

National Public Health Standards and Voluntary Accreditation: Implications and Opportunities for Public Health Performance Improvement in Minnesota

**A Report from the Performance Improvement and
Accreditation Work Group of the
State Community Health Services Advisory Committee**



December 2010



Office of Performance Improvement
P.O. Box 64882
St. Paul, MN 55164-0082
651-201-3880; TDD 651-201-5797



Government Center
555 - 18th Ave. SW
Cambridge, MN 55008

COMMISSIONERS

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Hannah Christenson,
Administrative Assistant

763-689-3859

December 20, 2010

Sanne Magnan, MD, PhD
Commissioner of Health
Minnesota Department of Health
Post Office Box 64975
St. Paul, MN 55164-0975

Dear Commissioner Magnan:

I am pleased to present to you the final report of the Performance Improvement and Accreditation Work Group of the State Community Health Services Advisory Committee (SCHSAC). The SCHSAC approved this report at its meeting on December 17, 2010.

Recognizing that public health systems around the country will be influenced by a new set of national public health standards and the voluntary national accreditation program scheduled for implementation in 2011, this SCHSAC work group was charged with (1) examining the proposed national performance standards and measures for Minnesota's state and local health departments, (2) exploring the implications of these standards and measures for Minnesota, and (3) making recommendations for Minnesota's public health system.

After extensive study, discussion and consultation with local public health departments, local elected officials and other key stakeholders, the work group came to view the national standards developed by the Public Health Accreditation Board (PHAB) and voluntary national accreditation as highly significant developments with major implications and important opportunities for public health in Minnesota.

Through these deliberations and consultations, the work group developed consensus on several points of agreement and a vision for public health performance improvement in Minnesota that formed the basis for the work group recommendations. The PIA Work Group encourages the state-local partnership to use the national standards as the foundation for a shared commitment to integrate standards, measures, quality improvement, and reporting into core operations. This will enable the achievement of public health outcome goals as efficiently and effectively as possible – and will also facilitate preparation for voluntary national accreditation.

The work group developed eight recommendations that address system-level changes, technical assistance and support, and voluntary accreditation. Together, the recommendations pave the way for strengthening performance improvement in Minnesota's public health system, while supporting the local decision to apply for accreditation. On behalf the SCHSAC I request your acceptance and approval of this report.

Sincerely,

Susan Morris, SCHSAC Chair
Isanti County Commissioner
Government Center
555 18th Ave SW
Cambridge, MN 55008



Protecting, maintaining and improving the health of all Minnesotans

December 20, 2010

Susan Morris, SCHSAC Chair
Isanti County Commissioner
Government Center
555 18th Ave SW
Cambridge, MN 55008

Dear Commissioner Morris:

Thank you for sending me the final report of the Performance Improvement and Accreditation Work Group of the State Community Health Services Advisory Committee (SCHSAC). The recommendations and report thoroughly address the issues laid out in the work group charge and provide a vision and recommendations to strengthen performance improvement in Minnesota's public health system. I accept this report and its recommendations.

I applaud the work group for its thoughtful consideration and respect for the need to balance a system-wide approach to performance improvement while supporting the local decision-making process regarding accreditation. I believe that the recommendations in this report set the stage for strengthening the capability of Minnesota's public health system to improve public health outcomes for all Minnesotans.

While I may not have the privilege of continuing to work with you on this issue as Commissioner of Health, I can assure that I will continue to watch your process with interest and will recommend support from my incoming successor.

Sincerely,

A handwritten signature in black ink that reads "Sanne Magnan". The signature is written in a cursive, flowing style.

Sanne Magnan, M.D., Ph.D.
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

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For more information contact:
Office of Performance Improvement
P.O. Box 64882
Phone: 651-201-3880
Fax: 651-201-3830
TDD: 651-201-5797

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Executive Summary

Since Minnesota's state-local public health partnership formed in 1976, it has remained steadfast in a shared commitment to improve health outcomes for all Minnesotans. Over the years, the partnership has developed systems and resources to improve local performance and accountability, just as the legislature and governor have acted to improve performance and accountability at the state level.

On a national level, several prominent public health organizations have joined together to advance the credibility, accountability and performance of public health departments. This collaborative work resulted in the development of national standards and a voluntary national accreditation program, and mobilizing incentives for their use. The State Community Health Services Advisory Committee (SCHSAC) convened the Performance Improvement and Accreditation (PIA) Work Group to examine these standards, explore their implications for Minnesota, and make recommendations. The work group produced several points of agreement and a vision statement that culminated in recommendations for system change, technical assistance and support, and voluntary national accreditation.

In Fall 2009, Hennepin County Human Services and Public Health (HCHSPH) was selected as a beta test site to test the voluntary national accreditation process. In Summer 2010, a 4-member site visitor team reviewed the HCHSPH self-assessment and documentation, facilitated a three day site visit, and produced a report highlighting strengths and suggestions for improvement. HCHSPH produced an improvement plan patterned after an after-action report and has begun implementing a quality improvement process identified in the plan.

Points of Agreement within the Work Group

After extensive study, discussion and consultation, the work group came to view the national standards developed by the Public Health Accreditation Board (PHAB), aka "national standards", and voluntary national accreditation as highly significant developments with major implications and important opportunities for public health in Minnesota. The following points of agreement formed the basis of the work group recommendations:

1. The PHAB standards represent a national consensus of the core functions and essential services of local and state governmental public health departments and largely reflect current practice in Minnesota.
2. The work group believes that achieving the national standards will improve performance, and that improving performance will ultimately improve public health outcomes.
3. The national standards provide a new framework and opportunity to improve Minnesota's local public health performance improvement system.
4. Community Health Boards (CHBs) play a pivotal role in the state-local partnership and Minnesota's public health system. As the governing entity responsible for protecting and

promoting local public health in Minnesota, the CHB is the most useful and meaningful unit of government to seek voluntary national accreditation at the local level. However, each multi-county CHB has unique legal agreements, and PHAB has the ultimate authority in determining the entities eligible for accreditation.

5. The state-local partnership should act collaboratively and systematically to improve performance and thereby facilitate achieving the national standards.
6. An organizational assessment that engages staff, management, advisory boards and governing entities is a crucial step to increase familiarity with the national standards and voluntary national accreditation process, gauge capacity to achieve the national standards, and prioritize areas for improvement.
7. MDH and CHBs should position themselves to capitalize on anticipated national incentives for voluntary national accreditation.
8. If the Minnesota Department of Health (MDH) offers any incentives to those who achieve voluntary national accreditation, (e.g., streamlined reporting and/or other administrative requirements), the incentives should not punish those who do not pursue or achieve voluntary national accreditation.
9. The external validation and objective feedback provided through an effective accreditation process could have significant potential to accelerate performance improvements in participating health departments.
10. Minnesota's state-local partnership should explore opportunities to streamline reporting and other administrative requirements for those who achieve voluntary national accreditation.

Vision Statement for Public Health Performance Management in Minnesota

Minnesota's governmental public health system demonstrates accountability, results and efficiency through the ongoing use of performance standards, measures and outcome reports that guide quality improvement efforts and decision-making for the ultimate purpose of improving and protecting the health of Minnesotans.

Recommendations

The PIA Work Group encourages the state-local partnership to use the national standards as the foundation for a shared commitment to integrate standards, measures, quality improvement, and reporting into core operations. This will enable the achievement of public health outcome goals as efficiently and effectively as possible – and will also facilitate preparation for voluntary national accreditation.

Brown County Public Health has been gradually introducing the national standards to staff, county commissioners and members of its advisory committee over the last nine months. They introduced one standard at a time to the staff and the commissioners each month and a few standards at each Advisory Committee meeting as time allows.

System-Level Change

1. Minnesota's state-local partnership should transition the local public health performance improvement system to align with the national standards rather than the essential local public health activities (ELAs).
 - 1.1. SCHSAC should provide oversight and input during the transition to align Minnesota's current performance improvement system with the national standards.
 - 1.2. The six areas of public health responsibility should remain as a framework to describe the work of public health, organize community health assessments and improvement plans; and report planning, staffing, financial and performance data.
 - 1.3. The performance measures used in the local public health reporting system and the key indicators used in the local public health accountability review process should be revised to reflect the national standards and measures rather than the ELAs.
 - 1.4. The PHAB *Local Standards and Measures Self-Assessment Tool* should replace the current capacity assessment in the Community Health Assessment and Action Planning Process (CHAAP).
2. CHBs should complete the PHAB *Local Standards and Measures Self-Assessment*, prioritize areas for improvement, and develop an improvement plan by the end of 2014. This process should engage staff, management, advisory boards and governing entities.

Technical Assistance and Support

3. MDH should develop and implement a plan to help CHBs and MDH improve performance and achieve the national standards.
4. MDH should *lead* outreach to state policy makers, and *support* outreach to local policy makers, to educate policy makers on the importance of national standards, performance improvement, and voluntary national accreditation.

Voluntary National Accreditation through the Public Health Accreditation Board

5. MDH should lead the way by preparing for state-level accreditation, and seeking voluntary national accreditation at the earliest opportunity (no later than 2013).
6. MDH and CHBs should work together so that all CHBs are prepared to apply for voluntary national accreditation by 2015.
7. CHBs and local health departments should review their governance and organizational structures, responsibilities, authorities and current legal agreements in relation to the national standards and the voluntary national accreditation program. The MDH Office of

Performance Improvement (OPI) should continue to provide information and technical assistance as needed on CHB governance and administration.

8. SCHSAC should convene a work group in 2013 to examine progress on the PIA Work Group's recommendations, assess developments with the voluntary national accreditation program, and revise these recommendations if appropriate.

Minnesota's new public health performance improvement program (*Strengthening Public Health Infrastructure for Improved Health Outcome*) will expand technical assistance opportunities to build capacity related to the national standards, and integration of standards, measures, quality improvement and reporting within a broader performance management framework.

National Public Health Standards and Voluntary Accreditation: Implications and Opportunities for Public Health Performance Improvement in Minnesota

This report presents the findings and recommendations of the Performance Improvement and Accreditation (PIA) Work Group, of the State Community Health Services Advisory Committee (SCHSAC). SCHSAC convened the work group in February 2010 in the midst of calls for more accountability and efficiency in governmental services, and in anticipation of the upcoming launch of a voluntary national accreditation program for state, and tribal local health departments.

