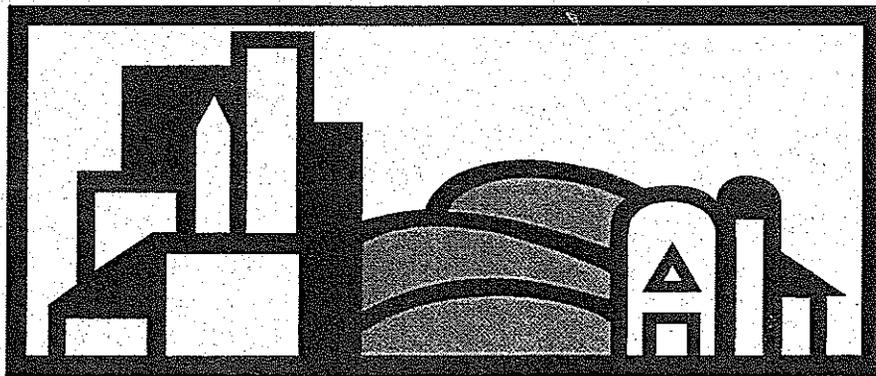
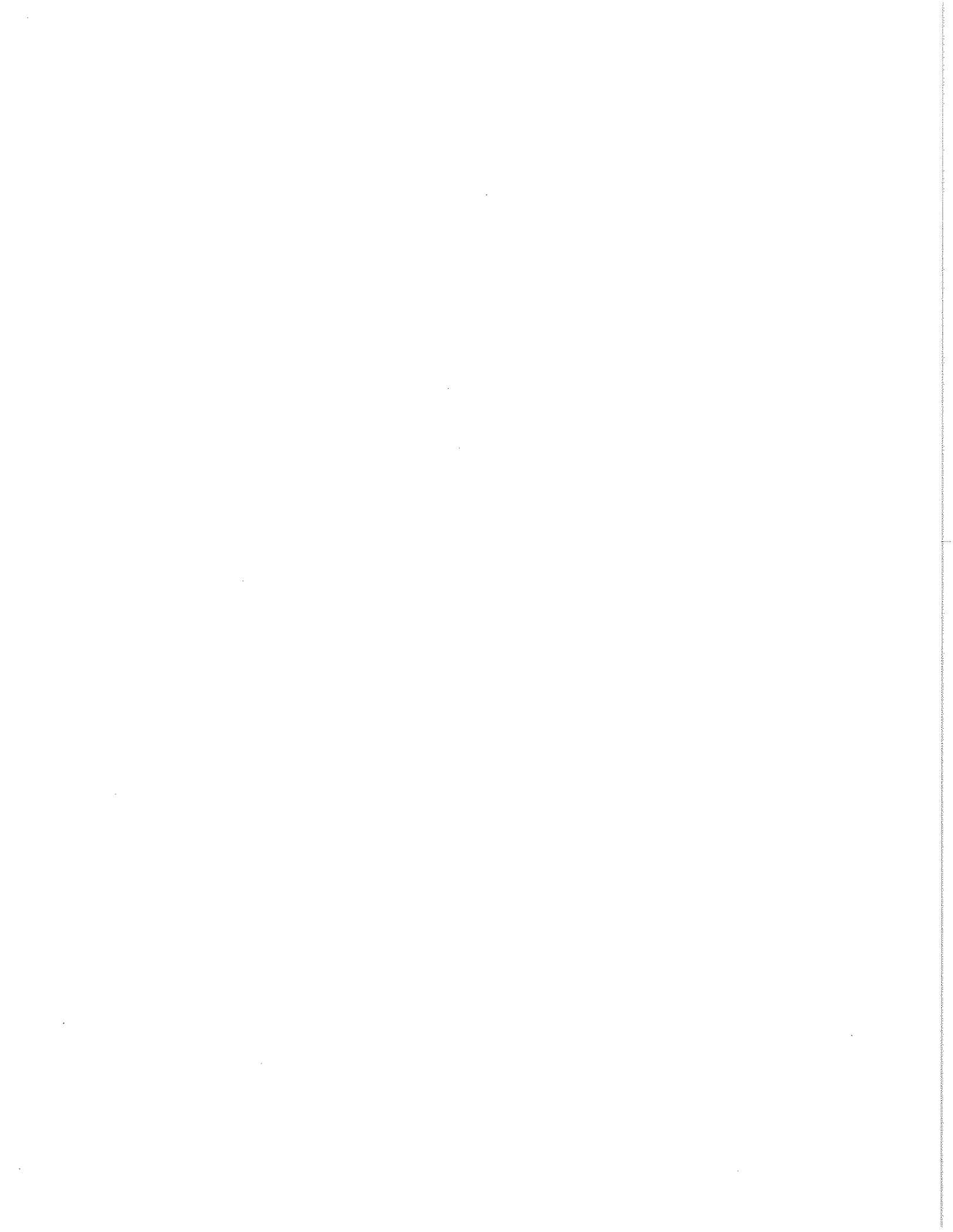


Local Public Health Accreditation



A report by the
State CHS Advisory Committee
Local Public Health Accreditation
Work Group

December, 1998



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Community Development Section
Community Health Services Division
Minnesota Department of Health

Executive Summary

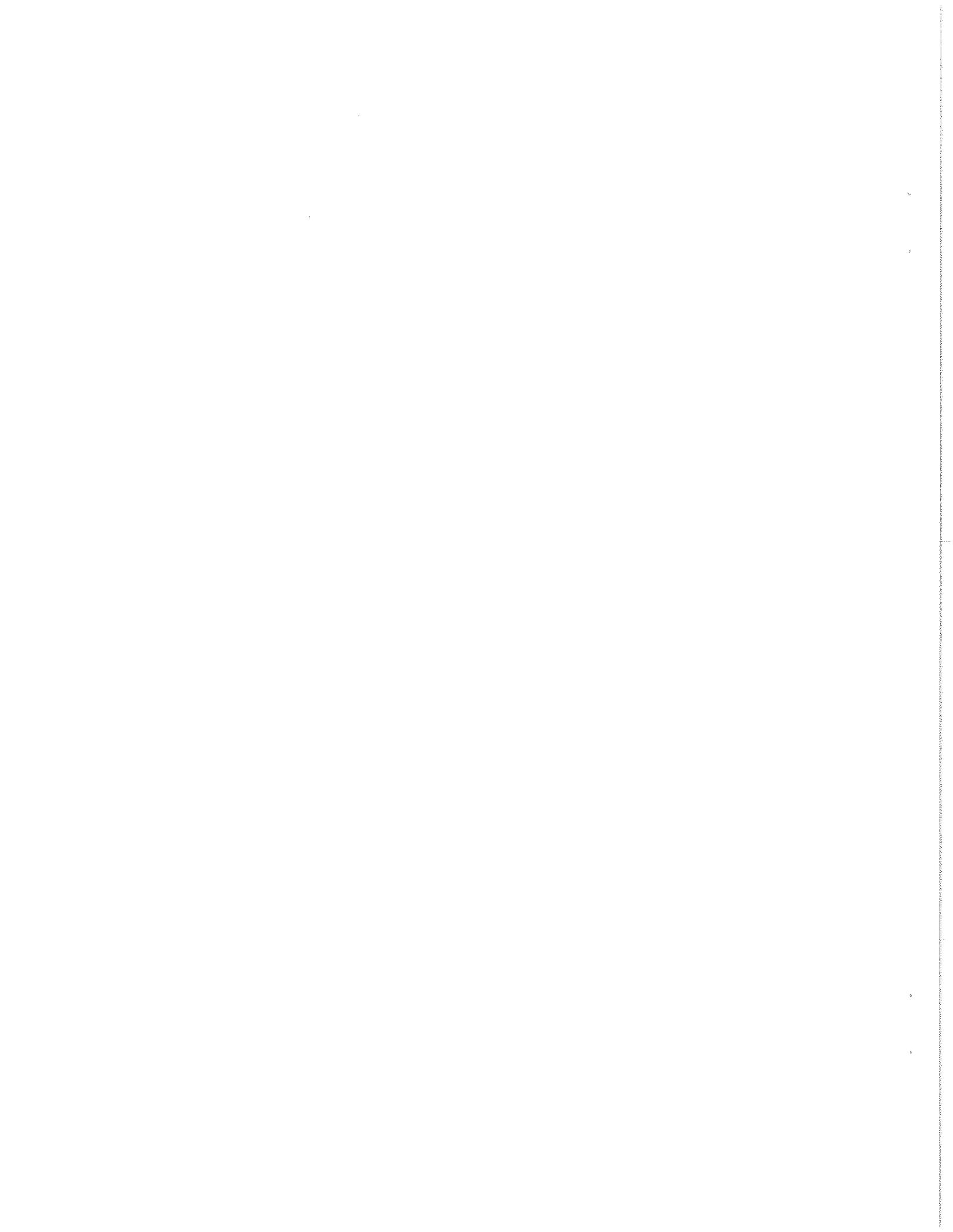
Several national organizations are currently developing performance measures and collectively are considering a process of national accreditation. In order to proactively consider how this activity might affect Minnesota's public health system, the State Community Health Services Advisory Committee (SCHSAC) authorized a work group in 1998 to study the issue of accreditation of local health departments and how Minnesota's system stands in relation to other states. The attached summary of findings, recommendations and background paper have been prepared to address this charge. A review of national discussions, states' efforts, and a review of Minnesota's local system suggests that accreditation is but one way to demonstrate accountability and improve performance. In fact, a continuum exists to describe the various means of establishing expectations between state and local public health units.

In each approach along the continuum, there are some common objectives. These include:

- assuring accountability for public resources to policy makers and local communities;
- establishing expectations for performance or practice;
- providing ongoing feedback regarding how individual public health departments "measure up" to established expectations; and
- identifying methods to improve performance.

As the background paper indicates, there are various ways to achieve these objectives. The work group considered which approach would be most likely to succeed within Minnesota's public health system. The work group agreed that local health problems, as well as community resources, vary throughout the state and a strict "one size fits all" approach to demonstrate accountability would not succeed. Thus, the work group did not foresee accreditation as the best solution for Minnesota's public health system at this point. However, there was agreement that establishing and communicating clear expectations for performance and organizational capacity would provide valuable information for decision-makers and practitioners. This in turn would improve public health practice in Minnesota.

The work group has recommended several steps that SCHSAC should take to develop and implement performance measures to be used by MDH and local public health agencies. In addition, the work group recommends continuing to monitor and participate in national discussions of accreditation and performance measurement.

