services according to a formula based on population and services delivered.

In 1998, New York was one of 21 states selected to participate in the National Turning Point Initiative. Funded by the Robert Wood Johnson Foundation, this initiative provided the opportunity to assess and strengthen the capacity of the state and local public health system. In 2000, New York was asked to join the Turning Point Performance Management National Excellence Collaborative because of its experience with a systematic approach to performance monitoring as part of the Article 6 Program.

In 2001, all 58 of New York's local health departments participated in a test of the National Public Health Performance Standards (NPHPS). In 2002, the State successfully competed for additional funding to conduct a pilot test of the Turning Point performance management model. With this funding, the DOH established the Performance Management Group (PMG) that included public health representatives from a dozen LHDs, the CDC Public Health Practice Program Office, and DOH program staff working in collaboration with the Public Health Foundation (PHF).

The PMG revised the APR using the NPHPS and Turning Point experience so that the local performance assessment process would incorporate key components of a performance management model including applying standards and setting targets, measuring performance, reporting information and improving quality.

The work of the PMG led to a version of a performance report that fulfills the law's accountability requirement and assists the organizations within the public health system to use the reports in management decisions. The PMG developed twenty-six measures that were incorporated into the Article 6 Program's APR. This version of the APR is being piloted by all 58 LHDs and is being evaluated.

The APR has two sections: Section I contains the twenty-six state-wide measures, which all LHDs must complete; Section II is designed to capture unique measures that LHDs may add to the report to more fully describe their performance over the year. The measures created by the LHDs must be accompanied by a template, which demonstrates the validity of the measure.

### **PROCESS**

The implementation of the program is conducted by the NYS DOH Office of Local Health Services and is supported by DOH resources and staff. Each LHD is responsible for completing its own report, annually.

### **PARTNERSHIPS**

The DOH maintains a close relationship with LHDs and their statewide association, NYSACHO. Formally organized in 1979, NYSACHO represents each of the 58 local health departments in New York State. The membership includes health commissioners, public health directors, deputy commissioners, environmental health directors and directors of patient services. NYSACHO acts as the advocate for public health in New York State and works to strengthen the provision of local public health programs and services.

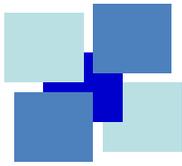
The DOH also partners with the University at Albany School of Public Health's Office of Continuing Education to assist the DOH achieve its continuing education and training goals for the state and local public health workforce. The SPH also sponsors the Northeast Public Health Leadership Institute (NEPHLI).

### **COSTS**

Detailed cost information is not currently available as this work is integrated into routine program management.

### **EVALUATION**

The APR and the measures are being tested by all LHDs and will be evaluated by the PMG for their usefulness, practicality, ease of use, problems and strengths. LHDs are currently in the process of submitting the APRs and the evaluations now.



# North Carolina Local Health Department Accreditation

## HISTORY

In 2002, the North Carolina Division of Public Health (DPH) and the North Carolina Association of Local Health Directors (NCALHD) initiated efforts to design a local health department accreditation system. The NCALHD Accreditation Committee included local health directors, DPH representatives, and North Carolina Institute for Public Health (NCIPH) staff. The committee reviewed existing accreditation models to develop an accreditation system and presented its final report and recommendations in June, 2003.

Subsequently, the Public Health Task Force 2004 Accreditation Committee developed a complete set of accreditation standards. NC conducted two pilot studies of the accreditation system, one in 2004 and one in 2005. Ten health departments participated in these pilots and all were accredited.

In 2005, the NC Legislature established a mandatory program requiring that all 85 local health departments be accredited by 2014. Accreditation is awarded by the North Carolina Local Health Department Accreditation Board.

## ACCREDITATION GOAL

To assure that local health departments have the capacity to provide a standard set of essential services on a statewide basis.

## ACCREDITATION BOARD

The NC Secretary of Health and Human Services appoints members of the Accreditation Board, which implements standards and awards accreditation status. Members include county commissioners, local boards of health, local health directors, NC DPH staff, and Department Environmental and Natural Resources staff.

## PROCESS

- Training
- Technical Assistance
- Agency Self-Assessment
- Site Visit to clarify, amplify and verify
- Action by Accreditation Board
- Appeals Process
- Corrective Action Plans
- Evaluation

## PARTNERS

The following partners work together to implement the North Carolina Local Health Department Accreditation program.