The work group was charged to examine national standards developed by the Public Health Accreditation Board (PHAB) for state and local health departments, explore their implications for Minnesota, and make recommendations. Members of the work group represented state and local health departments throughout Minnesota. Members represented a wide range of governance and organizational structures and populations served. See Appendix A: PIA Work Group Charge and Membership.

Methods

In exploring implications and making recommendations, the work group was also charged to consider factors such as the roles and interdependence of health departments in Minnesota, Minnesota's current performance improvement and reporting systems, the need for and possibilities of incentives for accreditation, and potential barriers to accreditation. To fulfill their charge, work group members:

- Examined and discussed the national standards and measures.
- Examined and discussed the linkages between the national standards and measures and Minnesota's current local public health performance improvement system.
- Completed and discussed organizational self-assessments to help estimate current capacity to meet the national standards in Minnesota.
- Surveyed Local Public Health Association (LPHA) members about their familiarity with the national standards and their expectations related to accreditation.
- Met with national, state, and local public health leaders in performance improvement and accreditation, including some who participated in the voluntary national accreditation beta test.
- Reviewed Minnesota initiatives related to performance improvement and/or accreditation that are recently completed, underway, or planned (e.g., the SCHSAC Blueprint Work Group, the Minnesota Public Health Quality Improvement (QI) Collaborative, infrastructure development funding awarded to the Minnesota Department of Health (MDH) by the Centers for Disease Control and Prevention (CDC)).
- Presented preliminary recommendations at the September 2010 SCHSAC meeting and to top local public health officials and leaders during the 2010 Community Health Conference.
- Identified points of agreement and a vision statement.
- Developed final recommendations.

Momentum for Performance Improvement in Minnesota

Minnesota's state and local public health partnership has systematically developed systems and resources designed to improve local public health performance and accountability. For example:

- Statewide goals/strategies and outcomes were developed;
- Essential Local Public Health Activities (ELAs) were developed to serve as standards for what all Minnesotans can expect from their local health departments;
- Community Health Assessment and Action Planning (CHAAP) was developed to streamline and improve the existing local assessment and planning process;
- Performance measures based on the ELAs, and the on-line Planning and Performance Measurement Reporting System (PPMRS) were developed to facilitate annual, local reporting of financial, staffing, and performance information to MDH; and
- An annual accountability review process was developed to assure compliance with statutory requirements of agencies that receive state funds.

Corresponding performance improvement efforts at the state level in Minnesota have ranged from a statutory requirement for all state agencies to submit performance reports to the state legislature, to a statewide website featuring state performance measures, and more recently, the Minnesota Drive to Excellence¹.

The Newborn Screening Unit at MDH examined the process for ensuring that infants who screen positive for hearing disorders are referred for diagnostic confirmation, and upon confirmation, receive appropriate intervention and long-term follow-up services. This QI initiative led to more strategic partnerships with local public health case managers and a 61% reduction in process time. This means that families will be notified and referred to services more quickly, and staff will have more time to be proactive rather reactive in efforts to assist newborns with hearing disorders.

Several statewide initiatives related to performance improvement and/or accreditation are underway, planned or recently completed. These initiatives are highlighted here, and described in more detail in the appendices.

Minnesota Public Health Quality Improvement Collaborative. In 2009, Minnesota was selected by the Robert Wood Johnson Foundation (RWJF) as one of 16 states to participate in the Multi State Learning Collaborative (MLC), which aimed to build quality improvement capacity in public health agencies across the country and prepare state and local health departments for voluntary national accreditation. The Minnesota Local Public Health Association (LPHA), Minnesota Department of Health (MDH) and the University of Minnesota, School of Public Health (SPH) formed the Minnesota Public Health Collaborative for Quality Improvement (aka QI Collaborative) in 2007 to steer Minnesota's participation in this national effort.

¹ Minnesota Drive to Excellence: <http://www.state.mn.us/portal/mn/jsp/home.do?agency=Excellence>

A small health department in southwest Minnesota used a quality improvement process to strengthen the relationship with local provider clinics and overcome barriers to immunization. Over a six-month period the rate of up-to-date immunizations among two year olds increased countywide from 32% to 47%.

The QI Collaborative has since engaged 37 Minnesota CHBs (approximately 68%) and provided more than 15 trainings to hundreds of state and local public health directors, managers and staff from every region of the state. Moreover, participation in the national collaborative has enabled 10 state and local leaders to attend national meetings and trainings that have accelerated performance improvement activities in Minnesota.

Training, technical assistance and mutual support offered through the QI Collaborative has enabled most Minnesota health departments to apply quality improvement approaches widely used in the private sector. The collaborative has demonstrated not only the feasibility of applying quality improvement within governmental public health departments, but also the significant potential to realize efficiencies by doing so. Project teams have reported “break through” improvements after only nine months of focused quality improvement activity. For example, local teams have reported:

- Time spent charting tuberculosis cases was reduced by over 17 %;
- Staff time devoted to testing on the Health Alert Network (HAN) decreased by 70%; and
- On-time reporting of personal care assistant reassessments increased from 62% to 100%.

These teams used a standard quality improvement process on locally-identified priorities for improvement. Teams typically capitalized on existing data to guide improvement efforts. This use of available data to tackle local priorities using tested quality improvement techniques epitomizes a performance oriented approach to management, and suggests that improvements realized in one department could multiply as they are adopted by others.

Despite this progress, MDH strategic planning and Minnesota’s QI Collaborative have elevated the need for more widespread use of performance management to integrate standards, measures and outcome reports that are used for quality improvement and decision-making. Minnesota local health officials typically report that it remains challenging to implement methods for assessing and improving quality, and most report that accurate and timely data is not available for managers to evaluate the quality of their services. See Appendix B: MLC Fact Sheet.

Performance Management. MDH has built on the success of the QI Collaborative in ways that will benefit the entire public health infrastructure in Minnesota. The CDC has awarded the MDH a 5-year cooperative agreement for a bold new infrastructure development program entitled *Strengthening Public Health Infrastructure for Improved Health Outcomes*. The goal of this new program is to systematically increase the performance management capacity of public health departments in order to ensure that public health goals are effectively and efficiently met. One central aim of Minnesota’s successful proposal is to provide technical assistance to support performance management and close gaps in current capacity to meet national standards. See Appendix C: Strengthening Public Health Infrastructure for Improved Health Outcomes.

The performance management model² below defines performance management as *the practice of actively using performance data to improve the public's health* and is embedded within Minnesota's new infrastructure development initiative:



MDH and CDC anticipate that performance management will help state and local health departments use resources more effectively and efficiently, and will expand the focus of decision-makers from cost to value. Traditional public sector budget processes focus on the questions “is it mandated?” and “how much does it cost?” rather than questioning what governments may be able to “provide” in return for an investment or expenditure. Performance management informs discussion on both costs and results. This in turn allows governments to maximize resources. See Appendix D: Reasons Why Performance Management is Important.

SCHSAC Blueprint for Successful Local Health Departments Work Group (BPWG). The BPWG convened in 2009 and presented recommendations to SCHSAC in September 2010. This work group developed a philosophy and vision for the future of Minnesota’s local public health system. The philosophy of the BPWG and the overarching message of its report can be summarized in three points.

- It’s time to “raise the bar”.
- This is the “new normal”.
- We need to create our own future.

The philosophy of the BPWG so closely matches that of the PIA Work Group that a description of these points, excerpted from the BPWG’s report³, is inserted on the following page.

² Turning Point National Excellence Collaborative on Performance Management

³ *Updating Minnesota’s Blueprint for Public Health*, SCHSAC Blueprint for Successful Local Health Departments Work Group, 2010

It's time to “raise the bar”. Too often we, as a system, have made recommendations and set requirements that everyone can meet (i.e., only setting minimum requirements). Work group members speculated that this approach may have limited our progress and success. The required minimums for qualifications, performance and reporting are clear; now higher expectations are needed to “raise the bar” and motivate continuous improvement throughout the system. To ensure the future strength of our system we need to set a vision and establish “stretch goals” for ourselves.

This is the “new normal”. The current financial hardships facing all levels of government make it appealing and convenient to put off implementing changes until additional resources become available. Yet according to recent presentations by Minnesota’s State Demographer, Tom Gillaspay and State Economist, Tom Stinson, there will never be more resources again, “this is the new normal”. They argue that this new normal presents opportunities to be creative and innovative in the way we do business, and the Blueprint work group agrees.

We need to create our own future. This isn’t the beginning; we are starting with a strong local public health system and the wisdom of more than 30 years of experience working within it. There are many other things in the state and national environments which can influence our direction and impact our success, like the economy, Human Services Redesign, and Voluntary National Accreditation to name a few. Setting our own vision and selecting our recommendations and priorities allows us to chart our own course

In addition, the BPWG has called for leadership that is *grounded in quality, effectiveness, outcomes, state and national standards, and sound/balanced/fair decision-making*; and actions related directly to performance management, performance improvement and accreditation. For example, again excerpted from the BPWG’s report [emphasis added]:

MDH should work internally to examine the performance of CHBs and local health departments (LHDs) from an *overall management perspective* (i.e., beyond individual grant management and fiscal accountability activities) to ensure that CHBs and LHDs are able to deliver public health programs as promised, and spend public health funding as intended.

MDH should continue to support the state-local partnership with a particular emphasis on:

- Promoting state and local commitment to improvement of the public health system by *building the capacity to fulfill the national public health standards and measures developed by the Public Health Accreditation Board (PHAB)*; and
- Advancing a culture of *continuous quality improvement* throughout the state and local public health system.

Voluntary National Accreditation through the Public Health Accreditation Board

SCHSAC initially explored the topic of public health accreditation in 1998, when it convened the *Local Public Health Accreditation Work Group*. See Appendix E: State and National Timeline of Public Health Performance Improvement Initiatives. Though that work group recommended

against developing a statewide accreditation program, the work group agreed *that clear program and performance expectations and related measurable indicators could promote consistent and improved public health practice in Minnesota*. The work group also recommended that SCHSAC monitor national developments related to accreditation and convene a future work group as needed.

In recent years on a national level, several prominent public health organizations joined together to advance the quality and performance of public health departments by championing development of a voluntary national accreditation program. These national organizations include: the CDC, the RWJF, the National Association of County and City Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the American Public Health Association (APHA), the National Association of Local Boards of Health (NALBOH), the National Indian Health Board (NIHB), the Public Health Foundation (PHF), and the National Network of Public Health Leadership Institutes. In addition, several of them provide technical assistance and support to health departments preparing for accreditation. This collective effort was largely motivated by the 1988 report entitled *The Future of Public Health*, in which the Institute of Medicine proposed that a stronger public health infrastructure and a public health system with substantially greater visibility and credibility were urgently needed to measurably improve population health outcomes.