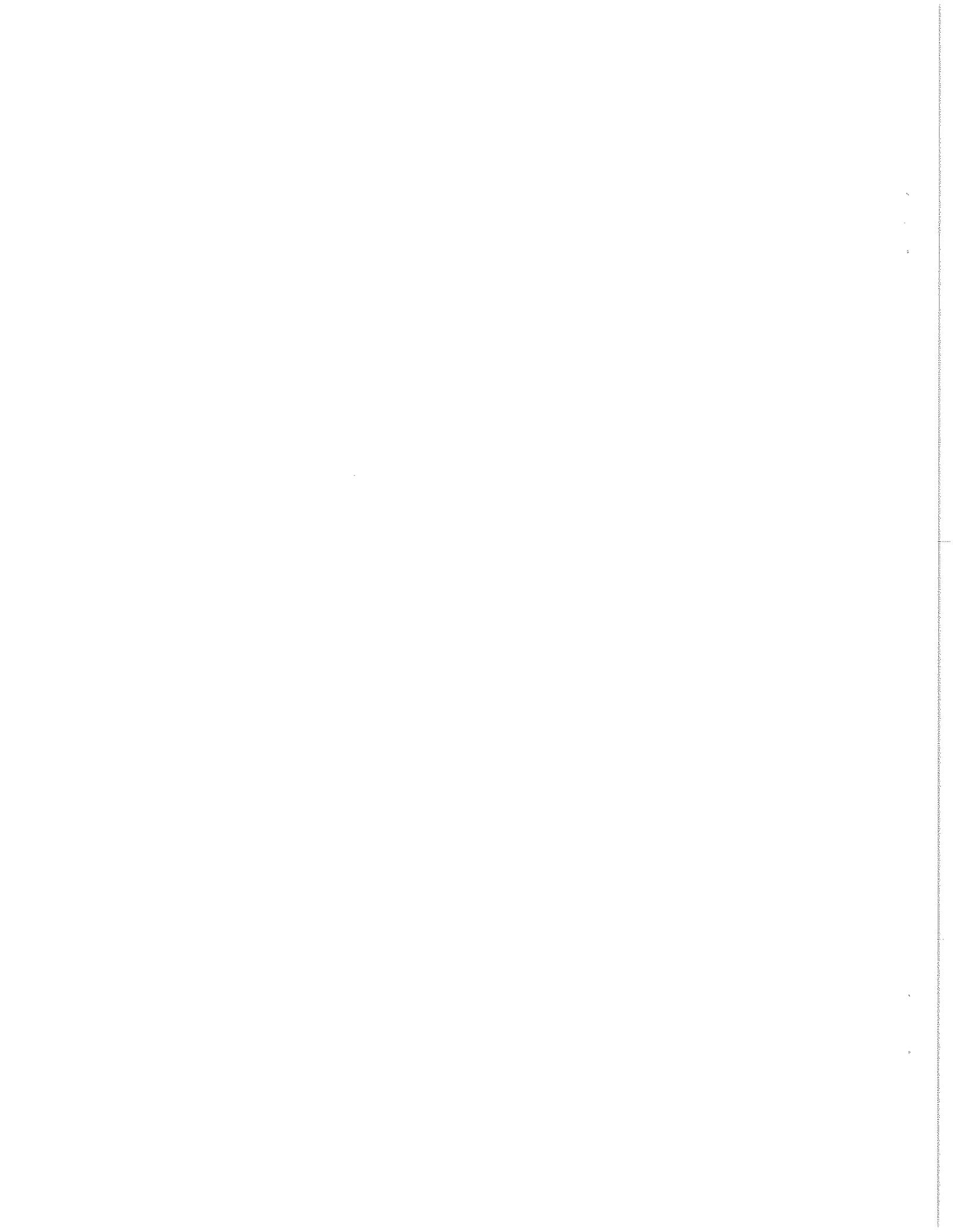


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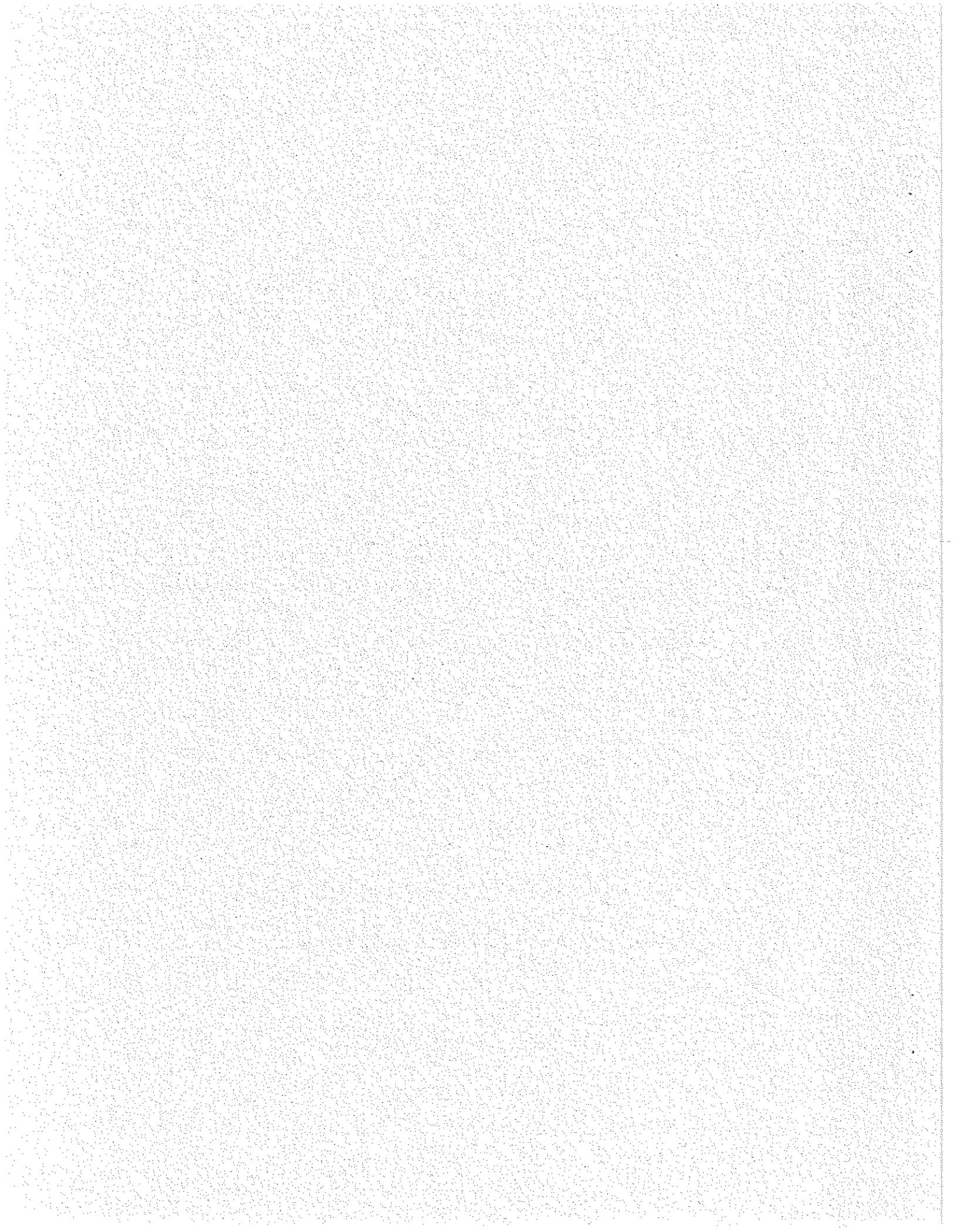
Local Public Health Accreditation

Findings and Recommendations

by the
State CHS Advisory Committee
Local Public Health Accreditation
Work Group

December, 1998

Community Development Section
Community Health Services Division
Minnesota Department of Health



Findings and Recommendations

Accreditation Work Group

State Community Health Services Advisory Committee

The Accreditation Work Group of the State CHS Advisory Committee (SCHSAC) was formed to consider the issue of accrediting local health departments in Minnesota. Accreditation is an issue that is currently being considered by many national organizations; thus SCHSAC thought it important to consider what the possible implications may be for Minnesota. The work group was charged to develop a background paper and recommendations on the impact accreditation may have on local public health in Minnesota. The work group met three times between June and November, 1998. The following is a summary of how the work group fulfilled each part of its charge.

Summary and Findings

Charge 1: Develop a discussion paper clarifying national discussions on local public health system accreditation and how Minnesota's system stands in relation to other states.

A background paper was prepared by staff to aid in the work group's discussion. The following presents a synopsis of this background paper's components. The work group's conclusions and recommendations for future action are presented at the end of the summary.

Overview

Accreditation is defined as:

a "conformity assessment process" in which an organization uses experts in a particular discipline or field to define standards of acceptable operation/performance and to measure compliance with them

Accreditation typically refers to a standard setting and review process (Hamm). It functions as a way to achieve accountability by holding community entities answerable for actions for which they have accepted responsibility (Durch, Bailey, Stoto). The critical question that the work group considered was: To what extent would an accreditation process help Minnesota's local and state public health agencies demonstrate the same level of accountability being demanded of other organizations in an evolving health care system?

Accreditation in Health Care

Accreditation has a long history in the health care industry. It is widely utilized as a method to assure consumers and/or payers of acceptable levels of service from providers. Most often, accreditation is performed by members of the industry itself as a way to “self-police” in lieu of direct regulation by an outside authority. In the health care industry, by far the largest and oldest such organization is the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). There is currently no organization which looks at accreditation of governmental public health agencies. One organization, the Community Health Accreditation Program (CHAP), which is a subsidiary of the National League for Nursing, does accredit all home and community-based health care organizations but historically has focused on the home care industry. As of January, 1998, CHAP began marketing a set of standards specific to public health organizations.

All accrediting bodies use a similar process. Performance expectations, often called *standards* or *criteria*, are negotiated between the industry and its accrediting body. Indicators are developed to determine whether an organization meets the standards. Standards can be established as one of the following:

- minimum expectations,
- expectations reflecting excellence in performance, or
- a set of graduated expectations ranging from “good” to “better” to best.”

The expectations are usually a combination of :

- capacity measures (i.e., appropriate governance and human, physical, and financial capital),
- process measures (i.e., doing the right thing at the right time and in the right way), and/or
- outcome measures (looking at results).

Using these consensus standards, the organization to be accredited usually carries out an extensive self-assessment first. This is followed by an on-site review by the accrediting body. Results of the two assessments are compared and a plan of action developed, either for remediation if problems are found or for service enhancement if not.

Accreditation is costly both in terms of resources required to prepare for the process and carry out recommendations and in fees required to become accredited. (For example, \$1000 application fee plus a base charge of over \$10,000 for a survey team site visit for JCAHO; \$1500 application fee plus annual fees ranging from \$3150 to over \$23,000 for CHAP.) The incentive in almost all cases is that accreditation status is required for eligibility for funding.

Accreditation and Performance Measures in Public Health

National Guidelines, Licensure and Certification

The Centers for Disease Control (CDC), in conjunction with other national organizations, has published several documents which are intended to guide or shape state and local public health performance. Examples include the editions of *Model Standards*, the several editions of *Healthy People* national health goals and objectives, and the *Assessment Protocol for Excellence in Public Health (APEXPH)* guide, including a supplement on environmental health assessment. All are voluntary; MDH and local public health agencies in Minnesota have not widely adopted or utilized these guides but rather developed our own versions of such guidelines.

Nationally, local public health agencies providing home care services and desiring reimbursement from Medicare, Medicaid (in some states) or other funding sources have acquired necessary Health Care Financing Administration (HCFA) certification and state licensure. Currently CDC's Public Health Practice Program Office is promoting the concept of developing and enacting public health performance standards with accreditation as a formal vehicle.

Other States

Around the country, states have employed a variety of mechanisms to ensure accountability. In Washington state in the early 1990s, for example, 39 performance indicators were developed and tested relating to that state's health improvement plan. They found that in order to make the indicators flexible enough to allow for differences across local agencies, the process became so subjective that comparison was difficult. Oregon has required a mandatory local agency review which they link to eligibility to receive state funds. In South Carolina, the state health agency itself is a certified Medicare home care provider with local agencies as branches; they have utilized the CHAP accreditation program for 25 years. Illinois has a long history of certifying local agencies as a condition for receiving state and federal funds. They revised their system in 1993 and is now based on 10 standards reflecting the core public health functions. In Michigan, a new accreditation process has been developed based on the state's public health code. It is currently being field tested and, once operational, will replace the current system of certifying each agency separately for each categorically-funded program. A legislatively created private, non-profit organization is developing the process and will serve as the accreditation body.

All states considered cited the extensive personnel time required to prepare and participate in the review process. However, all also indicated the vast amount of learning that occurs

during the self-assessment and external review. These states suggested that the increased dialogue between the agency and its reviewers around performance expectations has led to greater knowledge and understanding of performance expectations, rather than the performance standards in and of themselves.

Minnesota

In Minnesota, local government's responsibilities and authorities are broadly defined in the Local Public Health Act (MS145A), and further established in the related rule. Guidelines developed by MDH in cooperation with local public health boards and staff provide further clarification of common expectations. Primary examples include:

- *CHS Planning and Reporting Manual*
- *Guide for Promoting Health in Minnesota*
- *CHS Administration Handbook*
- *Environmental Exposures* handbook for PHNs
- *DP&C Common Activities* document
- *A Guide for Controlling Public Health Nuisances*

Programmatic performance expectations are established in each agency's CHS plan and further detailed in individual grant applications. Consultation, training, and technical assistance provided by MDH can help agencies achieve these expectations. The law contains provisions to withhold the CHS subsidy if an agency does not comply with the requirements of the law. However, historically sanctions have not been imposed if an agency did not meet its own performance expectations. Although the law contains requirements of local government for basic health protection, the success of the CHS system depends largely on the voluntary commitment of local government to public health. There has been periodic consideration of whether a more uniform set of expectations, either voluntary or mandatory, should be established statewide. The *Common Activities for Disease Prevention and Control* approved by SCHSAC in 1998 serves as a potential prototype. However, commitment to local flexibility in Minnesota remains strong, which has created a tension between desire for local control and desire for standardized level of quality.

Minnesota's public health system has several characteristics which have fostered effective public health practice:

- the early development of broad-based statutory authority for public health;
- considerable local financial commitment to public health;
- the evolution of a comprehensive community assessment and planning process;
- a long-standing history of state and local government working in partnership to achieve public health goals.

These features may have provided Minnesota with a stronger foundation for public health than in many other states, which may reduce the perceived need for accreditation.

A review of state and national experiences suggest that accreditation is but one means of demonstrating accountability. In fact, a continuum exists to describe the various means of establishing expectations between state and local public health units. On one end is Minnesota's model, where the framework for the relationship is embedded in the authorizing legislation and the expectations are broadly defined and left to the partnership to negotiate on an on-going basis. The most common method is that of establishing multiple program-specific contracts between the state and local agencies, each including, to various levels of specification, the performance expectations. On the far end are those states where a formal process of review exists (accreditation or certification).

Whatever approach is used, there are some common objectives. These include:

- **assuring accountability for public resources;**
- **establishing expectations for performance or practice;**
- **providing ongoing feedback regarding how individual public health departments “measure up” to established expectations; and**
- **identifying methods to improve performance.**

As the background paper indicates, there are various ways to achieve these objectives. What approach is most likely to succeed within Minnesota's public health system? Minnesota's system largely depends on the voluntary participation of local government (which overall provides far more than the required local match for the CHS subsidy). The work group agreed that local health problems, as well as community resources, vary throughout the state and a strict “one size fits all” approach to demonstrate accountability would not succeed. However, there was agreement that establishing clearer expectations for performance and organizational capacity would provide valuable information for decision-makers and practitioners that would improve public health practice.

Charge 2: Facilitate focus group discussions with local public health representatives on the impact, benefit, and barriers of public health accreditation on Minnesota's public health system.

