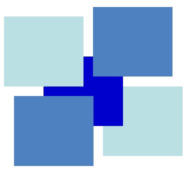

**Multi-State Learning Collaborative for Performance and Capacity Assessment or Accreditation of Public Health Departments**

# Florida
# County Health Department Performance Improvement Process

## 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 similar to Malcolm Baldrige criteria.
- In 1999, Florida piloted the National Public Health Performance Standards (NPHPS) State Assessment Tool, and repeated the assessment with all sixty-seven (67) county health departments in 2004-2005.

## 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 who have become an essential part of the Quality Improvement teams that review Florida's 67 county health departments. Some major steps in the process included:

- 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 the CHD, submitted information and conducted on-site reviews at CHD over a period of 3-5 days.
- The QI Central Office staff completed a report for the CHD documenting performance improvement issues and agreements.
- 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 departments, Central Office Program staff, and public health experts spent a collective 1,400 hours creating a self-assessment tool or Performance Report Card.

In August 2005, the Pilot Performance Improvement Process was deployed to twenty (20) selected CHDs, and each CHD completed the reporting tool designed to define organizational standards. Central Office Programs contributed supporting evidence and comments regarding the data entered into the 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. A statewide action plan was developed focusing on two opportunities for improvement: the performance improvement process and strategic planning.

Between January and April 2006, Performance Consultants facilitated on-site and off-site technical assistance to the twenty pilot CHDs based on needs determined from the CHD's data analysis. A tabulation of technical assistance needs among these pilot counties revealed clinic flow, strategic planning, development of a medical records review system, process management/mapping, and information linked to human resources as the most requested. Peer Reviewers were coordinated to fit the needs of the CHDs.

Best Practices were identified, and CHDs were encouraged to submit an application to share their practices and processes throughout the DOH.

Evaluations of the report card, on and off-site technical assistance, Peer Reviewers and overall performance improvement process were conducted. Some comments received included:

*Liked the use of red, yellow and green for trending.* (Report Card)

*The visit was beneficial, helpful, productive, and less stress-producing.* (Technical Assistance)

*Consider a tighter follow-up process with CHD to sustain improvement.* (Process)

Data from the evaluations was provided to the QI Advisory Council and used to revise the process, including the reporting tool.

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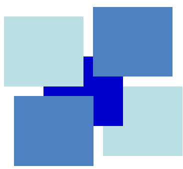




# Illinois
# Certification Process

## 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 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."[1] 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 Health Assessment of Needs (IPLAN) process
- IDPH reviews IPLAN submission for substantial compliance with Code
- LHD submits Certification Application
- If Certification Application provides self-affirmation of compliance with all practice standards, then IDPH director grants a 5-year certification to the LHD

## GOVERNANCE

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

- Develops, enhances and maintains IPLAN data system
- Conducts training and provides technical assistance
- Reviews submitted assessments and plans for substantial compliance with the administrative
- rules (every 5 years) and provides follow-up technical assistance

## STANDARDS

LHDs must assert that they meet the following set of 10 public health practice standards that are set in Illinois code:

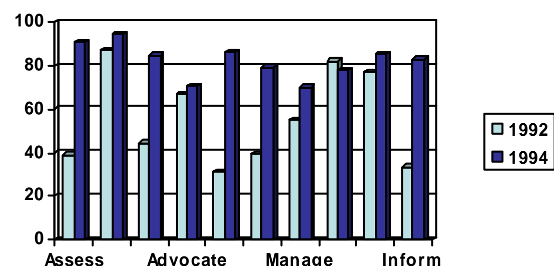
1. Assess community health needs
2. Investigate hazards within the community
3. Analyze identified health needs for their determinants
4. Advocate and build constituencies for public health
5. Prioritize among identified community health needs
6. Develop policies and plans to respond to priority needs
7. Manage resources and organizational structures
8. Implement programs and services to respond to priority needs
9. Evaluate programs and services
10. 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, Local Health Protection Grant (recipients are certified local health departments) and Estimated local IPLAN costs = $10,000-$15,000 in 1994

## EVALUATION

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

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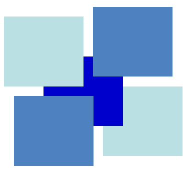
[1] Title 77: Public Health, Chapter 1: Department of Public Health, Subchapter H: Local Health Departments. Part 600: Certified Local Health Department Code. Section 600.100: Statement of Purpose. http://www.ilga.gov/commission/jcar/admincode/077/07700600sections.html





# Kansas

# Establishing an Assessment/Performance Measures System

## 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 NPHPSP 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 under-funded. 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 NPHPSP 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.