Implementation of the voluntary national public health accreditation program is now imminent. The CDC and RWJF have provided financial support to incorporate and convene PHAB; develop a framework of standards and measures for state, local and tribal health departments; and initiate the voluntary national accreditation program. The standards and accreditation processes have been tested in state, local and tribal health departments of varying sizes and structures, and PHAB is on schedule to begin accepting applications for accreditation in 2011. The RWJF, a major funder of public health services and research in Minnesota and around the country, aims to have 60 percent of the U.S. population served by an accredited public health department by 2015.

Many public health leaders and organizations in Minnesota have actively engaged in the development of the standards and the accreditation program, and many have begun to lay the groundwork to pursue voluntary national accreditation. For example:

- LPHA and MDH partnered in a Spring 2010 vetting process for the state and local standards. Recommendations submitted in a joint letter to PHAB reflect the collective discussion of more than 80 local public health officials during seven regional meetings, and a systematic review by senior managers within MDH.
- MDH and 37 CHBs participated in the QI Collaborative to build capacity to achieve the national standards, particularly Domain 9: *Evaluate and continuously improve processes, programs and interventions*.
- One Minnesota CHB was selected to test the standards, tools, and processes developed for voluntary national accreditation (e.g., selected by PHAB to serve as a “best test” site for the

accreditation program, and another was selected by NACCHO to serve as a demonstration site for accreditation and quality improvement).

In Fall 2009, Hennepin County Human Services and Public Health (HCHSPH) was selected as a beta test site to test the voluntary national accreditation process. In Summer 2010, a 4-member site visitor team reviewed the HCHSPH self-assessment and documentation, facilitated a three day site visit, and produced a report highlighting strengths and suggestions for improvement. HCHSPH produced an improvement plan patterned after an after-action report and has begun implementing a quality improvement process identified in the plan.

- Minnesota’s research and practice communities, including local and tribal health departments, have worked directly with PHAB in various capacities (e.g., as members of the Board of Directors, the Standards Development Committee, and the Tribal Standards Work Group). Four Minnesotans – including a former state health commissioner – were also trained as site visitors for the 2010 beta test of the voluntary national accreditation process.
- During Summer 2010, staff to PIA Work Group attended each of the seven regional LPHA meetings. Responses to a survey completed on-site after each meeting suggest that many local public health officials in multiple regions around the state have already directed significant attention to the national standards and/or voluntary national accreditation. See Appendix F: Local Public Health Association Regional Meetings: Summary of Key Findings and Considerations for the PIA Work Group.

Brown County Public Health has been gradually introducing the national standards to staff, county commissioners and members of its advisory committee over the last nine months. They introduced one standard at a time to the staff and the commissioners each month and a few standards at each Advisory Committee meeting as time allows.

Synthesis of Feedback to the PIA Work Group

The work group used a variety of channels to invite input and seek feedback on its initial conclusions and preliminary recommendations (e.g., regional LPHA meetings, the September 2010 SCHSAC meeting and a concurrent session at the 2010 Community Health Conference). The themes that emerged across these events cluster into several broad areas, incorporate multiple points of view, and contributed to the substantive discussions that produced the work group’s recommendations. See Appendix G: Summary of Feedback on Preliminary PIA Work Group Recommendations.

System Improvement. Voluntary national accreditation may increase credibility, transparency and accountability and is considered by some a “next step” in Minnesota’s ongoing effort to improve the public health system. Countervailing views emphasize that public health in Minnesota is already held in high regard and question whether new documentation requirements will mostly amount to “paperwork” with limited added value.

Cost. Some anticipate that the direct and indirect costs of accreditation may be significant and unrealistic, particularly at a time when budgets are tightening and staffs are shrinking. Others emphasize that potential financial incentives and performance improvements underscore the value of accreditation and may balance the investments required.

Visibility. The framework of national standards and accreditation may raise the visibility of public health, and inform local discussion and decision making related to governance and organization of public health services.

Variation and equity. Resources, capacity and structures vary around the state and have implications for readiness and pace for pursuing accreditation. Many recommend applying incentives and rewards for accreditation in a manner that avoids punitive consequences for the organizations – and people served by organizations – who don't achieve accreditation. Another view suggests that more standardization is needed to help assure that all Minnesotans should expect and receive a similar level of public health services, and that this standardization will facilitate accountability and equity.

Local control. The national accreditation program is voluntary. However, many express concern about what they see as a mounting, implicit mandate to pursue accreditation. Some also question whether the framework of national standards will stifle systems level change and innovations related to the social determinants of health

Partnership. Input to the PIA Work Group has consistently emphasized the critical importance of working together to: (1) create systems-level changes that align with, and facilitate achieving the national standards, and (2) develop, adapt and/or share templates and tools that will facilitate achieving and documenting the national standards.

Technical assistance. Few question the need or value of technical assistance, but many have offered pointed suggestions for its content, delivery and timing.

Points of Agreement within the Work Group

The work group came to view the national standards and voluntary national accreditation program as highly significant developments with major implications and important opportunities for public health in Minnesota. This viewpoint is reflected in the following points of agreement.

1. The national standards represent a national consensus of the core functions and essential services of local and state governmental public health departments and largely reflect current practice in Minnesota.
2. The work group believes that achieving the national standards will improve performance, and that improving performance will ultimately improve public health outcomes.
3. The national standards provide a new framework and opportunity to improve Minnesota's local public health performance improvement system.

4. CHBs play a pivotal role in the state-local partnership and Minnesota’s public health system. As the governing entity responsible for protecting and promoting local public health in Minnesota, the CHB is the most efficient and meaningful unit of government to seek voluntary national accreditation at the local level. However, each multi-county CHB has unique legal agreements, and PHAB has the ultimate authority in determining the entities eligible for accreditation.
5. The state-local partnership should act collaboratively and systematically to improve performance and thereby facilitate achieving the national standards.
6. An organizational assessment that engages staff, management, advisory boards and governing entities is a crucial step to increase familiarity with the national standards and voluntary national accreditation process, gauge capacity to achieve the national standards, and prioritize areas for improvement.
7. MDH and CHBs should position themselves to capitalize on anticipated national incentives for voluntary national accreditation.
8. If MDH offers any incentives to those who achieve voluntary national accreditation, (e.g., streamlined reporting and/or other administrative requirements), those incentives should not punish those who do not achieve voluntary national accreditation.
9. The external validation and objective feedback provided through an effective accreditation process could have significant potential to accelerate performance improvements in participating health departments.
10. Minnesota’s state-local partnership should explore opportunities to streamline reporting and other administrative requirements for those who achieve voluntary national accreditation.

Vision Statement for Public Health Performance Management in Minnesota

Minnesota’s governmental public health system demonstrates accountability, results and efficiency through the ongoing use of performance standards, measures and outcome reports that guide quality improvement efforts and decision-making for the ultimate purpose of improving and protecting the health of Minnesotans.

Recommendations

The PIA Work Group encourages the state-local partnership to use the national standards as the foundation for a shared commitment to integrate standards, measures, quality improvement, and reporting into core operations. This will facilitate the demonstration of accountability, validate public health activities, and enable us to achieve public health outcome goals as efficiently and effectively as possible. Moreover, this will also facilitate the preparation for voluntary national accreditation for those that choose to pursue it. The work group has organized its recommendations into three broad categories:

- System level changes to facilitate performance
- Technical assistance and support to improve performance
- National voluntary national accreditation through PHAB as an indicator of performance

System-Level Changes

Minnesota’s current public health performance improvement system is based on a set of 40 Essential Local Activities, or ELAs, that describe what all Minnesotans can expect from their local health departments, and includes guidelines and tools for community health assessment and planning, measures for and an on-line reporting system to collect local financing, staffing, and performance information (PPMRS), and an annual accountability review process.

The PIA Work Group believes that the emergence of the national standards should prompt system-level changes to Minnesota’s performance improvement system. Minnesota’s ELAs and the national standards both evolved from the 10 Essential Services and largely reflect current practice in Minnesota. Therefore, the work group believes that a re-orientation toward the national standards would bring Minnesota into closer alignment with others nationally – thereby enabling state to state performance comparisons – and maintain the integrity of Minnesota’s core functions and six areas of public health responsibility.

In addition, the work group believes that the state-local partnership should work together over time to minimize disruption, and avoid the time consuming crosswalks, duplication and confusion that would likely result from differences in language, organization and measurement between the ELAs and the national standards. See Appendix H: Comparison of Minnesota’s System to Accreditation Standards and Measures. Moreover, the work group viewed widespread and ongoing use of the more fully articulated national standards as a crucial next step toward integrating standards, measures, quality improvement and reporting in ways that meet heightened expectations for accountability, efficiency and results. See Appendix I: Summary of Standards.

Recommendation 1: Minnesota’s state-local partnership should transition the local public health performance improvement system to align with the national standards rather than the ELAs.

- 1.1 SCHSAC should provide oversight and input during the transition to align Minnesota’s current performance improvement system with the national standards.
- 1.2 The six areas of public health responsibility should remain as a framework to describe the work of public health, organize community health assessments and improvement plans, and report planning, staffing, financial and performance data.
- 1.3 Revise the performance measures used in the local public health reporting system and the key indicators used in the local public health accountability review process to reflect the national standards and measures rather than the ELAs.
- 1.4 The PHAB *Local Standards and Measures Self-Assessment Tool* should replace the current capacity assessment in the Community Health Assessment and Action Planning Process (CHAAP).

PIA Work Group members conducted and reported on an organizational self-assessment using the *Local Standards and Measures Self-Assessment Tool* (as referenced in recommendation 1.4).

This first-hand experience led the work group to view this organizational assessment as a strategic way to increase familiarity with the national standards and voluntary national accreditation process, gauge capacity to achieve the national standards, and prioritize areas for improvement.

Recommendation 2: CHBs should complete the PHAB *Local Standards and Measures Self-Assessment*, prioritize areas for improvement, and develop an improvement plan by the end of 2014. This process should engage staff, management, advisory boards and governing entities.