At its September meeting, the work group concluded that the national discussion on accreditation appeared to have been refocused on the development of performance measurement. Consequently, they determined **it was too early to pursue focus group discussions**. The work group suggested instead that its final report include a recommendation to share its conclusions to date and continue to monitor and provide input to national discussions. SCHSAC approved this change at its September 16 meeting.

Charge 3: Develop recommendations for how Minnesota's public health systems should engage in national discussion on accreditation, and position itself to respond if a national accreditation program is enacted.

The work group considered how discussions at the national level and experiences of other states might provide assistance in defining expectations for effective public health performance in Minnesota. As a result of its research and discussion **the work group concluded that accreditation is not the best method to assure accountability and improve performance for Minnesota.** In fact, the work group suggested that the effort and costs to become an accredited entity may outweigh the benefits derived. As Daniel Fox, president of the Milbank Memorial Fund, is quoted as saying in a recent article, "Accreditation, like war, is politics by other means...Accreditation, whether voluntary or mandatory, by national agencies or state government, is a marginally helpful way to keep programs accountable to somebody--but do not expect too much."

Although the work group did not foresee accreditation as the solution to ensuring acceptable performance at this point, **they agreed that establishing consistent program performance expectations and related measurable indicators could promote consistent and improved public health practice in Minnesota.** The following recommendations are intended to identify next steps toward this objective.

Recommendations

Recommendation 1: SCHSAC should undertake a process to develop, implement, and monitor measures and indicators of effective program performance.

Rationale: While there is not consensus about the need for accreditation at the national level, there is much discussion about the need for governmental public health agencies to be held accountable to decision-makers such as county boards and community health boards. Consistent program performance measures with measurable indicators is one accountability method frequently discussed. In some cases, such indicators have been associated with overall health status measures for populations, such as those established in the *Healthy People for 2010 Objectives* or targets established in states' health improvement plans (such as the *Healthy Minnesotans Public Health Goals*). In other cases, they are tied to program performance expectations mutually established between the state and local public health agencies. In Minnesota, establishing program performance measures is the logical sequel to selecting and carrying out strategies to address public health problems, which is a key component of the upcoming CHS community assessment and program planning and evaluation cycle.

This process should include: a review of similar work underway in other states; a review of similar work proposed or underway in Minnesota's local public health agencies; a report of expected or known costs and benefits to be derived from establishing such a process; and the extent to which program improvement resulted. To make the task more manageable, indicators could initially be designed and tested for the two most frequently listed activities (strategies) described by local agencies in their 1996-1999 CHS Program Plans, which were submitted to MDH in October of 1995.

Recommendation 2: SCHSAC should develop, adapt or utilize tools to assist local public health agencies assess their capacity to carry out core public health functions/essential public health services and develop plans for quality improvement processes.

Rationale: The capacity to look inward and adjust for improvement is a mark of a highly competent organization. Although total quality management/continuous quality improvement management techniques have not been widely adopted by local governments, such methods have been implemented widely by many of public health's local partners, as well as providing valuable internal organizational feedback. Willingness to participate in quality improvement processes would be seen as an asset by other community partners. In order to utilize such techniques, however, indicators of capacity must be identified. One existing model to consider is the APEXPH/Part I (Organizational Capacity Assessment) or its successor (APEX/CPH) which is currently under development. Such tools could be used by local public health agencies to identify areas for improvement and target future resources.

Recommendation 3: MDH should continue to monitor national discussions of accreditation and performance measurement and provide Minnesota's perspective to these discussions.

Rationale: The national discussion of accreditation and performance measures will continue. Representatives from Minnesota can provide a valuable perspective based on Minnesota's strong state-local public health partnership and current work on strategies and performance indicators in selected areas. Minnesota should continue to be involved in the national discussion, including possibly participating in pilot-testing national prototypes of performance measurement tools. Information regarding national discussions may be shared through the *CHS Mailbag*, electronic communication, and periodic updates with SCHSAC, LPHA and AMC.

Recommendation 4: The work group should reconvene in 1999 or subsequently to review these recommendations if future action is needed.

Rationale: Further progress at the national level may require that additional discussion is needed. In addition, several areas were discussed, but not resolved by the work group, including the following:

- creating a higher standard for review of CHS plans in exchange for increased funding;
- recognizing excellence in a local agency;
- conducting a local on-site review in lieu of multiple reports for grant-funded programs.

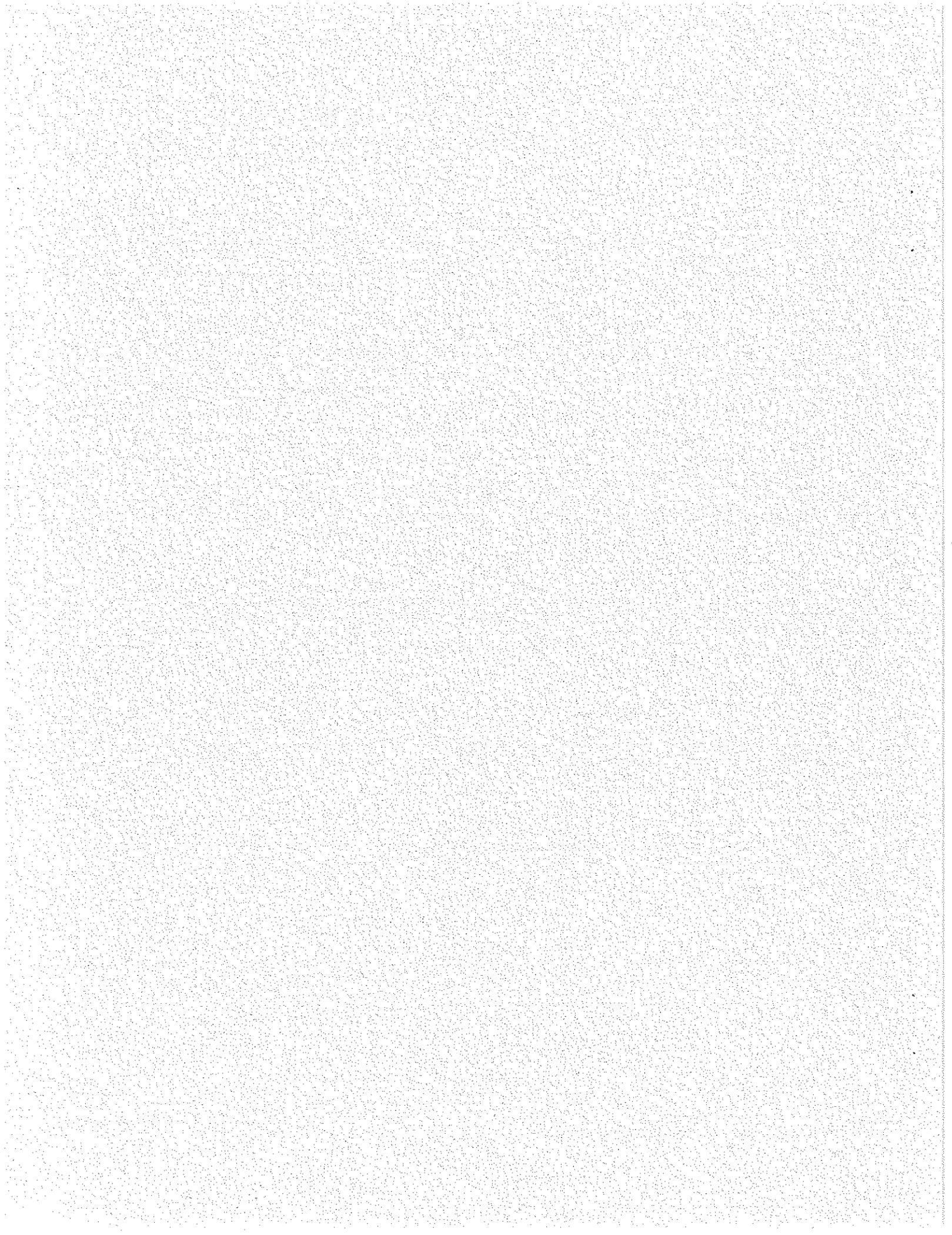
Local Public Health Accreditation

Background Paper

by the
State CHS Advisory Committee
Local Public Health Accreditation
Work Group

December, 1998

Community Development Section
Community Health Services Division
Minnesota Department of Health



OVERVIEW

Work Group Charge, Point 1: *Develop a discussion paper clarifying national discussion of local public health system accreditation and how Minnesota's system stands in relation to other states*

Considerable national discussion is occurring on whether a process for accrediting local and state health departments would be good for the public's health. In the summer of 1997 CDC's Public Health Practice Program Office (PHPPO) added Dr. Paul Halvorson to be their "point person" on the issue. At APHA's 1997 annual conference CDC coordinated a session on "local public health performance measurement, standards, and accreditation" which included a panel on accreditation facilitated by Halvorson. Panel members described Michigan's and Illinois' accreditation process development as well as the National League for Nursing's Community Health Accreditation Program (CHAP). Although each panelist was enthusiastic about his/her process and its benefits, the questions from the audience were marked with reservations. What was clear was the general acceptance that while not an "end all, be all" for public health, accreditation as a concept held sufficient merit to warrant further investigation.

This paper presents information on the topic of accreditation and related issues as a way to frame the national discussion for Minnesota's governmental public health system. It should be read for what it is--a discussion paper. As such it is intended to generate as many questions and comments as it may provide answers.

It should be noted also that many other public health organizations are also investigating the issue and, no doubt, will be producing papers themselves. As they become available every effort will be made to obtain them. Historically, CDC, NACCHO, ASTHO/ASTDN, NALBOH, APHA, and the Public Health Foundation have worked as partners in pursuing such issues; attempts will be made to access their network.

The current interest in accreditation for state and local public health agencies seems to be fueled by a general concern in the governmental public health community that progress toward achieving the current year 2000 Objective 8.14 [assuring that 90% of the American population are served by a local health department effectively carrying out core function activities] has been diverted or slowed by the focus on containing the cost of providing medical services. At least one national public health leader, Bernard Turnock, suggests that instituting an accreditation process might "kick start" the momentum needed to refocus on strengthening the public health infrastructure.¹

¹ Turnock, Bernard "Accrediting Public Health Organizations: 'The Ducks is on the Pond'" (editorial) J Public Health Management Practice 1998 4(4), p. vi

From a broader view, however, accreditation may be viewed as one form of demonstrating accountability. In general government there is currently an overall "push" to establish performance expectations/measurement/monitoring. The public health system has pressure from two avenues--from that of being a governmental entity and from its connection with the health care industry. And the pressure for performance measurement is, in turn, reflective of a general mood in the country for government at all levels to be held accountable for the public dollars it expends. Accountability, therefore, can be accomplished through accreditation but accreditation must be accompanied by measures of performance. Establishing performance expectations and designing methods to measure them becomes the central issue.

This paper develops the following major concepts in an attempt to broadly inform work group members on accreditation issues:

- I. Accreditation in Health Care
- II. Chronology of the Public Health System's Voluntary Efforts in Accountability
- III. Examples of States' Accountability Activities
- IV. Government Accountability and Performance Monitoring
- V. National Perspective
- VI. Glossary

I. ACCREDITATION IN HEALTH CARE

Accreditation is “a conformity assessment process. In this process an organization uses experts in a particular discipline or field to define standards of acceptable operation/performance...and to measure compliance with them. Accreditation typically refers to a standard setting and review process...”²

In Lieu of Regulation

In the health care arena, accreditation has long-standing acceptance as a method to demonstrate worthiness. It serves to “self-police” a product or service and, as such, often is carried out in exchange for less direct regulation from the government. At its core, however, it really is a vehicle for consumer or client protection necessary in a market economy. In an ideal market place, consumers purchase goods and services to meet their perceived needs based on price competition and value (i.e., quality/cost). This assumes that consumers possess all the knowledge necessary on which to base a rational choice. In a complex market, however, where either consumers cannot be expected to have sufficient knowledge because such knowledge would require advanced education (e.g., medical care), or because the consumer is otherwise disadvantaged (e.g., vulnerable because of age or condition), or where the value of the goods or services is not sensitive to price (e.g., selling assets to pay for needed life-sustaining treatments), then some method of consumer protection typically emerges.

Conventional methods of providing this protection include:

a. **direct oversight provided by whomever is paying for the goods or services**

In health care this is often the federal government. An example of direct regulation is HCFA’s establishment of Medicare Articles of Participation, with enforcement of oversight delegated to others. In Minnesota, for example, HCFA contracts with MDH to carry out certification of hospitals, nursing homes, and home care agencies

b. **enforcement of governmental responsibilities can also be granted to non-governmental organizations acting in their stead** These organizations themselves meet certain criteria imposed by the government and then are awarded “deemed status” (e.g., JCAHO or CHAP). This has been the conventional method for providing consumer protection in the medical care industry.

c. **states’ granting of licenses to health professionals** to assure the public using those professionals’ services of a given level of competence (usually at beginning levels)

² Hamm, Michael “The Fundamentals of Accreditation” (American Society of Association Executives) 1997, p. 3

d. **voluntary participation in a quasi-regulatory process** In this case, by demonstrating an organizations' compliance to standards (usually established by the industry itself) the consumer is to feel assured they are getting reliable and reputable goods or services. The process serves the same basic function of "The Good Housekeeping Seal of Approval" or a UL label. This process of meeting industry-established standards is what is usually achieved through an accreditation process.

e. **seeking voluntary professional credentialing from bodies with authority to grant them.** To be considered a public health nurse, by state law, the individual nurse must first be licensed as a registered professional nurse by the Minnesota Board of Nursing and then seek a voluntary registration as a public health nurse by the same board. In addition, a nurse with a BSN may seek separate credentialing as a certified public health nurse from the American Nurses Association. This requires passing a comprehensive exam in public health nursing (over and above the test required for state licensure).

