Implementing and Assessing Organizational Practices in Local Health Departments

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Synopsis

One of the most difficult forms of public health practice to characterize involves governmental public health agencies, especially at the local level. A lack of consensus within the public health community as to the purpose and content of organizational public health practice inhibits efforts to increase the capability of public health to address effectively its core functions of assessment, policy development, and assurance. Meaningful capacity building efforts must establish both benchmarks and expectations for the organizational practice of public health. Those markers must be established so that the impact of practice on outcomes and health status can be examined.

A model identifying 10 organizational practices was established through the work of the Centers for Disease Control and Prevention (CDC) in collaboration with national practice organizations. Early applications of the model to public health capacity building activities have been effective. Among the applications have been approaches to surveillance of health department practice, certification of local health departments using practice guidelines, and development of leadership within the public health enterprise. Although results are promising, use of the model requires additional external examination and validation, as well as acceptance and consensus within the public health community. The development of organizational practice guidelines for public health agencies may be useful in further efforts to characterize and measure public health practice and its impact on the public's health.

PUBLIC HEALTH PRACTICE faces an identity crisis, with much of its concepts and content not understood by experienced practitioners and largely unknown to the public it serves. While people generally understand the functions of, for example, private corporations, utility companies, and perhaps government agencies, they have little insight into what public health agencies do or how they benefit the citizens.

There is little understanding of the processes that comprise public health practice or the products that the public receives as the result of those processes. The ability to characterize and measure the operational aspects of the governmental presence in public health is essential both for capacity building and for research into the impact of practice on health outcomes and community health status.

The apparent lack of understanding and agreement concerning the content of organizational public health practice was one of the factors that led the public health community to reexamine its mission and identity. In "The Future of Public Health," the Institute of Medicine (IOM) ascribed an apparent "disarray of public health" to a widespread lack of appreciation for the principles, practices, and services offered through the efforts of public health *(1)*. One outcome of that landmark report was an impetus for local governmental public health agencies to serve as focal points for identifying and resolving community health problems.

While IOM emphasized the role of local governmental public health agencies in public health practice, no framework existed to describe or measure

effective practice by public health organizations. Despite the early importance and rapid development of local health departments (LHD) in the last 150 years, relatively few studies of their workings have been undertaken. Miller and Moos stimulated renewed interest in LHD practice with their 15 case studies *(2)*. Recently, the National Association of County Health Officials undertook an extensive survey of the current capacities and activities of LHDs *(3)*. An expanded survey was repeated in early 1993, with results to be available in 1994.

In 1991, the University of Illinois at Chicago School of Public Health (UIC–SPH) was funded by the Centers for Disease Control and Prevention (CDC) in work to determine whether States have sufficient data and information available to measure the effectiveness of LHD practice. Efforts were made to develop measures to assess local public health department practice, based on a framework of 10 organizational practices. The framework was developed by CDC working with national public health practice organizations. We present the CDC framework and its application in measuring public health practice by LHDs. Other applications of the model for public health capacity building efforts are described.

Organizational Practices

The basis of a framework to describe the optimum functioning of governmental public health agencies is found in the core functions of assessment, policy development, and assurance described in "The Future of Public Health" *(1)*. Components that are especially relevant to implementing and assessing community public health practice were identified in "Healthy People 2000" *(4)*, "Healthy Communities 2000" *(5)*, early editions of "Model Standards" *(6)*, and the "Assessment Protocol for Excellence in Public Health" (APEXPH) *(7)*. With the continuing support of CDC's Public Health Practice Program Office (PHPPO), national practice organizations were convened and a Steering Committee to Measure Public Health Capacity was appointed in 1989.

From the catalog of organizational indicators in part I of APEXPH, the Committee identified important LHD activities. Those activities were grouped in 10 categories, each of which has now been characterized as a process that has behavioral outcomes demonstrable in practice. The first box (page 480) describes the 10 practices. PHPPO has characterized them further in working papers and sought to explore the utility of the framework for capacity building at all levels of the public health system *(8–10)*.

The 10 practices encompass the three core functions of public health presented in the IOM report (assessment, policy development, and assurance). Three practices emphasize important components of the assessment function: assessing community health needs, performing epidemiologic investigations, and analyzing the determinants of health needs. Three practices address the policy development function: building constituencies, setting priorities, and developing plans. Four practices relate to major aspects of the assurance function: managing resources, implementing or assuring programs to address priority health needs, providing evaluation and quality assurance, and educating or informing the public. Further, the practices, like the assessment, policy development, and assurance functions, describe a continuum of problem solving activity, cycling from problem identification to evaluation in order to redirect interventions.