These system-level recommendations are intended to help *transition* Minnesota's local performance improvement system so that it *aligns* with the new national standards and they are consistent with the following recommendation from the Community Health Assessment and Action Planning (CHAAP) Process Evaluation Ad Hoc Group: "The CHAAP tools (handbook, website, worksheets and/or equivalents) should be updated to reflect the national accreditation standards and measures developed by the PHAB to assist CHBs in achieving the standards and assure those entities pursuing accreditation will not have to duplicate work."⁴ These broad recommendations are intended to guide the initial steps forward in the alignment process. Through Minnesota's new public health performance improvement program (*Strengthening Public Health Infrastructure for Improved Health Outcomes*), MDH will provide technical assistance and facilitate this transition with oversight and input from SCHSAC. CHBs are encouraged to begin their CHAAP process early in the 2010-2014 cycle to capitalize on the timing of these resources to strengthen the public health infrastructure.

Technical Assistance and Support

As noted earlier, work group members used the PHAB *Standards and Measures Self Assessment Tool* to conduct and share the results of an organizational self-assessment. Collectively, the self-assessments point to areas for improvement likely shared across Minnesota's public health system. Gaps in capacity were particularly apparent in two domains (*develop public health policies and plans* and *evaluate and continually improve processes, programs, and interventions*).

On a recent survey of top local public health officials in Minnesota, 57% reported a *high desire* for training in evaluation and quality improvement, far more than any other category. The work group concluded that substantial, long-term technical assistance and support related to the national standards and performance management are both desired and vital. Therefore, the workgroup recommends that:

Recommendation 3: MDH should develop and implement a plan to help CHBs and MDH improve performance and achieve the national standards.

Potential technical assistance strategies suggested by the work group include:

⁴ *Recommendations for the 2010-2014 CHAAP Cycle*, SCHSAC Community Health Assessment and Action Planning (CHAAP) Process Evaluation Ad Hoc Group, 2010.

- Use information from organizational self-assessments to inform technical assistance and training and build capacity to meet the national standards.
- Provide opportunities for peer to peer technical assistance, training and sharing of resources (e.g., through online sharing, conferences, and regional activities).
- Facilitate clarification of state and local roles and responsibilities in relation to the national standards.
- Realize efficiencies by developing and adapting model processes and policies, and by identifying and modifying state-level grant reporting requirements to more readily demonstrate national standards.
- Explore the potential for using legal agreements (e.g., Master Grant contract, Assurances and Agreements, or other) to document the achievement of local standards through action at the state level (e.g., infectious disease reporting, laboratory capacity).

Minnesota’s new public health infrastructure development program (*Strengthening Public Health Infrastructure for Improved Health Outcome*) will expand technical assistance opportunities to build capacity related to the national standards, and integration of standards, measures, quality improvement and reporting within a broader performance management framework.

The work group also recognized that MDH could offer vital support and leadership through communications with state and local policy makers. Performance improvement, system change and accreditation will involve time and effort. This expenditure of valuable resources needs to be seen as worthwhile and as having both immediate and long-term benefits not only for public health departments, but also for the communities served.

Recommendation 4: MDH should *lead* outreach to state policy makers, and *support* outreach to local policy makers, to educate policy makers on the importance of national standards, performance improvement, and voluntary national accreditation.

Voluntary National Accreditation through the Public Health Accreditation Board

The work group decided that MDH and CHBs should strive for voluntary national accreditation. Some may ask *Why not just use the national standards as a framework for improvement?* In other words, why take the extra step of becoming accredited? The work group recognized that the national accreditation program is voluntary, and some may choose not to participate. However, the work group agrees that the extra step of pursuing accreditation adds value. Based on Minnesota’s experience with the voluntary national accreditation beta test (i.e., a participating CHB and trained site reviewers) and consultations with beta test sites out of state, the work group agrees that the process of applying for accreditation – and obtaining objective feedback from reviewers – provides crucial validation that could be used to identify and accelerate performance improvements that lead to better health outcomes.

Additionally, some national public health organizations have begun to provide support (e.g., technical assistance, tools and in some cases funding) to pursue accreditation. Many of these same organizations (e.g., [RWJF](#), [NACCHO](#), [ASTHO](#), [NALBOH](#), [PHF](#)) have also advocated for

benefits or rewards (e.g., accreditation as a positive public relations tool in communities, monetary, preferential treatment for grants, etc.) to those who achieve and sustain accreditation. Incentives at the national level could include financial incentives, as well as non-financial incentives such as grants administration/application incentives, and technical assistance and training opportunities. The work group determined that such incentives may be an important factor in state and local decisions to pursue voluntary national accreditation. Although PHAB is not yet accepting applications for accreditation and the fee structure is not yet known, the work group favored proactive steps that would position Minnesota to capitalize on emerging and potential benefits and incentives. Moreover, this approach advances Minnesota toward a national goal to have at least 60% of the population served by an accredited public health department by 2015.

Recommendation 5: MDH should lead the way by preparing for state-level accreditation, and seeking voluntary national accreditation at the earliest opportunity (no later than 2013).

Recommendation 6: MDH and CHBs should work together so that all CHBs are prepared to apply for voluntary national accreditation by 2015.

A commitment to local determination and some characteristics of statute have provided local jurisdictions with considerable discretion in their governance and organizational structures for delivering local public health services. All jurisdictions provide public health through the oversight of a CHB; but in some cases a Human Services Board (HSB) assumes the duties of the CHB. Local public health in some cities and counties is organized as a stand-alone department, and in other areas governmental local public health services are part of a larger department (e.g., with human services, veteran's services, community services, etc) or organization (e.g., hospitals). Some local public health departments include two or more counties, while others are comprised of a single county, or even a single city.

The work group agreed with the SCHSAC Blueprint Work Group that governance and organizational structure may influence capacity and performance. Given the diversity in structures around the state, the work group recommends:

Recommendation 7: CHBs and local health departments should revisit their governance and organizational structures, responsibilities, authorities and current legal agreements in relation to the national standards and the voluntary national accreditation program. The MDH Office of Performance Improvement (OPI) should continue to provide information and technical assistance as needed on CHB governance and administration.

The 1998 SCHSAC Local Public Health Accreditation Work Group recommended that SCHSAC *monitor national developments related to accreditation and convene a future work group as needed*. The PIA Work Group made a similar recommendation:

Recommendation 8: SCHSAC should convene a work group in 2013 to examine progress on the PIA Work Group's recommendations, assess developments with the voluntary national accreditation program, and revise these recommendations if appropriate.

Conclusion

In summary, these recommendations are intended to assist Minnesota's governmental public health system achieve its ultimate goal of protecting and promoting the health of all Minnesotans in a way that demonstrates accountability, efficiency and results. The PIA Work Group believes that the national standards represent a core set of activities that all Minnesotans should expect from the governmental public health system, and that the standards in combination with performance improvement practices will serve Minnesota well.

Appendices

- Appendix A: PIA Work Group Charge and Membership
- Appendix B: MLC Fact Sheet
- Appendix C: Strengthening Public Health Infrastructure for Improved Health Outcomes
- Appendix D: Reasons Why Performance Management is Important
- Appendix E: State and National Timeline of Public Health Performance Improvement Initiatives
- Appendix F: Local Public Health Association Regional Meetings: Summary of Findings and Considerations for the PIA Work Group
- Appendix G: Summary of Feedback on Preliminary PIA Work Group Recommendations
- Appendix H: Comparison of Minnesota Local Public Health Quality Improvement System with National Standards & Measures: Select Key Findings
- Appendix I: Summary of Standards

Appendix A: PIA Work Group Charge and Membership

Charge

Most agree that public health systems around the country will be influenced by a new set of national public health standards and the voluntary national accreditation program scheduled for implementation in 2011. This SCHSAC work group will (1) examine the proposed national performance standards and measures for Minnesota's state and local health departments, (2) explore the implications of these standards and measures for Minnesota, and (3) make recommendations for Minnesota's public health system.

In exploring implications and making recommendations, the work group will consider factors such as:

- Minnesota's current performance improvement and reporting systems and the Essential Local Activities,
- The roles and interdependence of state and local health departments in Minnesota,
- The interdependence of the proposed national standards for state health departments, and the proposed national standards for local health departments,
- Incentives for and benefits of accreditation and/or demonstrated achievement of the standards,
- Barriers to accreditation and/or demonstrated achievement of the standards, and
- Perceived capacity of Minnesota state and local health departments to demonstrate achievement of the national standards.

Background

In the landmark 1988 report, *The Future of Public Health*, the Institute of Medicine (IOM) proposed that in order to measurably improve population health outcomes, a stronger public health infrastructure and a public health system with substantially greater visibility and credibility were urgently needed. The IOM advocated the creation of a national accreditation system for public health departments as a way to achieve both of these needs.

Public Health Accreditation Board

After many years of steady progress toward this recommendation, including development of standards and measures, the Public Health Accreditation Board (PHAB) is now in the beta-test phase of a voluntary, national accreditation program for state, territorial, tribal and local public health departments. The goal of the national accreditation program is to improve and protect the health of the public by advancing the quality and performance of state and local public health departments. The PHAB expects to begin accepting applications for accreditation in 2011.

SCHSAC

In 1998 SCHSAC charged a work group with developing 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 was enacted. The 1998 work group did not recommend accreditation as a means to *ensure acceptable performance*, but agreed that *establishing consistent program performance expectations and related measurable indicators could promote consistent and improved public health practice in Minnesota*. Over the next several years, Minnesota's state and local public health partnership systematically developed systems and resources designed to improve local public health performance and accountability.

More recently, in the *SCHSAC Strategic Plan 2009-2013*, SCHSAC proposes to *identify issues around voluntary accreditation for MDH and local health departments and develop a framework for implementation*. The SCHSAC subsequently included a Performance Improvement and Accreditation Work Group in its 2009 work plan. This work will carry forward into 2010.

Methods

This work group will be comprised of SCHSAC members, representatives of local and tribal health departments, and representatives of MDH.