JCAHO

The precedence for meeting industry-established standards in lieu of direct governmental regulation in medical care was set back in 1919 when the American College of Surgeons (ACS), itself a professional credentialing organization, branched out with an attempt to standardize hospital facilities in the face of the appalling conditions then common in institutional health care. This was known as the "Hospital Standardization Program" and although it was not then tied to reimbursement (no third-party payment system existed at the time), it accomplished significant change by offering consumers some assurance of standard acceptable service. [Remember that at this time "consumers" were the physicians and surgeons. Hospitals themselves are off-shoots of the hospitality industry, i.e., hotels, resorts, and restaurants.] In 1951 this large responsibility became too great for the ACS alone and the job was given over to the predecessor of today's Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Today the JCAHO is led by a board consisting of seven appointed by the American Medical Association, seven by the American Hospital Association, three by the American College of Physicians, three by the American College of Surgeons, and one by the American Dental Association. The remaining commissioners consist of one nurse (appointed by the JCAHO itself, not the American Nurses Association) and six members of the general public. By virtue of being first and oldest, the JCAHO process for accrediting has essentially become the standard in the accrediting business.

Throughout its history, much of this process has focused on structural issues thought to be related to quality care (i.e., physical structures, equipment, staffing complements, etc.) However, it has evolved to include a focus on functions or processes contributing to quality care, and, most recently to set out outcome indicators (the Indicator Monitoring System

or IMS) for inclusion in the accreditation process. The latest aspect, the IMS, is intended to "monitor trends and patterns of care with the aim of improving patient care."³

The issue of assuring a quality product/service took on new dimensions during the mid-1960's after the enactment of Titles 18 and 19 to the Social Security Act. The institution of these new programs, Medicare and Medicaid, now meant that enormous amounts of federal funding was infusing the medical care industry. Seemingly the right entity at the right time and the right place, the requirement for JCAHO accreditation in order for hospitals to receive Medicare reimbursement was actually written into the original Medicare statute. Furthermore, the statute made no provision for federal auditing of the JCAHO accreditation process. Indeed, the federal agency administering the Medicare program at the time did not even have access to the JCAHO accreditation reports to determine the basis (or lack thereof) for accreditation decisions.⁴

Over the years a series of lawsuits has modified and opened this process. Hospitals must now adhere first to Medicare certification standards when they exceed those of the JCAHO and make accreditation reports available to the government, among other requirements. Most recently JCAHO has been made to participate in an annual "cross walk" with HCFA to assure the congruence between JCAHO accreditation standards and the Medicare conditions of participation on which their deemed status depends.

Other Accrediting Organizations

The JCAHO is not the only accrediting body. It is common for segments of the health care industry to create their own accreditation bodies, often competing with one another. The home care industry, for instance, has accreditation available from the Accreditation Commission for Home Care (ACHC) and/or the Council on Healthcare Provider Accreditation (CHCPA) besides the JCAHO or the Community Health Accreditation Program (CHAP). However, the latter two are the only ones with HCFA deemed status.

In addition, as the health care industry continues to grow and change, other types of accreditation bodies have emerged. The National Commission on Quality Assurance (NCQA) accredits health plans. It uses a tool called the Health Plan Employer Data and Information Sets (HEDIS), a grouping of multiple measures of standardized reporting of information on financial stability, clinical performance, access to care, and customer satisfaction, to compare and track plans.⁵ Most recently the NCQA announced it will collaborate with the JCAHO and the American Medical Accreditation Program to form a 15-member Performance

³ Spoeri, Randall "Performance Measurement: Who's Doing what and Why" J. Healthcare Resource Management Dec. 1996, p. 30.

⁴ Hamm, p. 48

⁵ Gingerich, B and Ondeck, D "Credentialing and Accreditation: What Exists for Health Care Provider Organizations" Home Health Care Management Practice 1997 9(4) p. 67

Measurement Coordinating Council (PMCC) to evaluate doctors, hospitals, and managed care organizations. The coordinated focus on performance measurement is intended to “lead to broader participation in accreditation programs, which will lead to quality improvement, which will lead to better care and service for patients and the public.”⁶

The use of private accreditation bodies in lieu of direct regulation by the government to assure consumer protection is not unique to medical care. Higher education, for instance, has itself a long history of accreditation by a variety of private bodies. Like the medical industry, their importance became more intense with the infusion of significant federal funding into post-secondary education after WWII. However, unlike the medical side, the accreditors of higher education have from the beginning been themselves accredited by the federal government. The criteria set by the government, however, is largely linked with the accrediting body’s capacity to hold default on student loans to a minimum. For most post-secondary institutions, the institution itself is accredited but, in addition, its separate academic programs are customarily accredited separately by program-specific accrediting bodies. For instance, the University of Minnesota’s School of Public Health is accredited by the American Association of Schools of Public Health; the School of Nursing is accredited by the National League for Nursing.

Motivation to Participate

Motivation to participate in a regulatory process (e.g., a “Medicare visit” by a MDH surveyor) resulting in certification or a quasi-regulatory process (e.g., achieving accreditation by CHAP for a home care agency) is almost always linked with funding eligibility. However, the cost of the accreditation process is almost always borne by the organization being accredited. Thus, while accreditation by a quasi-autonomous non-governmental organization relieves the government the cost of directly regulating, the cost of becoming accredited must be carefully considered. Furthermore, the government still has to assume costs related to “overseeing the overseer.”

⁶ America Healthline, 5/21/98, “Quality Measurement: Three Leading Groups Form Alliance”

II. CHRONOLOGY

[Note: Minnesota-specific items are *italicized*.]

1. *1960's: In Minnesota, the wide-spread decision on the part of local public health nursing agencies to become certified as Medicare home care providers from the late 1960's forward brought with it the expectation for annual agency performance reviews as a requirement for on-going certification. Even prior to that, however, local agencies had a long history of producing annual reports for their advisory committees and county boards as a means of documenting accountability. These were often presented in concurrence with an annual meeting and provided a regular opportunity for consideration of agencies' performance and developing plans for change when indicated.*
2. *1976: Minnesota passed the Community Health Services Act establishing the availability of an annual state subsidy providing certain conditions are met: organizational and population requirements, completing community needs assessments, developing and implementing plans to address these needs, and annual reporting to the state regarding use of the subsidy and resulting public health accomplishments.*
3. 1979: CDC released the first edition of model standards, titled Model Standards for Community Preventive Health Services. This met the requirements of the Health Services Extension Act of 1977 which mandated the development of standards for community preventive health programs. The standards were designed as goal statements with related outcome and process objectives.

The importance of the release of this document includes the articulation of an enduring concept--that of "a governmental presence at the local level" (a.k.a. AGPALL) as being ultimately responsible for ensuring that standards are met in every community. The preamble suggests, "In most cases, the governmental entity is likely to be the health department, [but] other agencies may have responsibility for carrying out [specific programs]...The structure of government thus influences the utilization of public health standards...Regardless of the structure, every community must be served by a governmental entity charged with [the responsibility for ensuring that standards are met], and general-purpose government must assign and coordinate responsibility for providing and assuring public health and safety services."⁷

4. 1985: CDC released the second edition of model standards, this one titled Model Standards: A Guide for Community Preventive Health Services. They are specifically designed to complement the 1990 health objectives published as Promoting Health/Preventing Disease: Objectives for the Nation. The second edition distinguished between

⁷ Preamble to the first edition of model standards for public health, published in 1979 as a joint activity of DHHS/CDC, APHA, ASTHO, NACHO, USCLHO as reprinted in "Model Standards: A Guide for Community Preventive Health Services, 2nd Edition" published by the same collaborators in 1985 by APHA, page 4 [American Public Health Assoc., 1015 15th St. NW, Washington, DC]

“standards,’ which imply uniform objectives to assure equity and social justice, and ‘guidelines,’ which emphasize local discretion for decision making.”⁸ The standards also are designed as goals with both outcome and process objectives but, in addition, add related indicators.

5. 1987: *Minnesota statutes relating to public health were recodified; the CHS Act became part of MS 145A, referred to as the Local Public Health Act. Work on promulgating related rules, which serve to interpret and provide detail to the statute, was begun.*

6. 1988: The Institute of Medicine’s study concluded, in The Future of Public Health, that the nation’s public health system was in “disarray” and needed to refocus on the core governmental public health functions: assessment, policy development and planning, and assurance. This initiated a wave of collective soul-searching in the public health system...How do we stack up? What is true for our agency (whether that agency be state or local)?

7. 1990: Healthy People 2000: National Health Promotion and Disease Prevention Objectives was published, including Objective 8.14 calling for 90 percent of the US population to be served by local health departments that effectively address the core governmental public health functions of assessment, policy development, and assurance. This guideline, accompanied by national and state efforts at health care reform, resulted in extensive state and local public health agency soul-searching in response, attempting to assess their respective capacity to effectively perform these functions.

8. 1991: APHA published the third edition of model standards, this one titled Healthy Communities 2000: Model Standards subtitled “Guidelines for Community Attainment of the Year 2000 National Health Objectives.” The preface of this edition suggests “It is designed to help individuals in the public health community to be both leaders and managers--those who do the right things and do them in the right way. [This document] encourages public health leaders in communities to engage a whole host of players in setting the health priorities for their locales and in implementing programs designed to achieve their health objectives.”⁹ These standards also are designed as goals with outcome and process objectives and related indicators but also are each specifically referenced to the related Healthy People 2000 objective.

9. 1991: NACCHO published “Assessment Protocol for Excellence in Public Health” (APEXPH.) This workbook was developed for use by local health departments to “enhance their organizational capacity and strengthen their leadership role in their communities [under the premise that] (a) strong local health department will better enable a community to achieve

⁸ APHA with CDC, ASTHO, NACHO, USCLHO “Model Standards: A Guide for Community Preventive Health Services, 2nd Edition “ 1985, p. 1

⁹ APHA “Healthy Communities 2000: Model Standards; Guidelines for Community Attainment of the Year 2000 Nation Health Objectives, 3rd Edition 1991, p. viii

locally relevant goals.”¹⁰ “Part I: Organizational Capacity Assessment” provides multiple indicators in seven categories of capacity ranging from board functioning to personnel management; agencies were invited to self-assess on each of the indicators in terms of their strengths and weaknesses. Results are intended to serve as the basis of a plan for organizational improvement. *The guide was widely adopted across the nation but only minimally in Minnesota.*

10. 1991: CDC established projects to develop surveillance systems to measure progress toward 2000/Obj. 8.14. These had to be under a cooperative agreement with a member of the Association of Schools of Public Health and at least one had to be based on C. Arden Miller’s (U of North Carolina) earlier work in the 1970’s which looked at local agencies thought to be effective.

Miller and his group picked up this new work, developed and tested a method for monitoring public health performance based on 26 indicators of 10 key public health practices reflecting the three core government functions of public health: assessment=assessing, investigating, analyzing; policy development=advocating, prioritizing, planning; assurance=managing, implementing, evaluating, informing/educating. Miller reported that, as a result of this study, only 15 of the original 26 indicators seemed to “work” in terms of potential to monitor the extent to which communities fulfill core functions of public health.¹¹

11. 1993: Under another of the CDC/ASPH agreements, Arden Handler and Bernard Turnock (U of Ill. at Chicago) developed and tested a tool to measure effective local public health practice based on the 10 essential public health services and utilizing 29 associated indicators.¹² The tool was tested with Illinois local health departments at two points in time; improvement in performance was related to agency use of the APEXPH assessment guide. [See attachments for the Handler/Turnock measures.]