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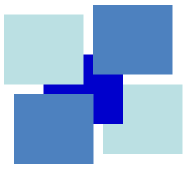



# Michigan
# Local Public Health Accreditation Program

## 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 (APEX*PH*) 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 (LHD) 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 LHDs and evaluating and accrediting LHDs 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 LHD to meet minimum administrative capacity requirements. The Program also conducts performance reviews for contractual local public health operations services and some categorical grant funded services provided by a LHD. The review process draws from a pool of approximately 50 state-agency reviewers, of which about 15 are used for each on-site review. The review cycle is 3 years and there are three steps to Accreditation:

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

An LHD receives one of two designations—Accredited or Not Accredited.

Michigan has reviewed each local health department twice and is in the third cycle. More than 100 on-site reviews have been conducted. All 45 LHDs are currently accredited.

## COSTS/FINANCES

The Michigan Department of Community Health (MDCH) is the lead agency and provides oversight and annual funding ($220,000 via contract to the Michigan Public Health Institute) for day-to-day program operations. Since inception approximately $2,155,000 of state funding has been dedicated.

LHDs and State Departments incur significant in-kind costs related to preparation and participation.

## GOVERNANCE

The governing authority is the MDCH. Three state agencies comprise the accrediting body:

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

An Accreditation Commission maintained by the Michigan Public Health Institute serves as the advisory body.

## 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 program is based on Minimum Program Requirements (MPRs), which are:

- Constructed through a formal state/local process (Policy 8000)
- Based on law, rule, department policy or accepted professional standards
- Composed of 122 standards and 202 measures

## EVALUATION

Accreditation Quality Improvement Process (AQIP)

- Began in 2003 with a locally-driven workgroup convened by MDCH (all partners represented)
- Used a state-wide survey to learn what/how to improve
- Produced 44 recommendations which have been implemented

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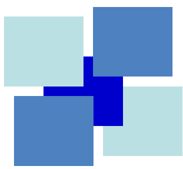

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# Minnesota

# Local Public Health Planning and Performance Measurement Process

## HISTORY

In 2001, a state-local work group began a strategic planning process to strengthen the statewide public health infrastructure. A survey conducted as part of the 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.

Key concepts from the strategic plan were codified by the Minnesota Legislature in 2003 through significant revisions to the Local Public Health Act. In 2004 and 2005, intensive work by state and local partners resulted in the development and pilot testing of standards and performance measures. In 2006, new components were added to the longstanding local public health planning process to address capacity assessment and capacity improvement planning; the performance measures were revised; and an accountability review process was finalized.

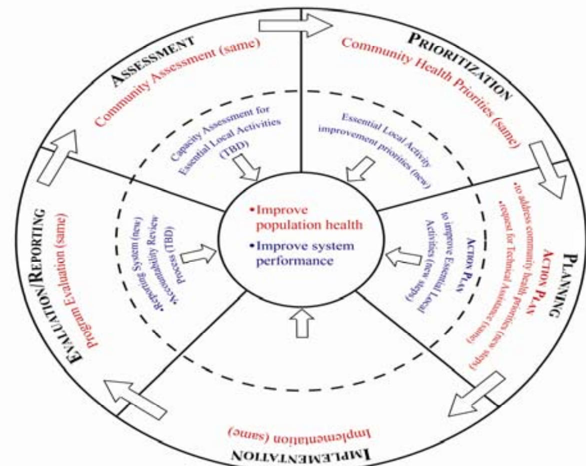
Several national initiatives including HHS Public Health in America (essential services), NPHPSP, and the NACCHO Operational Definition of a Local Health Department informed this work.

## 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 have been developed to help local health departments identify and address priorities for improvement, with consultation from the Minnesota Department of Health (MDH). The Local Public Health Act sets up an accountability framework that stresses quality improvement over time.




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

## COSTS/FINANCES

The primary costs involve staff time at the MDH and local health departments. The first phases were partially supported by the RWJ Foundation's Turning Point Program. Federal Preventive Health and Health Services Block Grant funds currently play a primary funding role at the state level. Flexible state funds (the Local Public Health Grant) provide a state subsidy for local public health operations.