Local Public Health Membership

Bill Groskreutz, Chair	Faribault-Martin CHB
John Baerg	Watonwan CHB
David Benson	Nobles-Rock CHB
Dave Brummel	Hennepin CHB
Sue Erzar	Aitkin-Itasca-Koochiching CHB
Allie Freidrichs	Meeker-McLeod-Sibley CHB
Rob Fulton	Ramsey CHB
Cris Gilb	Lincoln-Lyon-Murray-Pipestone CHB
Sue Hedlund	Washington CHB
Wendy Thompson	Kanabec-Pine CHB
Diane Thorson	Otter Tail CHB
Mary Wellik	Olmsted CHB
Rae Jean Madsen	Carver CHB
Karen Moritz	Brown-Nicollet CHB
Wendy Kvale	Northwest Region Public Health Nurse Consultant

Tribal Membership

Debra Smith	Fond du Lac Reservation
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Multi-State Learning Collaborative

Karen Zeleznak	Chair, Minnesota's Multi-State Learning Collaborative Steering Committee
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Minnesota Department of Health Membership

Pat Adams	Community & Family Health Promotion Bureau, MDH
Linda Bruemmer	Environmental Health, MDH
Kris Ehresmann	Infectious Disease Epidemiology, Prevention and Control, MDH
Wendy Nelson	Information Systems & Technology Management, MDH

Resources

The Community and Family Health Division, Office of Public Health Practice, will provide staff support to the work group.

Appendix B: MLC Fact Sheet Minnesota

The following information is intended to provide an overview of the performance assessment and quality improvement work in Minnesota, as well as the state's efforts as a participant in the Multi-State Learning Collaborative (MLC). The MLC is currently in its third phase – called *Lead States in Public Health Quality Improvement* – and is comprised of 16 states that are applying accreditation and quality improvement techniques to improve public health practice. For more information about the history and current work of the MLC, please visit: <http://www.nnphi.org/mlc>.

PARTICIPATION IN THE MULTI-STATE LEARNING COLLABORATIVE

Minnesota joined the MLC in its second phase and formed the **Minnesota Public Health Collaborative for Quality Improvement (QI Collaborative)** – a partnership of the Local Public Health Association (LPHA), the MDH and the University of Minnesota, School of Public Health (SPH). The goal of the QI Collaborative is to provide resources, tools, technical assistance and training on quality improvement techniques to MDH and local public health departments.

The MLC is currently in its third phase, running from 2008-2011. Through participation in *Lead States in Public Health Quality Improvement*, Minnesota is preparing for accreditation and advancing QI in public health through the following work:

Preparation for Accreditation: In addition to the quality improvement efforts, Minnesota is conducting the following activities focused on preparing for national accreditation:

- **Build capacity for quality improvement at MDH.** Minnesota will work to build awareness, skills and participation among key personnel at MDH by **engaging MDH leadership in discussions of the state role in quality improvement and accreditation.** Training and other capacity development activities will be enhanced to explicitly include MDH leadership and staff in order to strengthen and spread quality improvement efforts in Minnesota's public health system.

- **Assess how Minnesota's current performance measurement system aligns with the national standards and address gaps before accreditation begins.** MDH worked in partnership with the Local Public Health Association to conduct a statewide vetting process of the national accreditation standards. The MDH Health Steering Team, as part of their 2009 strategic thinking process, established a goal to become an accredited state health department. MDH will either participate in the national beta test of the accreditation standards or will conduct its own internal assessment and improvement process to strengthen capacity to meet the standards.
- **Provide quality improvement leadership training to state and local public health departments.** MDH staff, the MLC Steering Committee, and the LPHA Policy and Practice Committee will work with a quality improvement consultant to develop a training initiative for ten local public health leadership teams and two state teams. The training will promote leadership and the integration of quality improvement processes into organizational culture.

Quality Improvement Collaboratives: The collaborative was designed to support local and tribal implementation of the Statewide Health Improvement Program to reduce obesity and tobacco use/exposure in Minnesota. The collaborative facilitates the use of the rapid cycle improvement process to implement evidence-based strategies for policy, systems, and environmental changes that support healthy living in Minnesota. The Collaborative is made up of twenty-three teams representing 36 CHBs.

Target Areas: All states participating in the third phase of the MLC are focusing their quality improvement efforts on at least two specific target areas. States chose from a menu of five capacity/process target areas and five health outcome target areas. The quality improvement efforts of the collaboratives in Minnesota will be focused on the following target areas:

Capacity/Process Target Area:

Health Improvement Planning

Sub-target: A health department-led community health improvement planning process convenes partners and facilitates collaboration resulting in an improvement plan including health objectives and improvement strategies.

Health Outcome Target Area:

Reduce preventable risk factors that predispose to chronic disease

Sub-targets:

- Reduce the percentage of adults age 18 or older who have BMI greater than 25
- Reduce the percentage of obese adults aged 20 or older (HP 2010)
- Reduce the percentage of overweight or obese children and adolescents aged 6-19 (HP 2010)

Reducing the Burden of Tobacco Related Illness

Sub-targets:

- Reduce the percentage of adults age 18 or older who smoked at least 100 cigarettes in their lifetime, and are current smokers (HP 2010)
- Percent of adolescents in grades 9-12 who smoked one or more cigarettes in the past month (HP 2010)
- Reduce the percentage of the population exposed to secondhand smoke (HP 2010)

Project Lead and Partners: The **Minnesota Department of Health** provides technical assistance to local public health departments, builds local capacity, and offers guidance on best practices. The **MDH Office of Public Health Practice (OPHP)** is responsible for coordinating and facilitating assistance for local public health. OPHP staff strengthens Minnesota’s local public health system and the state-local partnership by supporting the collaborative development of state-local standards, and coordinating training and communication with local public health directors and local elected officials. MDH is the lead agency for the MLC grant and is responsible for coordinating and reporting on all aspects of the grant.

- The **MLC Steering Committee** is a committee of MDH staff, local public health directors, and University of Minnesota staff that monitors the progress of MLC activities and provides direction

to partners regarding financial, policy and operational matters of the project. The Steering Committee meets quarterly.

- The **Local Public Health Association (LPHA)** is a professional association comprised of county, city, and tribal public health directors. LPHA has been a key partner in the development of Minnesota’s community health assessment, planning process and performance measures. LPHA representatives will be active members of the MLC Steering Committee and will lead or participate on project teams in the collaboratives.

ADDITIONAL RESOURCES

Quality Improvement Collaborative:

<http://www.health.state.mn.us/divs/cfh/ophp/consultation/mlc2/index.html>

Storyboards:

<http://www.health.state.mn.us/divs/cfh/ophp/consultation/mlc2/projects.html>

Project	description	sheet:
	http://nnphi.org/CMSuploads/MN-75959.pdf	Minnesota Community Health Assessment and Action Plan:

<http://www.health.state.mn.us/divs/cfh/ophp/system/planning/chaap/index.html>

Planning and Performance Measurement System:
<http://www.health.state.mn.us/ppmrs/>
State Community Health Services Advisory Committee:

<http://www.health.state.mn.us/divs/cfh/ophp/system/schsac/>

To see all work produced by Minnesota, please visit www.nnphi.org/ecatalog. Under *Programs* select “The Multi-State Learning Collaborative.” Under *States* select “Minnesota.” Then click the Search button.

The MLC is funded by the [Robert Wood Johnson Foundation](#) and managed by the [National Network of Public Health Institutes](#).

Appendix C: Strengthening Public Health Infrastructure for Improved Health Outcomes

Project Abstract – Component I

The Minnesota Department of Health (MDH) has experience with performance management initiatives, and has worked to develop elements of a performance management system for local health jurisdictions for many years. However, MDH does not have a comprehensive performance management system in place. Key leaders are aware that to build, institutionalize, implement and sustain a performance management process within the organization, a significant commitment of leadership, time, and resources is needed. There is mounting excitement over this new opportunity to make these much-needed investments.

The overall goal of this project is to increase the capacity of MDH to routinely evaluate and improve the effectiveness of the department, practices, partnerships, programs, use of resources, and the impact the system's improvements have on the public's health. To do this, the project will establish a performance management infrastructure that includes standards, measures, a quality improvement process, and a reporting process. This system will incorporate key activities repeatedly shown to promote successful implementation of performance managements systems: 1) establishing a performance management framework, 2) engaging leadership, 3) focusing on customers, 4) using data to guide improvement and decision-making, 5) developing skills and capacity for quality improvement, and 6) providing resources to support the work.

MDH is well positioned to undertake this proposal due to its many strong partnerships throughout the state and national public health systems. These partners will provide assistance at various stages of the implementation of this proposal. MDH will strengthen partnerships with quality improvement experts such as the Public Health Foundation and Stratis Health, and will use this opportunity to reach out to new partners such as the Minnesota Quality Council. Our local partners will be kept apprised of progress and activities and asked to provide input and customer/stakeholder feedback.

Investments will be made in the areas of personnel, training, consultants and contracts to build infrastructure for MDH in the areas of performance measurement and quality improvement; workforce capacity and competency; health information analysis for decision making; and communications. These infrastructure investments will strengthen MDH workforce skills and capabilities to improve processes used to investigate health problems and hazards; inform and educate the public about health issues; engage with the community; develop public health policies and plans; enforce laws and regulations; improve access to health care; and evaluate and improve processes, programs and interventions across all of the Key Areas. Through these investments, this project will lead to organizational, system and practice improvements that increase agency efficiency and effectiveness, thereby maximizing the value of resources, and ultimately improving population health.

Project Abstract – Component II

This initiative will transform Minnesota’s public health infrastructure by mobilizing the public health system to face two of its most pressing challenges and promising opportunities – the need for Minnesota (MN) health departments to establish performance management systems that are based on a shared framework and align with national standards; and information technology (IT) systems that lack capacity for electronic health information exchange or have limited utility for data-based decision making. This investment will enable MN to capitalize on a broad consensus and commitment to act on these core infrastructure priorities, and avoid inaction or more piecemeal, half-actions that would otherwise result from the limited resources now available.

The goals of this initiative are to: 1) increase the capacity of MN health departments to continuously evaluate and improve public health practices, partnerships, programs, and use of resources; and 2) improve the delivery and accountability of public health programs and services by developing and enhancing the infrastructure for health information exchange (HIE).

MN will take a multi-faceted approach to achieve these goals. Key methods are to: 1) develop leadership and workforce commitment to performance improvement and to a unifying performance management (PM) framework; 2) develop workforce capacity for PM; 3) adapt current systems and processes to strengthen PM, with an initial focus on grants management; 4) implement standard reporting on organizational performance; 5) support implementation of PM systems and preparation for accreditation; 6) build policy and security into data exchanges and related activities; 7) improve and expand cross jurisdictional data sharing; and 8) increase analytical capabilities.

These activities are supported by investments in five key areas: 1) personnel to provide overall management and coordination; 2) hardware and software to enhance business process modeling and analytic capability; 3) training to increase workforce knowledge, skills, abilities and certifications; 4) consultants to align and augment multiple disparate systems and processes; and 5) contracts to provide a security audit and financial support to local and tribal health departments seeking accreditation.