12. 1994: *Minnesota Rules Chapter 4736 relating to MS 145A became effective March 19. These establish the specific expectations local health departments must currently meet in order to be awarded CHS subsidy.*

13. 1995: Miller noted in his article in the AJPM Supplement on research and measurement in public health practice that “Work is in progress to merge the indicators used in this study

¹⁰ NACHO “APEXPH: Assessment Protocol for Excellence in Public Health” March, 1991, p. iii [National Association of County Health Officials, 440 First Street NW, Washington, DC 20001]

¹¹ Richards, T...Miller, CA et al “Evaluating Local Public Health Performance at a Community Level on a Statewide Basis” J Public Health Management Practice 1995 1(4), p. 70-83

¹² Handler, A, Turnock, B et al “A Strategy for Measuring Local Public Health Practice” Am J Preventive Medicine 11(6) Supplement 1995, p. 29-35

with those reported by Turnock and Handler. The merged indicators will retain the jurisdictional emphasis and will be field-tested by both groups of investigators.”¹³

14. 1996: Turnock and Handler do, however, publish an article in the J. of Public Health Management and Practice (Vol. 2, No. 3) asking “Is Public Health Ready for Reform? The Case for Accrediting Local Health Departments.”¹⁴ In it they suggest that the public health community has been unable to capitalize on the inclusion of Objective 8.14 in the year 2000 objectives “largely due to the overwhelming challenges and threats that have intervened since 1990.” They infer the loss of momentum is attributable, in part, to the diversion of the system’s energies into recrafting the way in which the cost of medical care is managed. They urge that a “national program of accrediting local and state health departments could energize public health capacity building.”¹⁵

15. March, 1998: The final draft of the proposed public health infrastructure goal under the draft Healthy People 2010 National Objectives is a recrafting of the year 2000’s Objective 8.14. Considerable specificity has been added to identify areas needed to strengthen the public health infrastructure:

- a. Skilled Workforce, including
 - establishing competencies for public health workers
 - proposing that 100% of schools of public health be accredited by the Council on Education for Public Health
 - increasing the intensity with which state and local health departments provide continuing education and training
 - encouraging the voluntary adoption and use of the Standard Occupational Classification System recently updated to include a broad array of public health professionals
- b. Integrated Electronic Information Systems, including
 - electronic access to health information and surveillance data
 - community access to health information and surveillance data
 - tracking objectives for special populations
 - track and report on the progress toward the Healthy People 2010 Objectives at least every 3 years
 - increase the use of geocoding and geographical information systems (GIS) analysis

¹³ Miller, CA, Christenson, G et al “Creating and Validating Practical Measures for Assessing Public Health Practices in Local Communities” Am J Preventive Medicine 11(6) Supplement 1995, p. 27

¹⁴ Turnock, B and Handler, A “Is Public Health Ready for Reform? The Case for Accrediting Local Health Departments” J Public Health Management Practice 1996 2(3), p. 27

¹⁵ Turnock, B and Handler, A “Roles for State-Level Local Health Liaison Officials in Local Public Health Surveillance and Capacity Building” Am J Preventive Medicine 11(6) Supplement 1995, p. 41-46

- c. Effective Public Health Organizations, including
 - performance measurement, including development of common performance indicators and systematic comparisons requisite for the development of benchmarks, the basis of systems improvement
 - development and utilization of a state Health Improvement Plan at all levels and especially “Healthy Minnesotans” overarching priority theme related to improving the public health infrastructure
 - laboratory services
 - legal basis for public health is clearly delineated at all levels via statutes, ordinances, and/or charters
- d. Resources
 - public expenditures for public health should be collected and reported according to the ten essential services
- e. Prevention Research
 - promoting collaboration and cooperation among all levels of public health agencies, academic institutions, and philanthropic institutions to advance population-based prevention research and practice
 - developing an index of summary population health measures

Related Issues

16. 1997: CDC’s “Healthy People 2000 Review, 1997,” their fifth tracking report on progress toward meeting the year 2000 objectives, reported Objective 8.14 as one of three community-based program objectives progressing toward its year 2000 target of 90% of the US population being served by a local health department. However, no data is provided, with the explanation that the NACCHO surveys intended to provide tracking (i.e., NACCHO’s National Survey) could not be used because of “substantial difference in working of questions between (the surveys).”¹⁶

17. 1997: CDC/NACCHO published the results of their mid-1995 survey of local health departments. Based on a 44% response rate, the majority of respondents indicated that no change had occurred in their capacity to develop and implement policy since 1990, while 26% indicated that their capacity had increased and 4% indicated their capacity had decreased. For those reporting increased capacity, the major reasons cited were: increase in community need, increase in public support, and increase in support from appointing/delegating authority. For those reporting decreased capacity, the major reasons were: decrease in support from appointing/delegating authority, decrease in funds, decrease in public support. [Note: In Minnesota, 47% of local agencies completed the survey.]

¹⁶ Ibid, p. 42

18. 1997: NACCHO and CDC began efforts to revise *APEXPH*. The new development, Assessment and Planning Excellence Through Community Partners for Health (*APEX-CPH*), will focus on a community's (rather than a local health department's) capacity to protect and promote the health of the public. The two parts from *APEXPH* will be realigned with the ten essential public health services. The prototype is to be released Spring, 1999.

19. July, 1998: The entire issue of the Journal of Public Health Management and Practice is devoted to accreditation and performance measurements issues.¹⁷

(See Section V)

¹⁷ Richards, Thomas Editor, "The Accreditation of Local Health Agencies" *J of Public Health Management Practice* 1998 4(4), entire issue

III. EXAMPLES OF STATES' ACCOUNTABILITY ACTIVITIES

Expectations-Through-Guidelines

1. Minnesota: The accountability structure in Minnesota is embedded in MS 145A and its rules. In general, the responsibility to promote and protect the health of the public is established in MS 145 and interpreted through the rules. In addition, Article 7 of MS 625 further defines core public health functions. The evidence of accountability is essentially compliance with these rules which are broad and largely non-prescriptive. MDH has historically used common goals and voluntary guidelines as its chosen method for communicating an understanding of expectations. Perhaps the most familiar to local public health staff are the CHS Planning and Reporting Guidelines which are themselves based on the consensus of the state-local partnership. They do not, however, establish performance standards in the sense that agencies must comply with the guidelines to receive the CHS subsidy. The development of the compendium of "strategies that work" to support effective program planning in the 2000-2003 cycle will enrich this set-expectations-through-guidelines approach.

Established Certification Process

2. Illinois: The state health department has long maintained a system for requiring local agencies to meet programmatic/categorical standards to establish eligibility for contracting with the state for provision of public health services. Since 1993 they have moved to a local health agency certification process based on the essential services. [Note: Information from Illinois has been requested but not yet received.]

The development of a certification process was one of three efforts undertaken in Illinois to develop its public health capacity. In a separate effort, the Illinois Dept. of Health implemented the Illinois Plan for Local Assessment of Needs or IPLAN. Additionally a year-long Public Health Leadership Institute was initiated. Turnock and others surveyed local agencies regarding their capacities before and after these initiatives. The post-survey (1994) demonstrated significant capacity increases even in the smallest agencies where performance scores averaged 80%. The adoption of APEXPH and the IPLAN were credited with providing the major influencing factors in the improvement.

States Exploring Accreditation

3. Missouri: This state has 114 counties all of which have access to local public health agencies. Like Minnesota, a long-standing partnership between the state and local health departments has existed although it is somewhat more formalized. Since the mid-1980's the state has purchased services from local health departments, including those provided for MA eligible individuals; a sizable amount of these contracts were for personal medical care. Since 1988 a state/local "Partnership Council" has mediated the negotiation of these contracts and most recently has been strategizing alternatives for funding local public health given the changes pending at the federal level. The Missouri Dept. of Health has a stated goal of reaching a state funding support level of 25%.

In anticipating changes, the department also established a new unit in 1995 to “strengthen working relations and understanding between all public health providers in the state.” The workgroup of state and local partners integral to the establishment of the unit also proposed that one of the unit’s first activities should be to develop agency standards and/or certification plus a method for certifying public health workers. State reimbursement for local agency-provided services would be tied to this process.

In moving ahead with this commitment, fiscal year 1999 was targeted for implementation of an accreditation/certification system. As of March, 1997 they had developed a 43-page document identifying 213 state and 189 local agency roles in fulfilling core public health functions. The local roles have been categorized into four groups: staff competency; agency competency; commitment (i.e., extent of local agency financial commitment); betterment (a system for smaller agencies to “partner-up” with larger neighbors to share resources). Currently, state/local work teams have been established to determine possible accreditation elements (including existing standards/guidelines, budget and training needs) for each of the 189 local roles.

They are also proposing a classification system for local agencies based on population size. The smallest counties would be held accountable for basic core function roles, have to provide at least one nurse per 5000 population and have a medical consultant under contract; local match for this class agency would be 45%. As classes of agencies advance, there is accountability for more complex roles, provision of more diverse staffing complement, and lesser local match requirement. The “top” class, for instance, would serve a population >60,000, require a staffing complement of an administrator, a PHN director plus a staff of 1 PHN/10,000 population plus 1 RN/5000, an environmental director plus a staff of 1 sanitarian/15,000 population, an epidemiologist, a health education director plus a staff of 1/25,000 population, 1 nutritionist/20,000 population, a medical consultant contract, and laboratory services. Local match requirement for this class is 25%. Counties could opt to move up in class regardless of population size but not downward.

4. Michigan: As a result of the Michigan Dept. of Community Health’s examination of its code pertaining to the financing and delivery of local public health services, recommendations were made to establish an accreditation process as a “means to monitor and evaluate local health departments.” Core capacity services for local health departments were established, minimum program requirements for cost-shared services were set, and evaluation mechanisms developed for numerous categorically-funded program services as the foundation for the accreditation process.

The development of the process itself is being developed by the Michigan Public Health Institute, a private, non-profit organization. Using an 18-member steering committee, an accreditation process prototype has been developed and is currently being piloted. Two steps are involved: an agency self-assessment followed by an on-site review by the accrediting body (yet to be designated). Seven areas of capacity have been identified: health assessment,

policy development, quality improvement, health promotion, health protection, administration, and creating and maintaining a competent workforce. Indicators with "examples of verification" have been developed which serve to document the extent to which an agency meets "essential" requirements. If "important" requirements are also met they provide bonus points in the accreditation process. An agency fully meeting the essential requirements gets a three-year status; provisional status is imposed when essentials are not met but a corrective plan is in place; a commendation of excellence is awarded if, in addition to meeting the essential requirements, bonus points have been awarded. The draft self-assessment protocol currently being piloted is 87 pages in length.

[Note: Other states reported to be investigating accreditation include Kentucky, Indiana, and North Carolina.]

States Implementing Other Methods of Assuring Accountability

5. Texas: Texas has a system of local health departments consisting of single cities, single counties, city-county combinations, and county-county combinations. Regional offices of the Texas state health department operate clinics and provide other services in areas of the state not covered by a local agency. Where no local agency exists, services are either provided through the state's regional office or under a contract with other health care providers. Where no local government health department exists, services are either provided from the state's regional offices or under a contract with other providers. Texas does not have an accreditation process for local agencies.

However, since 1987 state contracts with local health departments for the provision of services at the local level have been based on performance-based objectives. These, in turn, were based on the 1984 work of a statewide committee which had developed model objectives for local agencies based on the national set of model standards. A manual, "Program Management Package: A Step by Step Guide to Program Planning, Monitoring, and Evaluation," was published in 1991 and serves as the basis for developing performance-based objectives in the following areas: asbestos control; bicycle helmet safety programs; child health; chronic disease prevention and control; dental health; family planning; Hansens' disease; HIV; immunization; maternity services; milk and dairy; public health promotion; refugee health; retail food protections; STDs; TB; and WIC. Once established they serve as the basis for negotiating funding with the state.

6. Iowa: Iowa does not have an accreditation or certification process but does require local agencies to use the APEXPH. In 1995 the Iowa Dept. of Public Health surveyed local departments using the capacity assessment tool developed by Miller and others. They found that Iowa counties fared as well as those included in Miller et al's original 6-state study and as well as Illinois' pre-survey capacity but lagged behind the post-survey results. The results were seen supportive of a set of 1994 recommendations regarding rural health care in Iowa: formations of community health networks involving cooperation between private and public health entities could improve coordination in health regions or districts with a regional officer

at its head who could work for categorical program integration and serve as a single point of contact regarding issues and coordination of effort; increase catchment areas to increase efficiency and effectiveness; provide information and informal training for board members and agency staff and formalized public health education in leadership training. It is unclear to what extent this plan has been implemented.

IV. GOVERNMENT ACCOUNTABILITY AND PERFORMANCE MONITORING

Performance measurement is the label typically given the many efforts undertaken within governments and within the nonprofit sector to meet the new demand for documentation of results...[It works by] linking the measures, or indicators, to program mission; setting performance targets; and regularly reporting on the achievement of target levels of performance...¹⁸

Kathryn Newcomer in
"New Directions for Evaluation"

The term "performance monitoring" applies to a continuing and evolving process--anchored in a context of shared responsibility and accountability for health improvement--for 1) selecting and using a limited number of indicators that can track clinical processes and outcomes over time and among accountable stakeholders; 2) collecting and analyzing data on those indicators; and 3) making the results available to inform assessments of the effectiveness of an intervention and the contributions of accountable entities.¹⁹

Durch, Bailey, and Stoto
"Improving Health in the
Community: A Role for
Performance Monitoring"

The move toward investigating accreditation and focusing on performance measurement in public health is reflective of a larger issue facing government as a whole--the pressure to "make government accountable for results." Historically that has been a matter of accounting, or simply reporting how the public funds were spent. In the last decade the concept of governmental accountability (and, to a large extent, that of non-profit organizations) has broadened to not only state how their funds were spent but including what benefit the public derived from the expenditure and whether the benefit achieved was the most effective choice. Organizations are being held responsible not only for their actions but also for the results of those actions. These are new questions requiring new kinds of data and new systems to collect them. Most often this phenomenon is referred to as "performance measurement" or

¹⁸ Newcomer, Kathryn "Using Performance Measurement to Improve Programs" *New Directions for Evaluation* Vol 75 Fall 1997, p. 5

¹⁹ Durch, J; Bailey, L; Stoto, M Improving Health in the Community: A Role for Performance Monitoring (Washington, DC: Nat'l Academy Press) 1997, p. 26

“performance accountability.” [See: New Directions for Evaluation, No. 75, Fall 1997, Jossey-Bass Publishing; Campbell, Michael “Outcome and Performance Measurement Systems: An Overview” Nat’l Academy of Public Administration/Alliance for the Redesign of Government; www.clearlake.ibm.com/Alliance/clusters/op/overview.6html)]

Campbell describes two types of emerging performance measurement systems. One monitors the outcomes of specific government programs. In these, specific outcomes desired or expected as a result of the program are identified, related measures and indicators selected, and performance standards regarding those measures and indicators are established. The program is implemented, measures of performance made, and reports generated. In some cases the level of reporting includes performance-based budgeting systems in which resource allocation is tied to performance objectives. Many CHS planning processes approach this type of measurement (although it is not currently an expectation of the CHS reporting system). Dakota County has implemented it across all county departments, including public health.