## EVALUATION

All local health departments report on the performance measures as well as financial, staffing and statistical data. Those data provide a basis from which to evaluate future efforts, as well as 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 by the MDH.

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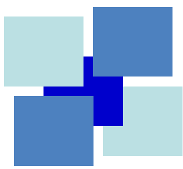



# Missouri
# Voluntary Accreditation Program for Local Public Health Agencies

## 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 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 they wish to apply for:

- Primary Accreditation - 230 Performance Measures
- Advanced Accreditation - 305 Performance Measures
- Comprehensive Accreditation - 322 Performance Measures

## 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 two sections:

- Standards for Agency Infrastructure
- Standards for Agency Performance

## 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.

| Type of Accreditation | Application Fees[2] | Accreditation Fees |
|---|---|---|
| Primary | $450 | $2,000 |
| Advanced | $700 | $3,000 |
| Comprehensive | $900 | $4,500 |

Additional funding for the program includes:

- Heartland Center for Public Health Preparedness & Workforce
- Accreditation Fees
- RWJF Multi-State Learning Collaborative
- Missouri Foundation for Health
- Missouri Department of Health & Senior Services

## 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

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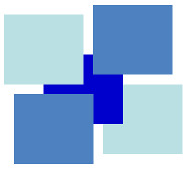
[2] Paid only once with initial application unless there is a break in accreditation status.



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# New Hampshire
# Performance Management through Partnerships

## 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, and the New Hampshire Institute for Local Public Health Practice at the Manchester Health Department (NHILPHP) 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 their contractors, the programs are in varying forms of sophistication in how the data are collected and utilized for performance enhancement.

At the local level, each of New Hampshire's 14 Public Health Networks (PHN) has completed a local public health systems assessment using the NPHPSP-local instrument. Each of the networks has developed a Public Health Improvement Plan (PHIP) based on the results of the assessment.

At the state level, PHIAP identified six strategic public health priorities following the use of the NPHPS state instrument. Strategic action plans have been developed for each priority and will be integrated into a performance improvement plan.

## STANDARDS

DPHS uses more than 30 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

**Community Health Institute** (CHI) works in partnership with DPHS on key performance improvement initiatives involving external state and local partners. This work includes assisting local public health systems with implementation of assessment activities based on national standards and associated development of local public health improvement processes.

**Division of Public Health Services** leads New Hampshire's performance improvement initiatives at the state and local level to improve public health capacity and quality through the application of standards, measures, reporting and improvement processes.

**The New Hampshire Institute for Local Public Health Practice at the Manchester Health Department (NHILPHP)** works to assure a competent local public health workforce through provision of core training programs for practicing local public health professionals. The NHILPHP provides a vehicle by which New Hampshire is addressing core public health workforce competencies that are prerequisite for improvement in the quality of public health practice and for moving toward workforce credentialing and agency accreditation

## 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.
CHI also commits staff and associated resources in their role as technical assistance provider to the PHN partners.

## EVALUATION

In June 2005, 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.

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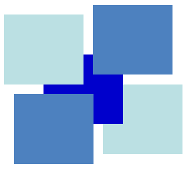



# North Carolina
# Local Health Department Accreditation

## HISTORY

Beginning in 2002, the North Carolina Division of Public Health and the North Carolina Association of Local Health Directors, with support from the North Carolina Institute for Public Health, developed a standards-based system for accrediting local public health departments. These partners created the basic system and conducted two system pilots.

The focus of the now legislatively mandated North Carolina Local Health Department Accreditation (NCLHDA) is the capacity of the local health department, as defined by the National Association of County and City Health Officials *Operational Definition of a Functional Local Public Health Agency*, to perform at a prescribed, basic level of quality the public health functions and the ten essential services**.** NCLHDA links basic standards to current state statutes and administrative code, and Divisions of Public Health and Environmental Health contractual and program monitoring requirements. As of January 2007, 25 of the 85 NC LHDs have been accredited.