Collectively, these actions and investments will bring about multiple, fundamental system changes that will improve performance, reduce costs through efficient and effective use of resources, and ultimately lead to improved population health. For example, by September 30, 2015, a performance management system will be in place and in use by MDH and 100% of local health departments in MN; and 100% of health departments will have HIE capability.

MN is poised for successful transformation. MDH is a cabinet-level agency with lead responsibility for public health and policy development related to MN’s recent health reform laws (which explicitly address health care *and* population health). Strong partnerships and a favorable policy environment support these activities. The state legislature has mandated that electronic health records (EHR) be in place throughout MN by 2015, and MN can leverage experience with PM and quality improvement to make rapid progress.

Appendix D: Reasons Why Performance Management is Important

1. Allows governments to use resources most effectively. In times of severely constrained resources it is important that governments are getting the "most bang for their buck."
2. Allows governments to use resources more efficiently. With less money to go around, governments' performance management allows for better management decisions so that limited funds can go farther.
3. Changes the focus from cost to value. Traditional budget processes only answer the question "how much does it cost?" It completely ignores what governments are able to "provide" in return. Performance management allows for a discussion on both costs and results. This in turn allows governments to achieve #1 above.
4. Greater transparency / accountability / communication. Again in times of severely constrained resources and ever increasing public pressure on governments, performance management links dollars spent with service levels and allows for greater understanding of where the money goes and what it does. Without performance management, the discussion is always focused on ways of reducing costs without a similar discussion of the realistic discussion.
5. Performance measurement is misunderstood. It is about using reasons 1-4 above to make better decisions. It is not about counting meaningless statistics that provide minimal value, but are nice to know. It is about having the information necessary to run an organization to meet current challenges. It is about finding a way to create a formal process for backing up decisions with evidence/common sense. It is about avoiding the trap of "it's the way we've always done it." It is strategic management that drives results.

Source: Government Finance Officers Association
http://www.gfoa.org/index.php?option=com_content&task=view&id=1429

Appendix E: State and National Timeline of Public Health Performance Improvement Initiatives

Major Developments Related to Performance Improvement and Accreditation in Public Health: A State/National Timeline

	1985-2000	2001-2004	2005-2010	2011-2015
National	<p>In <i>The Future of Public Health</i> (1988), the Institute of Medicine articulates the core functions of public health (assessment, policy development, assurance) and advocates creation of a national accreditation system for public health departments as a means to strengthen the public health infrastructure and improve population health outcomes.</p> <p>Motivated by national health reform discussions accelerating in 1994, the Core Functions of Public Health Steering Committee convenes to create a better definition and description of public health. The committee produces a statement called <i>Public Health in America</i>. The statement identifies 10 Essential Services of public health.</p> <p>1998 The CDC builds on the framework of the 10 essential services to initiate the National Public Health Performance Standards Program (NPHSP). The program is created to improve the quality of public health practice and performance of public health systems, engage and leverage partnerships, promote continuous quality improvement and strengthen the science base for public health. Partners include APHA, ASTHO, NACCHO, NALBOH, and PHF.</p> <p>1999 National Turning Point Initiative is funded by RWJF to advance performance management in public health. The Turning Point Performance Management framework includes standards, measures, reporting of progress and quality improvement. A Performance Management System is defined as the continuous use and incorporation of these elements into an organization's core operations.</p>	<p>In 2002 the National Public Health Performance Standards Program releases assessment instruments that have now been used in more than 30 states to assess the performance of state and local public health systems (e.g., the public, private, and voluntary entities that contribute to public health in a given area).</p> <p>In 2003, IOM releases <i>The Future of the Public's Health in the 21st Century</i>, which emphasizes accountability, systems, and diverse partnerships</p> <p>The CDC and RWJF fund the <i>Exploring Accreditation Project</i></p> <p>Steering Committee to consider whether and how a voluntary national accreditation program could lead to even better health for their constituencies.</p> <p>Participating organizations include NACCHO, ASTHO, APHA, and NALBOH.</p> <p>Some states begin state-based accreditation programs for local health departments. Examples include Washington State and North Carolina.</p>	<p>NACCHO releases <i>Operational Definition of a Functional Local Health Department</i>. This definition encompasses 10 standards that describe the functions of a local health department. The definition was intended to help people understand what they can reasonably expect from governmental public health in their communities and to help elected officials understand what LHs do and how to hold them accountable.</p> <p>With the release of the <i>Final Recommendations for Voluntary National Accreditation Program</i> in 2006, the <i>Exploring Accreditation</i> steering committee concludes that it is desirable and feasible to move forward and establish a voluntary national accreditation program.</p> <p>2007 The Public Health Accreditation Board (PHAB) is incorporated and begins operations in accordance with the recommendations of the Exploring Accreditation Steering Committee. PHAB is supported by CDC and RWJF. National partners include NACCHO, ASTHO, NALBOH, APHA, the National Indian Health Board (NIHB), National Network of Public Health Institutes (NNPHI), and Public Health Foundation (PHF).</p> <p>2009 PHAB releases draft standards and measures for a public vetting process. PHAB receives 4,000 individual comments, online surveys and group feedback forms. PHAB releases a revised set of standards and measures.</p> <p>Thirty state, local and tribal health departments are selected as beta test sites in 2010. A beta test is a formative evaluation and quality improvement method used when launching a new product for obtaining the feedback of future users of the product. The PHAB beta test is a way to test the accreditation standards, measures, proposed assessment process and requested documentation by having a variety of departments prepare for accreditation and report on the experience. The beta test will help determine how to weight the standards and measures and how to score applicants for accreditation.</p>	<p>PHAB begins accepting applications for voluntary accreditation from state, local, tribal and territorial health departments.</p> <p>By 2015, PHAB aims to have 60 percent of the U.S. population served by an accredited public health department.</p>

Produced for the Performance Improvement and Accreditation Work Group of the State Community Health Services Advisory Committee for discussion February 22, 2010.
For more information, contact kim.gearin@state.mn.us or chelsie.huntley@state.mn.us

Minnesota	<p>1985-2000</p> <p>1997 SCHSAC convenes <i>Performance Measurement and CHS Reporting Review Group</i>.</p> <p>In 1998, the SCHSAC <i>Local Public Health Accreditation Work Group</i> does not recommend developing a state level accreditation program, but agrees that <i>establishing consistent program and performance expectations and related measurable indicators could promote consistent and improved public health practice in Minnesota</i>.</p> <p>2000 Minnesota is one of three states participating in CDC's field test of the National Public Health Performance Standards Project. This work is coordinated with the SCHSAC <i>Assessing Organizational Capacity Work Group</i>.</p>	<p>2001-2004</p> <p>The Local Public Health Act of 2003 (MN Statutes 145 A. 10, Subd. 5a) leads to development of a local public health performance and accountability system with four major components:</p> <ul style="list-style-type: none"> Essential Local PH Activities (ELAs) - developed to assure that all Minnesotans receive at least a core set of public health services, and to simplify efforts to describe the system and its benefits. Community Health Assessment and Action Planning (CHAAP) process and toolkit - created to facilitate the local planning and assessment processes carried out routinely at the local level. The online LPH Planning and Performance Measurement Reporting System (PPMRS) - created to assess progress in meeting the ELAs and to inform decision making. A strengthened and streamlined annual review process to assure accountability for LPH Act General Funds. 	<p>2005-2010</p> <p>In 2006, Minnesota is funded by RWJF as one of 10 states participating in the RWJ Multi-State Learning Collaborative intended to (1) prepare local and state health departments for national accreditation, (2) contribute to the development of the national voluntary accreditation program, and (3) advance quality improvement practices in public health departments.</p> <p>Minnesota is represented on PHAB by Bill Riley and on the Standards Development Work Group by Rob Fulton. Annual Community Health conference includes accreditation update.</p> <p>In its 5-year strategic plan for 2008-2013, SCHSAC proposes to <i>identify issues around voluntary accreditation for MDH and local health departments and develop a framework for implementation</i>.</p> <p>MDH and the Local Public Health Association of Minnesota review the proposed national standards and submit joint recommendations to PHAB in 2009. The recommendations reflect a systematic review within MDH and the collective discussion of more than 80 local public health officials during seven meetings held in each region of the state.</p> <p>2009 SCHSAC convenes the <i>Blue Print for Successful Local Health Departments Work Group</i> to explore "What makes a strong local health department?" and "What factors contribute to its success?" Discussion to date has focused on issues related to the size, integration, organization, governance and financing of local public health. Recommendations may better position local health departments to meet the new national standards.</p> <p>2010 SCHSAC convenes <i>Performance Improvement and Accreditation Work Group</i>.</p>	<p>2011-2015</p> <p>Minnesota's public health system acts on the recommendations of the SCHSAC Performance and Accreditation Work Group.</p>
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For more information, contact kim.pearlin@state.mn.us or chelsie.huntley@state.mn.us.

Appendix F:
Local Public Health Association Regional Meetings:
Summary of Key Findings and Considerations for the PIA Work Group
Summer 2010

Overview

- As directed in the May meeting of the PIA WG, staff attended one LPHA meeting in each of the seven LPHA regions during June and July.
- The purposes were to (1) inform LPHA members about the recent activities of PHAB and the PIA WG, (2) obtain information on the level of activity across Minnesota related the voluntary national accreditation program and the draft national standards, and (3) obtain a list of items for the work group to consider in making its recommendations.
- Meeting attendees were asked to complete a brief survey (one per LHD or CHB).
- A total of 62 surveys were returned.

Familiarity with accreditation/standards

- No one responded *This is the first time I have heard about accreditation.*
- Five people from three regions indicated that it was the first time they had heard about the draft national standards.

Sharing information about accreditation/standards

- Many – but not most – have shared information about the standards or voluntary accreditation with staff or the CHB.
- Almost half of respondents (n=29, 47%) have shared information about accreditation with their staff about accreditation, and nearly one-third (n=19, 31%) have shared information about accreditation with their CHB.
- However, fewer respondents have shared information on the national standards with staff (n=11) or a CHB (n=4).

Actions taken with the national standards

- Some LHDs in six of seven regions have begun to use the standards (e.g., to complete a self assessment [n=9, 15%]; identify QI projects [n=8, 13%] or begin preparing for accreditation [n=4, 6%].