The second type of performance measurement systems goes beyond measuring program outcomes and focuses instead on measuring and reporting on overall community conditions. These generally involved establishing “benchmarks to gauge progress toward a strategic vision of how things should be at a given point in time. The MDH/ Minnesota Health Improvement Partnership work in establishing public health goals is an example of this as are the Washington State and Oregon health improvement plans.

V. NATIONAL PERSPECTIVE

What follows is a (brief) annotated review of articles published in the July, 1998 *Journal of Public Health Management and Practice* which focused on accreditation of local health agencies. These were invited articles intended to stimulate discussion regarding the pro's and con's of accreditation; **it was not intended to promote or endorse the concept** (although some authors obviously did). The material was organized around experiences of those states already involved in a review process of some sort with their local partners and a series of essays on "lessons learned" from organizations already doing accreditation processes.

Experience from States that have "Been There"

State of Washington

In the early 1990's Washington was one of the first states to produce a public health improvement plan. In 1994 their state department of health received a legislative mandate to identify capacity requirements of local agencies to fulfill the core functions of public health, estimate the related costs, measure the current capacity of local agencies, and estimate the resource requirement to "fill the gap." As a result, a "performance measures technical advisory committee" composed of representatives from the state and local partners developed 88 core function standards based on the health improvement plan. These were reorganized into 20 "clusters;" from these a set of 39 measurable performance indicators were developed and tested. These reflected four "major capacity elements" necessary to carry out core functions at the local level; these also served as the organizing framework for the agency evaluation final report:

1. presence of effective organizational structures and policies
2. presence of a skilled work force with access to appropriate resources to carry out their work
3. effective information and communication systems for both internal and external constituents
4. evidence of active involvement of the general public, community providers, and elected officials

The measures also needed to be flexible enough to accommodate the variety of agency sizes and situations which, in the end, became the stumbling block. To create flexibility sufficient measurement subjectivity had to be introduced and this, in turn, made it impossible to compare measures between agencies. It did, however, provide significant useful information for each agency to look critically at itself which was viewed as positive. However, the authors noted that those agencies with the best developed understanding of core functions tended to be more critical of their performance and rate themselves lower on their agency self-assessment than did the agencies with lesser developed understanding.

Oregon

Since the 1980's the state's division of health has required a mandatory local agency review linked with the local agencies' eligibility to receive state funding or state managed care funding. Initiation of the process was a mutual agreement between the state and locals to participate in one annual comprehensive review rather than having state program staff do program-by-program site reviews. A set of standards on each of 21 review elements has been negotiated between the division of health and the Conference of Local Health Officials; the review elements serve as the basis for the initial agency self-assessment and the site-visit review process. At the completion of the review a plan for technical assistance, training, and on-going consultation is developed. While the process is extremely time consuming for all involved, a 1995 survey of local agencies suggested the resulting program improvement was worth the time and resource requirements.

South Carolina

The state health department is a direct provider of primary medical and home care services throughout the state, which makes it a "horse of a different color" from Minnesota. The state is organized into 13 health districts, each considered a "branch office" of the state. The state itself is the Medicare certified home care agency and as such, has participated in the Community Health Accreditation Program (CHAP) since 1978. They state the accreditation has given them a competitive edge with other service providers and a recognition of credibility. On an annual basis CHAP surveyors review the agency for evidence of an organizational structure which reflects a consumer-oriented philosophy, a monitoring system showing consistent high quality services and products (including monitoring of personnel performance), adequate human, financial, and physical resources, and evidence that the organization is positioned for long-term viability. South Carolina believes they've benefitted significantly from a resulting increase in service integration, enhanced interdisciplinary process, improved service delivery, outcome evaluation, and refinement of their continuous quality improvement activity.

Illinois

The state has a long history of "certifying" local agencies as a condition for receiving state and federal funds. In 1993 the process was changed so that now local agencies are certified for up to five years. Every five years the local agencies must do a community needs assessment and develop a plan that addresses at least 3 priority health problems and identify related resource requirements. Thereafter agency administrators meet at least quarterly with IDPH regional staff for technical assistance. Maintaining certification remains as a condition for receipt of funding.

The certification is based on 10 standards reflecting core public health functions. Each has a set of indicators. The current standards are: assessment of local health needs; investigating occurrences of adverse health events; analyzing determinants of health needs; advocating for

public health, building constituencies, and identifying resources; setting priorities among health needs; developing plans and policies to address them; managing resources and organizational structures; implement programs; evaluate and provide quality assurance; inform and educate the public. In addition, certification requires that each local health department must have a qualified public health administrator hired. (Note: "Qualified" means 1) Masters degree in public health with 2 years public health administrative experience; or, a graduate degree in a related field with 2 years public health administrative experience; or, a bachelor's degree and four years administrative experience, two of which are in public health.) While the process is still considered a pilot, the reviewers noted positive perceptions of the process from both local and state partners; however, it was emphasized that success depends on strong state/local "coalitions."

Michigan

[Note: Michigan's experience was not addressed per se in the special issue. The following is drawn mostly from notes and minutes of meetings in which the pilot project in Michigan was described.]

Michigan is currently field-testing an accreditation process based on that state's public health code. If adopted it will replace the state's process of making multiple site visits to local agencies for assessing compliance to various categorical grant requirements. Meeting and maintaining accreditation status will allow local agencies eligibility for receipt of state and federal "flow-through" funding.

Michigan has the advantage of work done in the late 1980's by the University of Michigan/ School of Public Health (Pickett and Romani) working in conjunction with MI Dept. of Health and the MI Assoc. for Local Public Health, around the time of the publication of the IOM report on public health's future. In the studies, Pickett and Romani attempted to design a method to measure local agencies' public health "infrastructure" capacity, or "expression of the governmental presence in health." Local agencies were asked to first self-assess themselves against a set of 20 indicators covering six areas:

1. agency should be able to list and describe its most important objectives or programs, indicate whether the activity is mandated by statute, and determine the extent to which the objective is being attained
2. agency should have an up-to-date health code that includes current state statutes, local ordinances and all administrative rules that relate
3. agency should maintain ongoing system of assessment: the monitoring and analysis of community health status and services; specifically they should possess
 - the ability to carry out necessary epidemiological investigation
 - available and adequate lab services
 - current health status and health risk data
 - an inventory of resources against which an analysis of adequacy could be made

- capacity to do appropriate statistical analyses
 - the involvement of the community in the process of assessing local needs
4. community outreach and external relations
 5. agency should be actively involved in a leadership role in *policy* analysis and formation for the community
 - existence of a planning process
 - presence and use of a set of priorities to guide resources allocation
 6. agency should be able to ensure the efficient allocation and management of and appropriate accounting for the resources it has available
 - compliance with statutory requirements
 - system of management with trained individuals
 - ability to allocate discretionary resources in accordance with priorities and objectives
 - presence of program objectives
 - existence of evaluation procedures
 - program standards
 - interdisciplinary review of health problems and programs

The results of the studies indicated that discussion of the criteria and the self-assessment guide alone was found valuable in and of itself as a method of advancing knowledge and skill of program implementation and evaluation. While the overall results were deemed positive by both local agencies and their state partners, the following critical issues were left to be addressed:

1. If accreditation is to advance public health, deficiencies must bear some consequences or the process is an exercise only.
2. The composition of the accrediting board must be representative and therefore, should include reps from the local agencies (i.e., peers), local authority boards, state program experts, and consumers.
3. The instruments and/or strategies used to assess local agency performance must be well tested for validity, reliability, and acceptability.
4. The length of time over which the accreditation period extends must be considered.

More recently the MI Public Health Institute has picked up the work for further testing and refinement. The Institute, a unique non-profit organization established by the MI legislature and fulfilling a quasi-governmental role, is working in conjunction with the U of MI/School of Public Health and the MI Association of Counties. They designed and are now field-testing a refined two-stage accreditation process also using a self-assessment phase followed by on-site review teams of peers and state program administrators. The process includes provision for non-accreditation status after two failed attempts to gain it. The latter would make the local agency ineligible for state administered funds. [Note: The accreditation process is available for review for those interested.]

Lesson Learned from the Perspective of Accrediting Agencies

Council on Education for Public Health

This organization has long accredited schools of public health and finds the accreditation process “a well-accepted way of exercising quality control and establishing accountability.”

They offered the following lessons:

1. To be effective, the accrediting body must be isolated from external sources of influence
2. The process should be focused on improvement rather than punishment. They’ve found just the process of reaching consensus on standards a highly mutually rewarding experience.
3. Involve representatives of any and all stakeholders in the process. (In the case of higher education, that means students.)
4. Consider what accreditation status “buys” an organization before moving forward.
5. The survey process must be based on fair and equitable procedures.
6. There must be clear understanding “up front” about the nature and extent of disclosure of accreditation survey results.
7. Valid and reliable standards with agreement on them developed through consensus must be available. **[Note: This was deemed “most important.”]**
8. Involvement in accreditation must have benefit both for those being accredited as well as for those doing the accrediting.
9. Consider also the extent which attaining accreditation will promote accountability/credibility.

Community Health Accreditation Programs, Inc.

This organization has a long history of associations with visiting nurse and public health nursing organizations. Begun in 1965 as a voluntary accreditation arm associated with the National League for Nursing working in conjunction with APHA, in 1987 it became a fully independent subsidiary. They have deemed status from HCFA as an accreditor of home care programs. In 1997 it revised its accreditation process to fit a variety of organizations including public health. It’s now called *Standards of Excellence for Public Health Organizations*. It’s based on 20 standards organized into four categories: structure and function, quality, resources, and long-term viability.

No information was provided regarding how many public health organizations they currently certify or the costs of certification; neither were any “lessons learned” provided. CHAP does make the following statement: “Accreditation results in improving services, decreasing staff turnover, increasing referrals, and increasing staff productivity.”

JCAHO

This organization has the longest history in the US of accrediting health care organizations (since 1951). Initially focusing only on hospital accreditation, that group now accounts for only 1/3 of all accreditations done by JCAHO. [Note: JCAHO also has HCFA deemed status as a home care agency accreditor but generally only does hospital-based organizations.] JCAHO offered the following list of considerations before an organization launches into accreditation:

1. Why do this? What are the objectives?
 - a. Is it for service improvement mainly (in which case a peer-consultation model is usually used)?
 - b. Is it to assure the public/consumer group that it meets a minimum requirement for safety and health (in which case a regulator model is usually used)?
 - c. Is it to provide a source of comparative information for marketing purposes?
 - d. Is it to generate information to guide the development of regulations for a whole category of providers?
2. How will the standards be developed against which an organizations' performance will be measured? Will they reflect minimum standards to assure health and safety, suggest so-called "best practices," or portray what are thought to be standards of excellence?

To what extent are the standards intended to be prescriptive (i.e., if an organization doesn't do x, y, or z they will be determined as deficient)?

What is the balance of input into standards' development among research findings, practice realities, management interests, and/or consumer rights?
3. How well developed are the operational requirements such as
 - a. Standards* (see above)
 - b. Surveyors'* training and status [Note: If accreditation intent is improvement, surveyors will need to be recognized as leaders and innovators by peers. If the intent is regulation, surveyors will need to reliably and consistently provide standardized overall judgments.]
 - c. What are the decision-rules?
 - Are all standards considered to be of equal importance?
 - Are certain standards considered "core" and others as "optional?"
 - Is there a provision for "conditional status" or "probation?"
 - d. What is the agreement regarding disclosure of accreditation findings (i.e., who gets to know the findings and to what level of detail)?

*Standards and surveyor capability are considered the most important operational requirements.

4. How will performance be measured?

Including measures of both structure and process in an accreditation process is considered a “given.” In addition, every attempt should be made to include outcome measures which answer the questions, “So what happened because a,b,c resources were provided and x,y, z were done?” In the health care arena, outcomes are considered to consist of three components: health status change+consumer satisfaction+costs.