## PROCESS

- 10 initial and 6 reaccreditation LHDs per year
- Agency Self-Assessment
- Site visit to clarify, amplify and verify
- Adjudication by Accreditation Board
- Appeals Process
- Corrective Action Plan with up to 2 years to complete for health departments that receive conditional accreditation
- Evaluation

## PARTNERSHIP

These partners implement the program

***North Carolina Department of Public Health***

- Provides technical assistance through consultants
- Participates in Board
- Through DHHS appoints Accreditation Board

***NCALHD committee and health directors***

- Prepare for Accreditation
- Provide input on changes needed to benchmarks and activities
- Participate in Board
- Promote continuing quality improvement
- Share best practices

***NCIPH***

- Functions as Accreditation Administrator
- Supports Accreditation Board
- Conducts evaluation

## STANDARDS

Benchmarks are organized into 4 standards:

1. Essential Services;
2. Facilities and Administrative Services;
3. Core Staffing and Training;
4. Governance/Board of Health

## COSTS/FINANCES

NCLHDA is funded at $700,000 per year

- $25,000 for each health department undergoing initial accreditation
- $350,000 for administration
- $100,000 for DPH accreditation consultants

## EVALUATION

NCIPH Evaluation Services conducts an annual system evaluation for continuous quality improvement purposes and to examine system impact.

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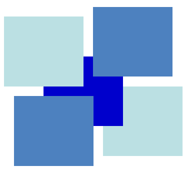




# Ohio
# Public Health Agency Performance Assessment

## HISTORY

Ohio is a "home rule" state. There are 134 local public health agencies of which 88 are considered county and 46 are city jurisdictions. 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 an application indicating compliance with a set of standards and a financial report to determine eligibility for state subsidy. Often, the subsidy was the only type of flexible funding a LHD would receive; making it an incentive for completing the program. At least every three years a department would undergo an on-site review of the standards by LHD peers and an ODH coordinator. The peer review process proved to be time and resource-intensive. On-site reviews were discontinued in favor of revision and updating the standards.

In 1997, ODH and state public health organizations jointly completed a comprehensive report on the state and local public health system, **The Ohio Public Health Plan**. One initiative of the report outlined 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 in August 2004, the new standards process commenced using an on-line reporting tool for the six goals and twenty-five standards with the respective performance measures.

## PROCESS

Ohio has two distinct paths for public health agency performance assessment. The state and local goals, though distinct, are both founded in the Ten EPHS. 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

| *Ohio LHD Performance Goals* | *# Standards Under Goal* | *Associated EPHS* |
|---|---|---|
| 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 ASSOCIATED WITH ODH'S LHD IMPROVEMENT STANDARDS

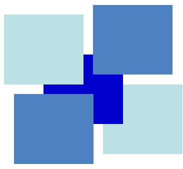
- $60,000: Start-up computer development costs
- $6,000: Continuous maintenance and upgrade
- $99,541: State's expenses (largely personnel costs) for administering the local and state performance assessment
- Local health agency personnel costs associated with completing the on-line tool average around 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, ODH has begun to use a new web-based tool, called *Performance Ohio,* to track annual performance measures. The State uses this tool to track selected 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 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.

*The MLC is funded by the Robert Wood Johnson Foundation and managed by the National Network of Public Health Institutes*



**Multi-State Learning Collaborative for Performance and Capacity Assessment or Accreditation of Public Health Departments**

# Washington
# Standards for Public Health

## 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 to perform and completeness. 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.

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 visit results of this assessment were analyzed, a report summarized the results and individual results were distributed.

In 2006, the Standards for Public Health were completely revised, a new structure was created, and the administrative capacities were addressed in the measures. A set of Local Public Health Indicators were proposed, and a quality improvement collaborative focused on the high priority of improving performance with goals, objectives and performance measures.

Goal for the Standards - 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, receive overall reports

**Performance Management Committee**

Implement Standards Workplan, including:

- Training and assessment schedule
- Input to and Oversight of products
- Participate in joint work with other committees

## STANDARDS

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

Standard 1: Community Health Assessment
Standard 2: Communication to the Public and Key Stakeholders
Standard 3: Community Involvement
Standard 4: Monitoring and Reporting Threats to the Public's Health
Standard 5: Planning For and Responding to Public Health Emergencies:
Standard 6: Prevention and Education
Standard 7: Helping the Community Address Gaps in Critical Health Services
Standard 8: Program Planning and Evaluation
Standard 9: Financial and Management Systems
Standard 10: Human Resource Systems
Standard 11: Information Systems
Standard 12: Leadership and Governance

## COSTS/FINANCES:

**Direct Costs**

- Consultant time: Approximately $70,000 to $150,000 per year
- Training, site visits, reports, presentations and consultation to Performance Management Committee
- Travel for participants – 15 days for peer reviewers
- Personnel: $40,000

**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
- Reports of Documentation of Local Health Jurisdiction and Department of Health use of the standards to improve the public health practice

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