### **North Carolina DPH**

- Provides technical assistance through consultants
- Participates in Board

### **NCALHD committee and health directors**

- Prepare for Accreditation
- Participate on Board
- Promote continuing quality improvement
- Share best practices

### **NCIPH**

- Conducts and direct administration process
- Supports Accreditation Board
- Conducts evaluation

## STANDARDS

The standards are based on the 10 essential services and the NACCHO Operational Definition of a Local Health Departments and are divided into three components:

1. Agency core functions and essential services
2. Facilities and Administrative Services
3. Governance/Board of Health.

## FINANCES

The accreditation program receives \$700,000 per year from the Legislature

- \$25,000 for each health department undergoing initial accreditation
- \$350,000 to NCIPH for administration
- \$100,000 to DPH for technical assistance

## COSTS

The actual costs for a health department to prepare for accreditation are not determined.

## EVALUATION

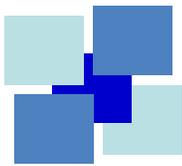
NCIPH Evaluation Services conducted comprehensive evaluations of the pilot processes. Evaluation results were used to improve system process and instruments. Ongoing system evaluation will include 1) monitoring system performance for quality improvement, 2) examining accreditation costs and benefits, and 3) identifying improvements in local health department capacity and performance.

## ENHANCEMENT PROJECT

- Public Health Improvement Fund –For accredited LHDs to address quality improvement initiatives identified during accreditation process.  
This initiative will provide a financial incentive for continuous performance improvements by local health departments
- Benefits and Costs of Accreditation  
This project will identify concrete benefits and costs of accreditation to local health departments.
- Standards Improvement—Board of Health Section  
This project will improve self-assessment standards and further standardize accreditation processes, particularly in the Boards of Health section.
- Technical Assistance
  - Accreditation Readiness Tool
  - DPH Technical Assistance to LHDs

## CONTACT

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NCIPH  
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**HISTORY**

Ohio is one of very few “home rule” states. There are more local health agencies than counties (currently 135 LHDs in 88 counties). These agencies work in collaboration with the State Health Department, which has some limited oversight, but are independent, self directing organizations. The state and local goals are not identical; however, they are both rooted in the Ten Essential Public Health Services (EPHS).

In the early 1980’s, the Ohio Department of Health (ODH), in cooperation with local health departments, established a performance standards program of minimum and optimal standards for local health districts (LHDs). This program required health departments to submit a checklist indicating compliance with a set of standards and a financial report to determine eligibility for an ODH subsidy. Often, the subsidy was the only type of flexible funding a LHD would receive; making it an incentive for completing the program. Every three years each department (district) would undergo an on-site review of the standards by their peers and an ODH coordinator. The peer review process proved to be too time-intensive and ultimately was not widely implemented.

In 1997, the state and local health departments jointly completed a comprehensive report on the state and local public health system, **The Ohio Public Health Plan**. The report called for a complete change in the original minimum and optimal performance standards for local health departments. As a result, in November of 2003, a complete revision of the standards - organized under *six broad goals* and *25 minimum standards* - was completed.

In the spring of 2004, the six new goals, 25 minimum standards and associated performance measures were pilot tested among 22 randomly selected LHDs using a state-developed, web-based assessment tool. The results of the field test were very favorable and the new standards using the online tool were officially launched in August, 2004.

**PROCESS**

Ohio has two distinct paths for public health agency performance assessment. At the local health agency level, the performance standards process is established in statute and requires local health agencies to measure their performance under the six broad goals and 25 standards using over 180 optional measures in order to qualify for a state subsidy. This process is an annual agency-based (jurisdictionally-based) performance measurement process grounded in a continuous quality improvement framework.

**LHD Performance Standards & the Ten EPHS**

<i>Ohio LHD Performance Goals</i>	<i># Standards Under Goal</i>	<i>Associated EPHS</i>
Protect People From Disease and Injury	5	1,2,3,6,8,9,10
Monitor Health Status	3	1,2,3,4,5,7,9,10
Assure a Safe and Healthy Environment	5	1,2,3,5,6,8,9,10
Promote Healthy Lifestyles	3	3,4,6,7,10
Address Need for Personal Health Services	4	1,3,4,5,7,8,9,10
Administer the Health District	5	1,2,3,4,5,6,8,9,10

Local health districts have maximum latitude in selecting from the list of measures provided in the web-based tool or inserting preferred measures from a variety of other sources – such as Healthy People 2010 measures, Mobilizing for Action through Planning and Partnerships (MAPP) measures, Protocol for Assessing Community Excellence (PACE) measures, or personalizing any measure by drafting additional “text” comments.