Designing meaningful measures of outcomes requires:

- a. identifying which kind of outcomes are important (i.e., there must be consensus on the balance to be achieved between scientific outcomes and practice outcomes).
 - b. selecting data elements that can be reasonably collected (i.e., are simple to get and don't take much time)
 - c. constructing standardized algorithms for calculating the measures from the data elements
 - d. using reliable data collection techniques
 - e. applying accurate risk adjustment techniques (to allow for differences in populations)
 - f. designing useful analysis and feedback information from the data
5. When focusing on population health, it is important to:
- a. have a functional community needs assessment to provide a baseline against which to measure any changes
 - b. identify clearly what is meant by “population”
 - c. identify clearly who or what is the accountable authority to receive the accreditation report and act on its recommendations

American Accreditation HealthCare Commission

This organization largely accredits managed care organizations, applying the following definition of accreditation:

“(The) process by which the structure and function of an organization is measured against established performance standards...In the private sector..accreditation provides a market and marketing advantage. In the public sector, accreditation indicates that the organization has the infrastructure and resources to accomplish its objectives.”²⁰

The author believes accreditation for local health departments would be a positive, given the challenges she sees public health currently facing: the dilemma of core functions which cross-cut programs but funding which remains largely categorical; the fact that effectiveness

²⁰ Greenberg, E. Liza “How Accreditation Could Strengthen Local Public Health: An Examination of Models from Managed Care and Insurance Regulators” J Public Health Management Practice 1998 4(4), p. 33

in public health means that nothing happened; facing the general public backlash against government; the “credibility gap” stemming from the fact that public health continues to insist it promotes and protects when resources available do not support the claim. She believes that accreditation would provide: definition of the core elements constituting government public health agencies; clear articulation of what is considered adequate public health services; increased leverage with decision makers regarding resource requirements; identification of populations put at risk because of inadequate public health capacity. She asserts that the foundation work of an accreditation process for public health agencies already exist in the statement of core functions and 10 essential public health services combined with the APEXPH self-assessment process. All that would be needed is the development of standards and measurement criteria.

Community and Health Accreditation Standards Program (CHASP)

CHASP is a system of national standards developed and used in Australia; states may modify the standards to suit their own circumstances. The accreditation process is based on TQM/CQI concepts. It views accreditation as: “...based on an organizational learning model where the standards and the review process are intended to create a culture and environment for organization change, growth, and development, not imposed from above, but facilitated by CHASP.”²¹

Since 1993 a system of 58 standards in 10 sections has been applied. The sections are:

1. assessment and care
2. early identification and intervention
3. health promotion
4. community liaison and participation
5. rights of consumers
6. client health and program records
7. education, training, and development
8. planning, quality improvement, and evaluation
9. management
10. work and its environment

In 1997 CHASP became an independent organization and is now branching out to accredit a variety of organizations besides local public health departments.

²¹ O'Tarpey, Margie “Quality Improvement, Standards, and Accreditation for Community Health Services in Australia, 1983-1995” J. Public Health Management Practices 1998 4(4), p. 38

VI. GLOSSARY*

Accountability: liable to be called to account: answerable (from Webster)

Accreditation: “a conformity assessment process. In this process an organization uses experts in a particular discipline or field to define standards of acceptable operation/performance...and to measure compliance with them. Accreditation typically refers to a standard setting and review process...”. (Hamm, M.S. “The Fundamentals of Accreditation”, 1997)

Algorithm: an ordered sequence of steps or instructions, with each step or instruction depending on the outcome of the previous one, that is used to tell how to solve a practical problem. An algorithm is specified exactly, so there can be no doubt about what to do next, and it has a finite number of steps. [Note: This is opposed to a decision tree: a device used in decision analysis, developed to express alternative choices in quantitative terms that can be made in the process of thinking through a problem. A series of decision options are presented as branches, and possible subsequent outcomes are represented as further branches. The junction where a decision must be made is called a decision node.)

Certification: the procedure and action by which a duly authorized body evaluates and recognizes (certifies) an individual, institution, or educational program as meeting predetermined requirements, such as standards. Certification is essentially synonymous with accreditation, except that certification is often, but not always, applied to individuals whereas accreditation is applied to institutions or programs. Certification programs are generally non-governmental and do not exclude the uncertified from practice as do licensure programs. While licensure is meant to establish the minimum competence required to protect the public health, safety, and welfare, certification enables the public to identify those practitioners who have met a standard of training and experience set above the level required for licensure.

Criteria: expected levels of achievement or specification against which performance or quality may be compared

Guidelines: a statement or other indication of policy or procedure by which to determine a course of action

Indicator: 1) a quantitative measure used to measure and improve performance of functions, processes, and outcomes...2) a statistical value that provides an indication of the

* Unless otherwise marked, all items are from “Lexikon: Dictionary of Health Care Terms, Organizations, and Acronyms for the Era of Reform.: Ed: Margaret O’Leary (JCAHO) 1994

condition or direction over time of performance of a defined process or achievement of a defined outcome...3) a substance used to test for a particular reaction because of a predictable, easily detected change

Infrastructure: The executive ability, responsibility, and authority to determine and implement health policy and the knowledge, skills, and support systems needed to

- Maintain an ongoing system for the monitoring and analysis of community health status and services;
- Ensure the use of appropriate and necessary public health knowledge and technology in all aspects of agency operations, including knowledge of biological, physical, and chemical determinants of disease;
- Inform and assist the community in appropriate actions necessary to promote health and prevent disease and injury;
- Ensure the efficient allocation and management of and appropriate accounting for the resources available to the agency; and
- Incorporate the functions, knowledge, and expertise of the public health agency into an ongoing community health planning process.

[Pickett and Romani *Journal of Public Health Management Practice* 1998 4(4), p. 55]

Intervention: any action that is intended to interrupt or change events in progress

License: an official or legal permission, granted by competent authority, usually public, to an individual or organization to engage in a practice, an occupation, or an activity otherwise unlawful...A license is usually needed to begin lawful practice; thus, it is usually granted on the basis of examination and/or proof of education rather than on measurement of actual performance

Licensure: a legal right that is granted by a governmental agency in compliance with a statute governing the activities of a profession...or the operation of an activity (such as a hospital)

Measure: 1) a quantitative tool or instrument used to make measurements; as an indicator of one kind of measure; 2) a unit specified by a measurement scale (i.e., an inch); 3) the act or process of measuring

Outcome: in health care, the cumulative effect at a defined point in time performing one or more processes in the care of a patient...

- outcome **assessment**=evaluation
- outcome **criteria**=level of outcome achieved
- outcome **data**=evaluate a specific outcome
- outcome **indicator**=indicator that measures what happens or does not happen
- outcome **measure**=a measure of what happens or does not happen

Outcome standard: a statement of expectation set by a competent authority concerning a degree or level of acceptable outcome achieved by an individual, group, organization, community, or nation according to pre-established requirements and/or specifications

Parameter: 1) in mathematics, a constant in an equation or model; in statistics and epidemiology, one set of measurable characteristics; 2) in medicine, statements that delineate the ways in which it is acceptable for physicians and other health professionals to treat patients

Personal health services: health services provided to individuals, in contrast to health services directed at populations, such as environmental health, community health, public health, consultation and education services, and health education

Policy: 1) the act, method, or manner of proceeding in some process or cause of action adapted and pursued by an individual or organization; 2) any course of action or way of doing something adopted as proper, advantageous, or expedient...Policies bear the same relationship to rules (regulations) as rules do to law, except that unlike regulations, they do not have the force of law.

Population: 1) the inhabitants of a geographical area considered together; 2) the number of inhabitants of an area

Practice guideline: description, tool(s) or standardized specification for care of the typical patient in the typical situation, developed through a formal process that incorporates the best scientific evidence of effectiveness with expert opinion

Procedure: 1) a series of steps taken to accomplish a desired end, as in therapeutic or cosmetic procedures; 2) a unit of health care, as in services and procedures

Process standard: a statement of expectation set by competent authority concerning a degree or level of acceptable outcome achieved by an individual, group, organization, community, or nation according to pre-established requirements and/or specifications

Protocol: a plan or set of steps, to be followed in a study, an investigation, or an intervention, as in clinical protocols used in the care of patients (see also algorithm, practice guideline)

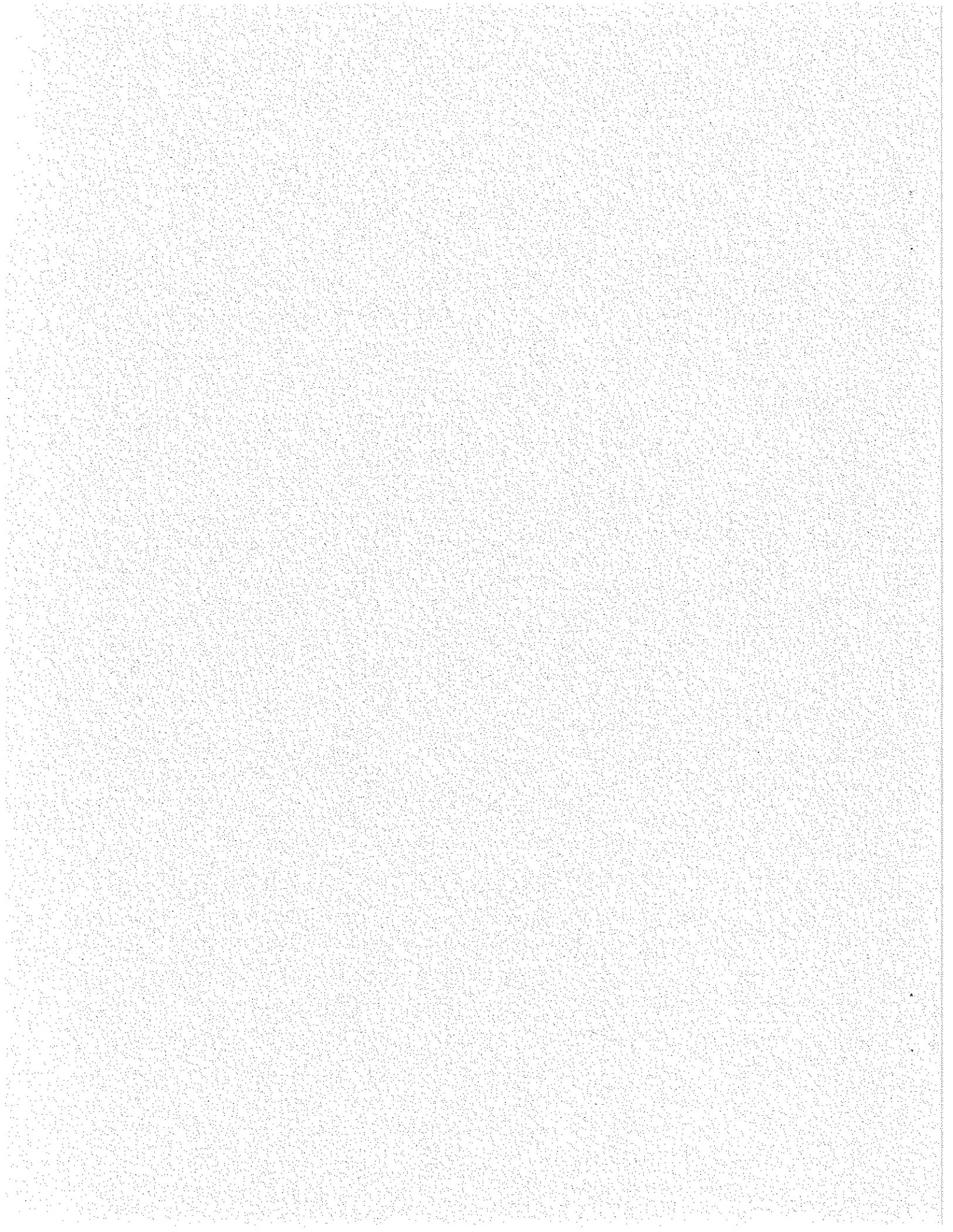
Public health: the science and art of protecting and improving the health of the community, as by preventive medicine, health education, control of communicable disease, application of sanitary measures, and monitoring of environmental hazards

Standard: a statement of expectation concerning a degree or level of requirement, excellence, or attainment in quality or performance. A standard may be used as a criterion or acknowledged measure of comparison for quantitative or qualitative value. Conformity or compliance with standards is usually a condition of licensure, accreditation, and payment for services. In health care organizations, a standard is a statement of expectation that defines the processes that must be substantially in place to enhance the equality of care and entitle the organization, in the aggregate, to achieve accreditation, as from JCAHO

Structural standard: a statement of expectation that defines a health care organization's structural capacity to provide quality care; pertains to characteristics of organization's resources and form