Action and intent toward accreditation

- Six respondents from three different regions reported that their LHD/CHB is taking active steps to prepare for accreditation.
- Most respondents said their LHD/CHB *is considering applying for accreditation* (n=24, 40%). One respondent indicated that their CHB/LHD is not planning to apply for accreditation.
- Two respondents from two regions reported that their CHB/LHD will apply in the first two years; 12 others expect to “eventually” apply. Together, these LHD/CHBs represent five regions.

Focal areas for system improvements

Attendees were asked to select two domains as initial focal areas for improvement. Top selections were

1. Evaluation and continuous improvement of processes, programs and interventions
2. Maintaining a competent public health workforce
3. Contributing to and applying the evidence base of public health
4. Developing public health policies and plans

Attendees were also asked to identify important considerations for the PIA WG.

Considerations are clustered below:

- Human/financial resources and capacity vary around the state.
- Cost of accreditation; financial implications of becoming and not becoming accredited.
- Work together. Coordinate. Collaborate. Develop templates. Build on what some may already have in place. MDH support.
- Keep it simple; streamline reporting processes; Consolidate activities.
- Potential for accreditation incentives to serve as “punishment” for those who don’t pursue accreditation.
- Consider technical assistance and training. Focus future CHS Conference.
- Regional collaboration and application.
- Be realistic. Be reasonable. *I want the process to be worthy of the time and resources dedicated to the outcome.*

Appendix G: Summary of Feedback on Preliminary PIA Work Group Recommendations

From the September 29, 2010 SCHSAC meeting
and the October 1, 2010 Community Health Conference

People from across the state and local public health system were invited to provide feedback on the proposed recommendations through four questions: (1) What excites you about the recommendations? (2) What concerns you about the recommendations? (3) What questions do you have about the recommendations? (4) What specific changes (if any) would you like to see in the final recommendations? Written comments have been transcribed, and summarized below.

Question 1: What excites you about the recommendations?

Comments included the expectation that voluntary national accreditation would strengthen public health practice and the public health system, and that it would provide support and credibility for local public health efforts. Some expressed hope and excitement that the systems development activities can build on what we already have in place, promote consistency and accountability, decrease duplication, and improve connections among health departments.

Strengthens/improves local public health

- Provides definition, consistency, standardization, framework and assurance for and strengthens public health practice throughout the state.
- Standards across all counties; more unified, accountable and stronger system; ability to compare with others in state/nation.
- Assures public health practice in human services organizations.

Support and credibility for local efforts

- Will bring credibility, professionalism, visibility, transparency and respect to state and local public health; assures quality agency/staff.
- Increased accountability for and improvement in public health practice; moves us forward; makes things easier; demonstrates the value-added/worth of public health.
- Doing it with MDH brings authenticity and integrity to the process; going through the process with other LHDs will help too.
- Supports public health in re-organizations.
- Can help to strengthen messaging to the public, legislators and stakeholders; provides language to talk about infrastructure.
- Potential for additional funding if accredited.

Streamlining potential; consistent with other efforts

- Well thought out transition to align could decrease duplication and simplify.
- Builds on what we are already doing, e.g., CHAAP, Blueprint, PPMRS, etc.
- Provides a framework for QI and evaluation.

Other comments

- Peer-to-peer connection within MN while preparing; site visit by a peer and outsider.
- Timeline seems doable.
- Well thought-out; concerted/deliberate thinking behind the recommendations.

Question 2: What concerns you about the recommendations?

Comments on this question clustered in five main areas: the costs (including time) of preparing for accreditation; issues related to multi-county arrangements and human services boards, the potential for inequities among CHBs and their local health departments, especially those that are smaller in size; the feeling that although accreditation is being called voluntary, so many organizations are pushing for it that it feels forced, and the need for good technical assistance.

Costs/time/paperwork

- Costs, time commitment - tighter budgets and shrinking staff; added work; already doing less with more; would like info about cost to help make these decisions; more red tape; costs to apply.
- Reality that most will have to give up something in order to do this work – will mean cuts in “good” programs and work; need to choose this over other things; how to prioritize, what to give up?
- Need to describe value-added/costs vs. benefits (e.g., why would MN want to do this when we are already at the top?); potential for major resentment if this is just a paper exercise; have been part of accreditation at other agencies and it was a bad experience; it’s just another regulatory requirement; all staff need to see the value.
- Amount of paperwork/documentation required.
- Complete accreditation in a legislative policy year – not a budget year.

Multi-county and human services

- Issues related to multi-county CHBs, e.g., what happens when one of the counties holds out when the CHB decides to become accredited; a county independently goes for accreditation when the CHB decides not to; one of the counties isn’t able to meet standards; “weak” counties riding on the coattails of “stronger” counties in a CHB; CHBs that includes two different structures (human services agency, and other).
- Issues related to human services agencies, e.g., lack of authority to obtain involvement from parts of the agency outside of public health, such as Environmental Health (EH).
- Accreditation could lead to mergers.

Inequities

- Must be cautious regarding incentives, e.g., what happens to those health departments that don’t get them; could create inequities and partner issues especially across borders.
- Issues related to small counties/agencies, e.g., inability to meet standards leads to inability to get incentives; be punished; greater inequities between have’s/have-not’s.
- Standards are “one size fit all” but counties aren’t all the same.
- Concern that agencies that can’t meet standards will be punished.

- Technology – if this is a computer-based process, some small agencies may not have the capability to participate; potential paper overload – needs to be web-based and paperless, like CHAAP.

Not voluntary, too soon/too fast

- Doesn't feel voluntary, e.g., NACCHO, APHA, etc. are really pushing it; RWJ is already hinting that funding will be attached to accreditation.
- Resistance to additional/complex requirements; takes away independence and control; costs; fear accreditation will bind us somehow; cost shifting for TA; concerned that a match will be required; another level of governance.
- Timeline – five years is too soon; appropriate for MDH, however.
- This change comes too soon after CHAAP; makes CHAAP seem less credible; feel patronized and jerked around to hear “just forget those”; explain what relationship new standards have to the old.

Other comments

- Perception of public that accreditation is “empire-building.”
- Need to involve staff throughout the agency especially where the agency management will be gone in a couple/few years; staff need the capacity and knowledge to do this.
- Cements the status quo – standards don't consider social determinants of health.
- Involvement of Minnesota's American Indian tribes – can they be accredited; can the standards and measures be adapted for tribes?

Question 3: What questions do you have about the recommendations?

Questions about the recommendations reflected similar concerns as Question #2: concerns about the value and effect of accreditation (will it really make a difference?), concerns about costs, the need for technical assistance, questions related to multi-county CHBs and human services agencies, concerns about potential unfairness, questions about what MDH is going to do, and the importance of communication. Sample comments are below.

The effect of accreditation

- Why does PH need improved credibility? Why is accreditation important? How will results of accreditation help health departments improve?
- What are the downsides of accreditation, e.g., would it impede differences in approaches, will collaboration with partners slow or impede it, is the assessment process capable of recognizing differences between CHBs?
- Don't these standards actually prevent innovation and limit a systems approach by focusing on traditional public health activities and preventing agencies from going into new things like systems changes, social inequalities/justice?
- How do they work related to city ordinances?
- Can accreditation result in meaningful and sustainable change, instead of new manuals?

Costs

- What are the costs? How much time and effort does it take? FTEs?
- Will there be any specific advantages/incentives to counties to offset financial commitments? How will incentives/reward affect CHBs that do not become accredited?

Technical assistance

- What resources and TA will be available to help? Will MDH take the lead in facilitating the process or do we work independently?
- How do we get started? How do we apply? What documentation be presented?
- How can we effectively work with other entities that have gone through accreditation to share resources/expertise, e.g., hospitals, colleges/universities, etc.? What can we learn about other accreditation systems?
- What specifically should we include to make sure our joint powers or governmental structure is in line with PHAB standards?
- Does MDH have the capacity with upcoming budget cuts to provide needed TA?
- What accreditation models have worked well? What other organizations use accreditation? Which work, which don't?
- How do we go from 42 essential local activities to 10 essential services?

Multi-county/human services

- How will it work? How many measures will you have to meet in order to become accredited? How will PHAB look at a combined Health and Human Services agency in a CHB with two different structures?
- In a human services agency, how do I meet those standards that are out of my control/agency?

Inequities

- How can everyone be held to the same standard? Some things, like research, some health departments won't be able to do.
- What happens to those CHBs that do not apply for accreditation? What happens to those that are not successful?
- Are we ready to "name" those underperforming CHBs?
- Do you have to meet 100% of the standards/measures to become accredited? Is there only one level of accreditation?
- What happens now when a CHB is not meeting expectations? Who monitors now? Who penalizes?

MDH

- Will MDH stay neutral in influencing whether PHAB accredits individual counties or CHBs or both?
- How soon will MN adopt the PHAB self-assessment?
- How will Tribes become accredited?
- How will MDH work toward their accreditation?
- Would this be put into the Master Grant Contract? In statute?

Communications

- We need help framing accreditation for our stakeholders, e.g., increased efficiency and productivity, better product, etc.

Question 4: What specific changes (if any) would you like to see in the final recommendations?

The final question posed for feedback on the recommendations solicited suggestions for changes. These suggestions (some for the recommendations, some just about accreditation in general) again reflected very similar concerns raised in the previous questions: making sure different sizes and structures of public health were considered, the desire/need for technical assistance, concerns about the costs of accreditation, and the importance of good communications. Sample comments are below.

Multi-county/human services

- Be respectful of the current structure of multi-county CHBs, and that each knows what's best for its community.
- Consider unique needs and challenges of human services agencies.

Technical assistance

- Provide statewide training; work together – MDH and CHBs; local public health should help MDH develop the TA; take groups through it together; work with regional LPHA groups; nurse consultants should lead local accreditation effort; provide info regarding time and resources needed; develop a model for how to do the self-assessment.
- Incorporate how work that is primarily ‘system change’ (as opposed to individual service) fits in these recommendations and accreditation standards.
- Work with counties that are all ready to go to help the others.
- Design this in tier levels, like in Emergency Preparedness.
- Timeline should be seven years, not five.
- Make it web-based.

Costs

- Needs to be some kind of incentive.
- Need to know what it will cost.

Communications

- Emphasize that this is not a mandate – recommended only.
- Develop communication tools to use with Boards and others – this will be a very difficult sell.

Appendix H: Comparison of Minnesota Local Public Health Quality Improvement System with National Standards & Measures: Select Key Findings¹

This document highlights key findings from a comparison of Minnesota's quality improvement system to the national standards and measures developed by the Public Health Accreditation Board (PHAB).