At the state agency level, the Director of Health established six broad goals and multiple annual performance priorities and associated performance measures. The state agency process is also an annual agency-focused and performance-based process. Over the past five years the agency has met or exceeded 80% of annual performance priorities.

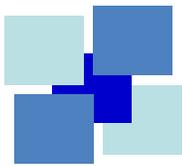
**COSTS**

- \$60,000: Start-up computer development costs
- \$6,000: Continuous maintenance and upgrade
- \$99,541: State’s expenses (largely personnel costs) for administering the local and state performance assessment
- Local health agency personnel costs associated with completing the on-line tool average around 1% of their annual personnel costs.
- State subsidy payments to the LHDs average twenty-nine cents per capita, roughly 1% to 2% of a local health agency’s annual budget.

**EVALUATION**

**State Health Agency Level:** Starting in 2005, the state agency has begun to use a new web-based tool, called *Performance Ohio*, to track annual performance measures. The State currently uses this tool to track selected Director’s performance goals.

**Local Health Agency Level:** Based on the 2005 aggregate data, the range of measures selected by each local district was evenly distributed. Ninety-two percent of the 135 health districts selected more than the minimum number of measures required in order to submit the report. The Standards program positions the LHD for future accreditation as well as increases its accountability for state subsidy.



## HISTORY

In 2003, the Vermont Department of Health (VDH), Vermont's governmental infrastructure for public health at the state and local levels, committed to the following: "We will succeed through excellence in individual achievement, organizational competence, and teamwork within and outside the Department of Health."

Vermont's public health system consists of one statewide governmental entity, the Vermont Department of Health. Its chief executive is the Commissioner of Health, who, with the approval of the Governor, is appointed by the Secretary of the Agency of Human Services. Vermont also has a State Board of Health whose members are appointed by the Governor. Vermont has no local or county boards of health. VDH directly operates 12 district offices, which are located throughout the state and compose Vermont's local public health infrastructure.

## GOVERNANCE

Responsibility for Vermont's public health mandate and the programs VDH administers is shared between the Department's central and local (district) offices.

## PERFORMANCE IMPROVEMENT ACTIVITIES

### *Performance Improvement Initiative*

In early 2004, the Commissioner hired VDH's first Public Health Quality Improvement Director (QI Director). In December 2005 VDH put in place an Operations and System Support structure. Its head, the VDH Operations Chief, and the QI Director co-lead the Performance Improvement Initiative (PII), a systematic approach for documenting aims and target populations, measuring progress against timeframes and measurable objectives, and engaging in a continuous process of assessment and refinement. The VDH Senior Management Team oversees the PII, which includes the Asset Management Inventory (AMI).

The goal of the Performance Improvement Initiative is to support the Department in managing organizational performance improvement through development and implementation of the following four focus areas:

- Performance Standards
- Performance Measurement
- Analysis and Report Production
- Quality Improvement Process

The Performance Improvement Initiative's initial purpose has been to carefully examine and document VDH's activities and priorities. As a result, the initiative's focus has been internal in the early phase. Since Vermont's public health system does not include autonomous local or county health departments, VDH has, thus far, not engaged external entities as partners in this initiative.

## COST

The Performance Improvement Initiative operates at a cost of \$160,000 per year which covers the salaries for employees dedicated to the performance improvement efforts.

### *Assessment Management Inventory (AMI)*

The AMI includes all 85 VDH programs, each one of which is overseen by one of VDH's Deputy Commissioners--for Public Health, Alcohol and Drug Abuse Services and Mental Health Services. Subsidiary to these 85 programs are 950 projects whose activities are tied to specific program aims. These numbers underscore the broad scope, diverse and numerous focus areas, and multiple funding sources that contribute to the complexity of the Department's role and several functions. The AMI exists as an automated database of standardized data about each VDH program and is available to staff via the VDH Intranet. Senior managers and program leaders use the AMI to edit measurable objectives data and produce reports and graphs that visually demonstrate program performance. In addition to evaluating the performance of their own program, access to the Asset Management Inventory aids program leaders in identifying opportunities to coordinate with other programs based upon common goals and target populations.