Attachment

**Currently Developing Measures
of
Public Health Practices**



APPENDIX

Local Public Health Practice Performance Measures

Practices	Practice measures (standards and indicators)	5. Set priorities among health needs	(13) there has been a public review of the health department's mission and role within the past five years Community health needs are prioritized. (14) based on the consequences of the identified health problems (15) based on the acceptability, economic feasibility, and effectiveness of interventions (16) with community input and participation
1. Assess the health needs of the community	<p>A community health needs assessment process that systematically describes the prevailing health status and health needs of the community is in place.</p> <p>(1) reviews the health status and health needs of the entire jurisdiction (2) includes community input and participation (3) includes mortality and morbidity information available through vital records as well as other sources (4) includes information from behavioral risk-factor surveys to identify community risk factors, their prevalence, and inter-relationships</p>	6. Develop plans and policies to address priority health needs	<p>A health action plan for the community and a long-range strategic plan for the health department, both of which include the current year, are available and address priority community health needs as well as reflect the participation of constituents and other groups in their development.</p> <p>(17) community health action plan addresses priority health needs (18) community health action plan incorporates public and other constituency participation in its development (19) a long-range strategic plan for the health department is linked to the community health action plan</p>
2. Investigate the occurrence of adverse health events and health hazards in the community	<p>Timely investigations of the occurrence of adverse health events and health hazards in the community are conducted on an ongoing basis.</p> <p>(5) epidemiologic surveillance systems (such as sentinel physicians, hospital reporting, and disease register) are in place and functioning (6) monitoring of any outbreak/adverse health event to prevent the spread of disease or additional adverse outcome is routine</p>	7. Manage resources and organizational structure	<p>The department has the necessary organizational structure, as well as a strategy for identifying and/or securing funding to address priority health needs.</p> <p>(20) an organizational self-assessment and plan for responding to identified capacity needs has been completed (21) up-to-date written job descriptions for each position in the health department including minimum qualifications and written plans or policies regarding staff recruitment, selection, development, and retention (22) a current strategy to identify or secure funding to address priority health needs</p>
3. Analyze the determinants of identified health needs	<p>Health needs are analyzed to establish their determinants and contributing factors, the adequacy of existing health resources, and the population groups most impacted in the community.</p> <p>(7) health needs are analyzed to determine causes of health problems (8) health needs of population groups at highest risk are analyzed (9) adequacy of existing health resources is analyzed</p>	8. Implement programs	<p>Priority health needs are effectively addressed in the community through implementation of mandated programs and services, or through assurance that other priority services are either provided or available in the community.</p> <p>(23) health department-mandated programs are being addressed (24) for each priority health need, the health department is currently providing services or has assured that another agency(ies) is providing such services</p>
4. Advocate for public health, build constituencies, and identify resources in the community	<p>There is a network of support and communication relationships that includes health-related organizations, the media, and the general public.</p> <p>(10) health department meets at least annually with representatives of health-related organizations in the community to define roles and responsibilities (11) reports regarding public health issues are widely disseminated to the community regularly (12) background information and news information are provided to the local media regularly</p>	9. Evaluate programs and provide quality	<p>Health department programs and services are delivered in compliance with applicable professional and regulatory standards, and goals and objectives exist for each of its</p>

- assurance programs, are monitored on a regular basis, and are used to redirect programs and resources as appropriate.
- (25) the health department's periodic review of programs, services, and personnel demonstrates compliance with applicable professional and regulatory standards
 - (26) the health department periodically monitors programs to assess compliance with program goals and objectives
 - (27) health department program changes are made on the basis of evaluation and quality assurance activities
10. Inform and educate the public
- The public is informed and educated about current health status, health care needs, positive health behaviors, and important health care policy issues.
- (28) the public is informed and receives education and information about health status, health care needs, positive health behaviors, and important health care policy issues on an ongoing basis
 - (29) public health services are routinely publicized to high-risk groups
-

Handler, AS; Turnock, BJ; Hall, Wm; Potsic, S; Munson, J; Nalluri, R; Vaughn, EH;
"A Strategy for MEasuring Local Public Health Practice" Am J of Preventive Medicine, Supplement to 11(6), Nov/Dec, 1995, pages 34-45

Richards, TB; Rogers, JJ; Christenson, GM; Miller, C. Arden; Gatewood, DD; Taylor, MS; "Assessing Public Health Practice: Application of Ten Core Function Measures of Community Health in Six States" Am J of Preventive Medicine, Supplement to 11(6), Nov/Dec, 1995 pages 39-40

APPENDIX 1

Abbreviations used for indicators for the assessment core function

Item	Abbreviation	Indicator
Q1	Needs	In the past three years in your jurisdiction, has there been a health needs assessment that included using morbidity, mortality, and vital statistics data?
Q2	Age-specific	In the past three years in your jurisdiction, have there been age-specific surveys to assess participation in preventive and screening services?
Q3	Behavioral	In the past three years in your jurisdiction, has the population been surveyed for behavioral risk factors?
Q4	Investigation	In the past year in your jurisdiction, has there been timely investigation of any unusual adverse health events?
Q5	Hospital ?	In the past three years in your jurisdiction, has there been a review of hospital discharge data to determine age-specific leading causes of hospitalization?
Q6	Work-related	In the past three years in your jurisdiction, has there been a review of work-related morbidity and mortality?
Q7	Immunized ?	In the past three years in your jurisdiction, has there been an analysis of data on children two years of age who have been immunized with the basic series?
Q8	High-risk	In the past three years in your jurisdiction, has there been an analysis of health services needed by high-risk population groups?

APPENDIX 2

Abbreviations used for indicators for the policy development core functions

Item	Abbreviation	Indicator
Q9	Review ?	In the past three years, has there been a public review of the public health mission for your agency's jurisdiction?
Q10	Meetings ?	In the past year, as part of the job, have you and your senior staff members regularly participated in meetings with other community health organizations?
Q11	Officials ?	In the past year in your jurisdiction, has there been a formal attempt at informing elected officials about the potential public health impact of actions under their consideration?
Q12	Advocates	In the past year in your jurisdiction, have elected or other government officials been strong advocates for public health?
Q13	Prioritized	In the past three years in your jurisdiction, have community health initiatives been prioritized on the basis of established problems and resources?
Q14	Policy ?	In the past three years, has your health department published an explicit policy agenda for the department?
Q15	Candidates ?	In the past year, has there been a formal attempt to inform candidates for elective office about health priorities in your jurisdiction?
Q16	Plan developed	In the past year in your jurisdiction, has a community health action plan developed with shared input from local, regional, and state levels been used?
Q17	Plan used ?	In the past year in your jurisdiction, has a community health action plan developed with public participation been used?
Q18	Agreements	In the past three years, has your health department entered into any written agreements with key health care providers or funding sources to define service roles?

Note: Items with question marks denote those found to be weak items and not usable as is.

APPENDIX 3

Abbreviations used for indicators for the assurance core function

Item	Abbreviation	Indicator
Q19	Codes	In the past three years in your jurisdiction, have health codes that apply to your jurisdiction been reviewed to assure they were up-to-date?
Q20	Standards	In the past three years in your jurisdiction, have public health services been reviewed to assure they comply with applicable professional and regulatory standards?
Q21	Safety	In the past year in your jurisdiction, has there been a program to assure environmental safety?
Q22	Access	In the past year in your jurisdiction, has there been a program to assure access to basic personal health services for those unable to afford them?
Q23	Effect	In the past year in your jurisdiction, has there been any evaluation of the effect that public health services have on community health?
Q24	Budget	In the past year in your jurisdiction, has there been any evaluation of the effect that budget changes for your health department would have on public health problems?
Q25	Informing	In the past year in your jurisdiction, has there been a formal attempt at informing the public about health problems?
Q26	Media	In the past year in your jurisdiction, have reports on public health problems been provided to the local media?

Core Function-Related Measures of Local Public Health Practice Performance

Developed Collaboratively by University of North Carolina and University of Illinois-Chicago Investigators, 1995

Assessment

1. For the jurisdiction served by your local public health agency, is there a community health needs assessment process that systematically describes the prevailing health status and needs of the community?
2. In the past three years in your jurisdiction, has the local public health agency surveyed the population for behavioral risk factors?
3. For the jurisdiction served by your local public health agency, are timely investigations of adverse health events, including communicable disease outbreaks and environmental health hazards, conducted on an ongoing basis?
4. Are the necessary laboratory services available to the local public health agency to support investigations of adverse health events and meet routine diagnostic and surveillance needs?
5. For the jurisdiction served by your local public health agency, has an analysis been completed of the determinants and contributing factors of priority health needs, adequacy of existing health resources, and the population groups most impacted?
6. In the past three years in your jurisdiction, has the local public health agency conducted an analysis of age-specific participation in preventive and screening services?

Policy Development

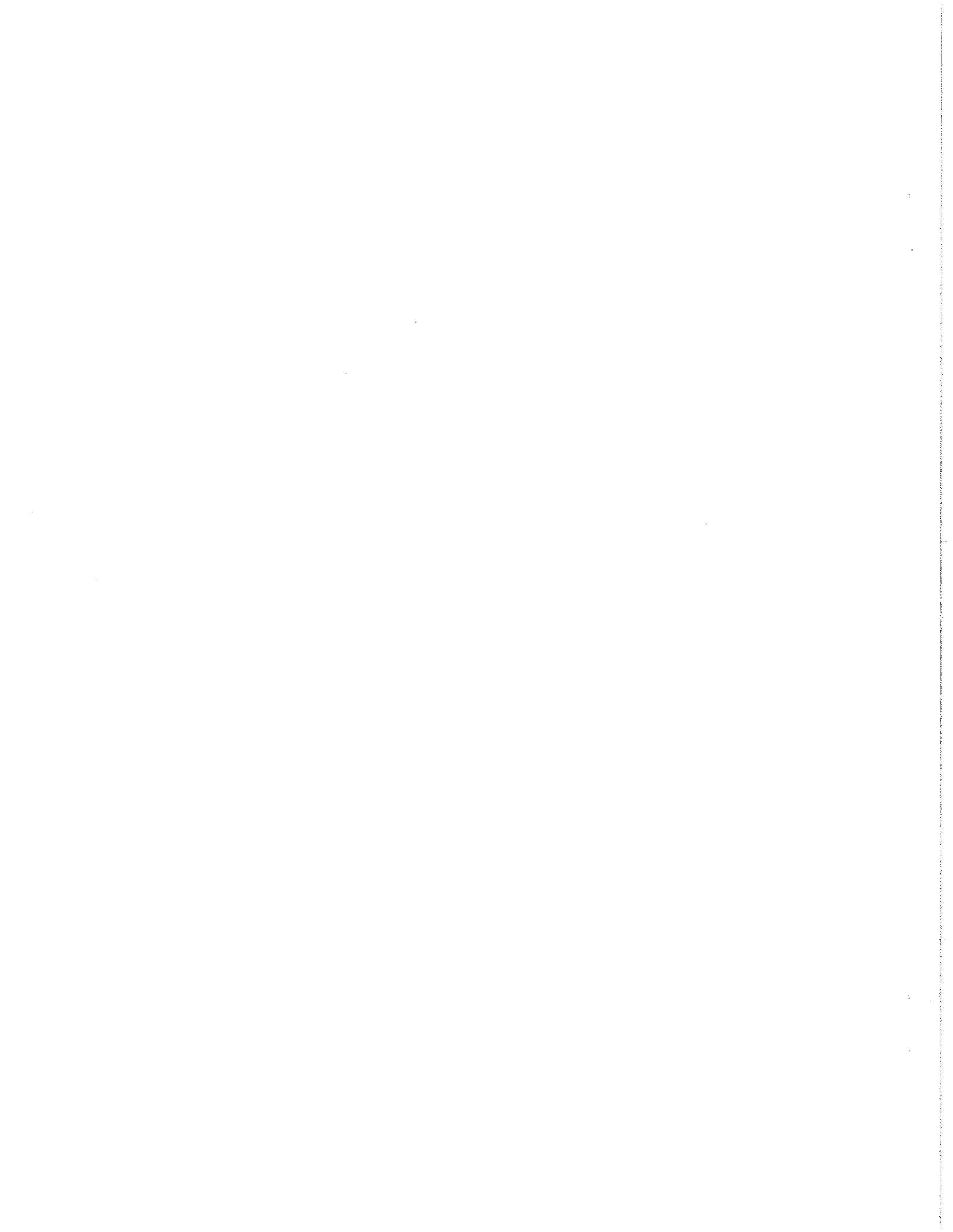
7. For the jurisdiction served by your local public health agency, is there a network of support and communication relationships, which includes health-related organizations, the media, and the general public?
8. In the past year in your jurisdiction, has there been a formal attempt by the local public health agency at informing elected officials about the potential public health impact of actions under their consideration?
9. For the jurisdiction served by your local public health agency, has there been a prioritization of the community health needs that have been identified from a community needs assessment?
10. In the past three years in your jurisdiction, has the local public health agency implemented community health initiatives consistent with established priorities?

11. For the jurisdiction served by your local public agency, has a community health action plan been developed with community participation to address community health needs?
12. During the past three years in your jurisdiction, has the local public health agency developed plans to allocate resources in a manner consistent with the community health action plan?

Assurance

13. For the jurisdiction served by your local public health agency, have resources been deployed, as necessary, to address the priority health needs identified in the community health needs assessment?
14. In the past three years in your jurisdiction, has the local public health agency conducted an organizational self-assessment?
15. For the jurisdiction served by your local public health agency, are age-specific priority health needs effectively addressed through the provision of or linkage to appropriate services?
16. In the past three years in your jurisdiction, has there been an instance in which the local public health agency has failed to implement a mandated program or service?
17. For the jurisdiction served by your local public health agency, have there been regular evaluations of the effect that public health services have on community health status?
18. In the past three years in your jurisdiction, has the local public health agency used professionally recognized process and outcome measures to monitor programs and to redirect resources as appropriate?
19. For the jurisdiction served by your local public health agency, is the public regularly provided with information about current health status, health care needs, positive health behaviors, and health care policy issues?
20. In the past year in your jurisdiction, has the local public health agency provided reports to the media on a regular basis?

Source: Reprinted from B.J. Turnock, *Public Health: What It Is and How It Works*. © 1997, Aspen Publishers, Inc.







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