Minnesota QI System Overview

Essential Local Public Health Activities Framework is intended to:

1. Define a set of “essential” local public health activities that Minnesotans can count on no matter where in the state they live and recommend a statewide plan for implementation.
2. Provide a consistent framework for describing local public health to state and local policy makers and the public.
3. Provide a basis for ongoing measurement, accountability and quality improvement related to the implementation or assurance of essential local activities.

The activities are organized according to six “areas of public health responsibility.” The framework is based on the “Public Health in America” initiative that outlines the “what” (areas of public health responsibility) and “how” (ELAs and 10 essential public health services) of public health. The framework is consistent with the Core Functions of Public Health and the Ten Essential Services.

Performance Measures and Activities of the Planning and Performance Measurement Reporting System (PPMRS)

The web-based PPMRS was developed to collect and report on the activities, funding, staffing and performance of Minnesota's local public health departments. Measures and activities were derived from the ELAs. Each year, all Community Health Boards in Minnesota respond to approximately 220 questions on PPMRS. The purpose is to:

- Describe key aspects and accomplishments of the local public health system that demonstrate the purpose and value of local public health;
- Facilitate on-going evaluation, informing technical assistance, and improving decision-making about public health activities, funding and programs; and
- Meet state and federal reporting requirements (e.g., Minnesota LPH Act).

Community Health Assessment and Action Planning (CHAAP) The Community Health Assessment and Action Planning process or "CHAAP" is the process that local public health departments in Minnesota use to:

- Assess and prioritize the health needs of their communities;
- Assess and prioritize their own internal capacity to meet those health needs; and
- Develop an action plan (community health improvement plan and capacity improvement plan) to meet those needs.

Additional components of Minnesota's QI system include the Accountability Review Process and the Statewide Objectives for Local Public Health Departments.

¹ Developed by the MDH Office of Performance Improvement as a starting point for discussion by the State Community Health Services (SCHSAC) Performance Improvement and Accreditation Work Group (PIA WG). For more information, contact Chelsie.Huntley@state.mn.us or Kim.Gearin@state.mn.us.

Analysis and Observations

1. It is clear that the state and national systems share common origins.
 - More than 75% of Minnesota’s ELAs link to one or more of the 30 national standards
 - More than half of the 30 national standards are linked to one or more ELA.
 - Approximately 75% of Minnesota’s performance measures relate to one or more national measure(s).
 - CHAAP relates directly and/or indirectly to measures within four PHAB domains.
2. A “crosswalk” between the two systems is not a straightforward item by item comparison.
 - The national standards are intended to measure the overall capacity and quality of a public health department. The standards are not organized by Minnesota’s six areas of public health responsibility. So although we may have identified a “link” between an ELA and a national standard, that “link” may pertain to only one area of PH responsibility, though the intent of the standard may be broader.
 - In many cases it is believed that the intent of the ELAs is the same or similar to a national standard, but the individual completing the analysis must assume or interpret the ELA. For example, ELA ID3 talks about assessing infectious disease risks, apprising the community, and assuring appropriate interventions. One could assume, but it is not stated that data collection and analysis, risk communication, and evidence-based practice are intended by that ELA.
3. Some national standards and measures don’t correspond to Minnesota ELAs or performance measures/activities (and visa versa).
 - There are 10 standards with no direct link to the ELAs:
 - A2 B: Provide Financial Management Systems
 - 1.1 B: Collect and Maintain Population Health Data
 - 2.3 B: Maintain Provision for Epidemiological, Laboratory, and Support Response Capacity
 - 5.4 B: Maintain All Hazards/Emergency Response Plan
 - 6.1 B: Maintain Up-to-Date Laws
 - 6.2 B: Educate About Public Health Laws
 - 9.1 B: Evaluate the Effectiveness of Public Health Process, Programs, and Interventions
 - 9.2 B: Implement Quality Improvement
 - 10.2 B: Promote Understanding and Use of Research
 - Four domains of the national standards cover aspects of local public health performance that seem minimally reflected in the performance measures and activities reported to PPMRS:
 - Administrative Capacity and Governance [Part A]
 - Maintain a competent public health workforce [Domain 8]
 - Evaluate and continuously improve processes, programs and interventions
 - Contribute to and apply the evidence base of public health [Domain 10]
4. Although the two systems have many areas of alignment, it’s it is unknown at this time if a local public health department using CHAAP, implementing the ELAs, or reporting on activities through PPMRS would necessarily meet the national standards. For example community engagement is encouraged throughout the CHAAP process; the standards and measures are very specific about when community engagement needs to occur and how it needs to be documented.

Appendix I: Summary of Standards

Proposed State Standards and Measures Adopted by the PHAB Board of Directors July 16, 2009 for PHAB Beta Test

Part A: Administrative capacity and governance

<p><i>Provide Infrastructure for Public Health Services</i> Standard A1 B: Develop and maintain an operational infrastructure to support the performance of public health functions.</p>
<p><i>Provide Financial Management Systems</i> Standard A2 B: Establish effective financial management systems.</p>
<p><i>Define Public Health Authority</i> Standard A3 B: Maintain current operational definitions and statements of the public health roles and responsibilities of specific authorities.</p>
<p><i>Provide Orientation / Information for the Governing Entity</i> Standard A4 B: Provide orientation and regular information to members of the governing entity regarding their responsibilities and those of the public health agency.</p>

Part B

Domain 1: Conduct and disseminate assessments focused on population health status and public health issues facing the community

<p><i>Collect and Maintain Population Health Data</i> Standard 1.1 B: Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population.</p>
<p><i>Analyze Public Health Data</i> Standard 1.2 B: Analyze public health data to identify health problems, environmental public health hazards, and social and economic risks that affect the public's health.</p>
<p><i>Use Data for Public Health Action</i> Standard 1.3 B: Provide and use the results of health data analysis to develop recommendations regarding public health policy, processes, programs or interventions.</p>

Domain 2: Investigate health problems and environmental public health hazards to protect the community

<p><i>Investigate Health Problems and Environmental Public Health Hazards</i> Standard 2.1 B: Conduct timely investigations of health problems and environmental public health hazards in coordination with other governmental agencies and key stakeholders.</p>
<p><i>Contain/Mitigate Health Problems and Environmental Public Health Hazards</i> Standard 2.2 B: Contain/mitigate health problems and environmental public health hazards in coordination with other governmental agencies and key stakeholders.</p>
<p><i>Maintain Provision for Epidemiological, Laboratory, and Support Response Capacity</i> Standard 2.3 B: Maintain access to laboratory and epidemiological/environmental public health expertise and capacity to investigate and contain/mitigate public health problems and environmental public health hazards.</p>
<p><i>Maintain Policies for Communication</i> Standard 2.4 B: Maintain a plan with policies and procedures required for urgent and non-urgent communications.</p>

Domain 3: Inform and educate about public health issues and functions

Provide Prevention and Wellness Policies, Programs, Processes, and Interventions

Standard 3.1 B: Provide health education and health promotion policies, programs, processes, and interventions to support prevention and wellness.

Communicate Information on Public Health Issues and Functions

Standard 3.2 B: Provide information on public health issues and functions through multiple methods to a variety of audiences.

Domain 4: Engage with the community to identify and address health problems

Engage the Public Health System and the Community in Identifying and Addressing Health Problems

Standard 4.1 B: Engage the public health system and the community in identifying and addressing health problems through an ongoing, collaborative process.

Engage the Community to Promote Policies to Improve the Public's Health

Standard 4.2 B: Promote understanding of and support for policies and strategies that will improve the public's health.

Domain 5: Develop public health policies and plans

Establish, Promote, and Maintain Public Health Policies

Standard 5.1 B: Serve as a primary resource to governing entities and elected officials to establish and maintain public health policies, practices, and capacity based on current science and/or promising practice.

Develop and Implement a Strategic Plan

Standard 5.2 B: Develop and implement a health department organizational strategic plan.

Conduct a Community Health Improvement Planning Process

Standard 5.3 L: Conduct a comprehensive planning process resulting in a community health improvement plan [CHIP].

Conduct a State Health Improvement Planning Process

Standard 5.3 S: Conduct a comprehensive planning process resulting in a state health improvement plan [SHIP].

Maintain All Hazards/Emergency Response Plan

Standard 5.4 B: Maintain All Hazards/Emergency Response Plan (ERP).

Domain 6: Enforce public health laws and regulations

Maintain Up-to-Date Laws

Standard 6.1 B: Review existing laws and work with governing entities and elected officials to update as needed.

Educate About Public Health Laws

Standard 6.2 B: Educate individuals and organizations on the meaning, purpose, and benefit of public health laws and how to comply.

Conduct Enforcement Activities

Standard 6.3 B: Conduct and monitor enforcement activities for which the agency has the authority and coordinate notification of violations among appropriate agencies.

Domain 7: Promote strategies to improve access to healthcare services

Assess Healthcare Capacity and Access to Healthcare Services

Standard 7.1 B: Assess healthcare capacity and access to healthcare services.

Implement Strategies to Improve Access to Healthcare Services

Standard 7.2 B: Identify and implement strategies to improve access to healthcare services.

Domain 8: Maintain a competent public health workforce

<i>Maintain a Qualified Public Health Workforce</i> Standard 8.1 B: Recruit, hire and retain a qualified and diverse public health workforce.
<i>Maintain a Competent Public Health Workforce</i> Standard 8.2 B: Assess staff competencies and address gaps by enabling organizational and individual training and development opportunities.

Domain 9: Evaluate and continuously improve processes, programs, and interventions

<i>Evaluate the Effectiveness of Public Health Processes, Programs, and Interventions</i> Standard 9.1 B: Evaluate public health processes, programs, and interventions provided by the agency and its contractors.
<i>Implement Quality Improvement</i> Standard 9.2 B: Implement quality improvement of public health processes, programs, and interventions.

Domain 10: Contribute to and apply the evidence base of public health

<i>Identify and Use Evidence-Based and Promising Practices</i> Standard 10.1 B: Identify and use evidence-based and promising practices.
<i>Promote Understanding and Use of Research</i> Standard 10.2 B: Promote understanding and use of the current body of research results, evaluations, and evidence-based practices with appropriate audiences.



Office of Performance Improvement
P.O. Box 64882
St. Paul, MN 55164-0882
Phone 651.201.3880; Fax 651.201.3830; TDD 651.201.5797

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