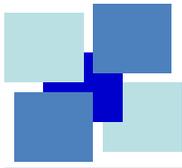
### *Pursuing Public Health Excellence (PPHE)*

A group of VDH district directors has developed a process for assessment and quality assurance broadly focused on local performance, management, and implementation of VDH programs. Much of this work has been concurrent with development of the Performance Improvement Initiative. The design draws key ideas and applications from the National Public Health Performance Standards, Assessment Protocol for Excellence in Public Health (APEX-PH), Mobilizing for Action through Planning and Partnership (MAPP), and other initiatives.

The foundation of this local initiative is each district office's self assessment, which consists of four essential elements:

- Comprehensive community health assessments
- A management assessment tool
- A quality improvement checklist
- Measurement of district office performance relative to AMI standards

The planning and design of PPHE, to date, have been accomplished due to the district-director workgroup's commitment to bringing the initiative to fruition in a no-additional-resources context. Progress toward actual implementation, however, will require additional resources to support comprehensive community health assessments and ensure complete and first-rate self-assessments and meaningful exchange with program staff.



# Standards for Public Health in Washington State

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## HISTORY

Washington began developing Standards for Public Health in the mid-1990's. By 2000, a set of standards and measures had been developed, reviewed and revised. The Standards were based on a framework that used five topic areas, but also drew from the Core Functions of Public Health and the Ten Essential Services. The development process relied on an ongoing Standards Committee, as well as multidisciplinary workgroups, comprised of state and local public health workers who represented all areas of the state. For each topic area, a single set of four or five Standards was selected, but measures for each Standard were tailored to state and local roles, acknowledging the different work expected at the state and local levels.

In 2000, the Standards and measures were field tested statewide for clarity, measurement ability and completeness. Following the field test, the measures were revised. In 2002, the Baseline Evaluation measured performance in all 34 Local Health Jurisdictions (LHJs) and in 38 programs within the State agency. On-site visits were made to each LHJ and DOH program. Prior to the assessment, special training sessions were held for state and local staff regarding both the content of the standards and the approach and process of the site visit to assess performance.

In 2003, the Standards Committee identified the need to create a regular schedule for assessing performance against the standards and set a goal to reassess every three years. Measuring administrative capacities was identified as a missing piece and work was begun to write Administrative Standards.

In 2005, using the Revised Performance Standards the second assessment was conducted. The 2005 assessment included 26 programs at DOH and 35 LHJs. The site visits also included a field test of the Administrative Standards and program specific reviews in the Environmental Health and Prevention/Promotion topic areas. The site visits were conducted in the spring and early summer and the results of this assessment will be available in late October.

For all three evaluations, the field test in 2000 and the two assessments in 2002 and 2005, the consulting firm of MCPP Healthcare Consulting (MCPP) played a major role in the work plan for the Standards Committee.

Goal - A predictable level of public health protection throughout the state

*"What every person has a right to expect."*

## PROCESS

- Reassess every three years
- Staff training in preparation process
- Self assessment phase
- Onsite review phase
- Reporting phase

## GOVERNANCE

### PHIP Board of Directors - Steering Committee

- Select Priorities

### Standards Committee

Implement Standards Workplan, including:

- Joint: Key Health Indicators Committee
- Joint: Workforce Development Committee
- Administrative Standards Workgroup

## STANDARDS

The Washington Standards are designed to be stretch standards that address five topic areas:

- Community Health Assessment
  - *Understanding health issues*
- Communicable Disease Protection
  - *Protecting People from disease*
- Environmental Health Protection
  - *Assuring a safe, healthy environment for people*
- Community Health Promotion
  - *Prevention is best: Promoting healthy living*
- Assuring Health Services and Access
  - *Helping people get the services they need*

## COSTS/FINANCES:

### Direct Costs

- Consultant time: Approximately \$100,000 to \$150,000 per year
- Training, site visits, reports, presentations
- Travel for participants – 15 days for peer reviewers

### Donated Costs – Staff time

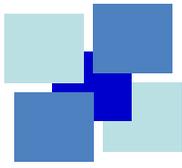
- Attend training
- Assemble documentation
- Receive and review reports

## EVALUATION

- Continuous improvement of the Standards and measurement process
- System measurement of our ability to perform the Standards
- Documentation of Local Health Jurisdiction and Department of Health use of the standards to improve the public health practice

## ENHANCEMENT PROJECT-

- Experience increased efforts in the state Department of Health and four local health jurisdictions
- Broaden communications and understanding
- Promote use of the standards for quality improvement across the public health system in Washington state



## HISTORY

Wisconsin has implemented a powerful, policy-based public health law approach to local health department certification. This process is called the *HFS 140 Local Health Department Review* and is named after the state's administrative rule promulgated under the authority of state statute, which specifies the required services for each of three levels of local health departments. The statutes are reflective of the core public health functions that have been mandated in state law since 1993.

The *HFS 140 Local Health Department Review* document was updated in 2004 based on changes to Wisconsin Administrative Rule and experience in using it for the first cycle of reviews in 1999 – during that year, one pilot review was conducted in each of the five Public Health regions. After final refinement of the review process, statewide implementation began in March 2005.

The current *HFS 140 Local Health Department Review* document is divided into 13 sections. The first section explores the structure of health departments and boards of health; the remainder of the document is divided by the Essential Public Health Services (EPHS). Wisconsin is unique in that it has defined 12 EPHS – the same ten used nationally, plus two unique to Wisconsin: 1) Assure access to primary health care for all and 2) Foster the understanding and promotion of social and economic conditions that support good health.

## CERTIFICATION AND REVIEW PROCESS

The local health department certification process has been driven and sustained through a state and local governance structure. It has been formatted using Wisconsin's 12 Essential Public Health Services and is directly linked to the State Public Health Plan (*Healthiest Wisconsin 2010*) developed during Wisconsin's participation in the Turning Point Initiative. Wisconsin assures that every local health department meets minimum standards in all of the essential public health services. The administrative rules that govern the certification process require the Division of Public Health to review all local health departments at least once every five years. The local health department review process consists of three levels of certification. Financial incentives are awarded by the state to those health departments who meet the requirements of Level II or III certification.

**Level I Certification:** The Local Health Officer serves as the lead agent responsible for gathering all necessary documentation and evidence needed for the review. An on-site review generally takes up to five hours to complete and state-level staff from the regional and central offices make up the review team. As part of the review process, Board of Health members and local government officials are encouraged to participate in the

review process. This provides an opportunity for them to hear a presentation on the strength of public health law in Wisconsin, and provides an opportunity for the Local Health Officer to share success stories with the local and state officials.

If the local health department successfully meets all performance standards in the *HFS 140 Local Health Department Review* document, they have met the minimum requirements for Level I certification.

**Level II Certification:** This more advanced certification moves beyond a statute/rule review to one that documents 1) connection of public health programs and services within the community, 2) delivery of services, 3) complexity of services, and 4) direct linkages with the health and infrastructure priorities set forth in the State Public Health Plan. To be certified as a level II health department, the health officer must meet the level II qualifications provided in statute and the health department must provide or arrange for at least seven programs or services, which address at least five of the eleven health priorities identified in the State Public Health Plan.

**Level III Certification:** Level III certification requires a Health Officer with a higher level of credentials, and documentation that the health department provides or arranges for at least fourteen programs or services, which address at least seven of the eleven health priorities in the State Public Health Plan. They must also be formally designated as "agents" of the state for inspection of licensed facilities (e.g., hotels/ motels, restaurants, schools, recreational camps).

## PARTNERS

- The Wisconsin Association of Local Health Departments and Boards;
- The Wisconsin Public Health Association;
- The Wisconsin Environmental Association;
- University of Wisconsin - School of Nursing;
- Joint Planning/Governance Committee consisting of a team of Local Health Officers convened by the Division of Public Health

## COSTS

The entire cost of performing the *HFS 140 Local Health Department Review* is absorbed by existing state and local funds. Local health departments report that a review requires approximately 80 hours of staff time to complete all of the necessary evidence and documentation. Estimating staff time, salary, and fringe, the cost is about \$7,500 per review.

## EVALUATION

Preliminary findings from an evaluation of the 2005 HFS 140 Local Health Department Reviews show that there are fewer deficiencies in the minimum requirements; local health departments are increasing the level of programming and the level of service; and there is a strong linkage between these improvements and the State Public Health Plan.