The potential importance of the 10-practice construct is based partly on its validity (does it correctly describe the organizational practice of public health?) and its utility (is it accepted as a way to describe and measure the organizational practice of public health?) To address validity, one must examine and critique the framework through the national practice organizations and ultimately to correlate the 10 practices with health department outputs and outcomes. While validation is expected to be a long-term process, efforts to garner acceptance for the 10-practice construct can begin and are the first step in testing its validity.

The 10 practices have been applied in a number of capacity-building activities. The results of those applications suggest that the framework is generally understandable and acceptable within the public health community. The following are descriptions of some of those applications.

Surveillance of LHD effectiveness. National health objectives for the year 2000 call for 90 percent of the population to be served by LHDs that are effectively addressing the three core functions of governmental public health (objective 8.14) *(4)*. When the objective was established, neither baseline data nor adequate methods were available to measure progress. Those limitations have delayed the development and deployment of capacity building interventions for LHDs that are not serving the public effectively.

The basic question for the project was to determine if States had sufficient information to measure LHD effectiveness, and to determine if LHDs were adequately addressing core functions of public health. The results of that effort will be published separately.

Ten Categories of Local Health Department Organizational Activities in Public Health Practice

Assessment practices

1. Assess the health needs of the community by establishing a systematic needs assessment process that periodically provides information on the health status and health needs of the community.

2. Investigate the occurrence of adverse health effects and health hazards in the community by conducting timely investigations that identify the magnitude of health problems, duration, trends, location and populations at risk.

3. Analyze the determinants of identified health needs in order to identify etiologic and contributing factors that place certain segments of the population at risk for adverse health outcomes.

Policy development practices

4. Advocate for public health, build constituencies and identify resources in the community by generating supportive and collaborative relationships with public and private agencies and constituent groups for the effective planning, implementation and management of public health activities.

5. Set priorities among health needs based on the size and seriousness of the problems, the acceptability, economic feasibility and effectiveness of interventions.

6. Develop plans and policies to address priority health needs by establishing goals and objectives to be achieved through a systematic course of action that focuses on local community needs and equitable distribution of resources, and involves the participation of constituents and other related governmental agencies.

Assurance practices

7. Manage resources and develop organizational structure through the acquisition, allocation and control of human, physical and fiscal resources; and maximizing the operational functions of the local public health system through coordination of community agencies' efforts and avoidance of duplication of services.

8. Implement programs and other arrangements assuring or providing direct services for priority health needs identified in the community by taking actions which translate plans and policies into services.

9. Evaluate programs and provide quality assurance in accordance with applicable professional and regulatory standards to ensure that programs are consistent with plans and policies, and provide feedback on inadequacies and changes needed to redirect programs and resources.

10. Inform and educate the public on public health issues of concern in the community, promoting an awareness about public health services availability, and health education initiatives which contribute to individual and collective changes in health knowledge, attitudes and practices towards a healthier community.

SOURCE: Adapted from Reference *9*.

We report our development of measures to assess LHD practice. Initially we identified 30 possible organizational practice measures and performance indicators from information from State health department officials responsible for coordinating activities between the State agency and LHDs, and from PHPPO staff members *(11)*. The 30 measures were linked with the 10 practices with 2 to 5 measures describing aspects or elements of each of the 10 practices. We were able to refine further the practice measures and performance indicators by surveying local health liaison officials about the importance of the practice measures and indicators and the availability of information and documentation at the State level to measure LHD performance. Additional examination of those initial measures and indicators focused on the extent to which one State's (Illinois) local health liaison official could provide information on the 30 performance measures for each of 86 recognized LHDs.

The reliability and validity of the local health liaison responses were assessed by seeking information directly from the Illinois LHDs and by on-site examination of available documentation at each of five local health agencies. All inputs contributed to refinements of the measures and indicators that might be used in a national surveillance system in which information on LHD effectiveness could be collected, using local health liaison officials of State health departments.

As a result of those activities, a preliminary design of a surveillance system has been developed. The core of the system is a panel of 10 practice measures (one for each practice) and 32 indicators. In essence, an expectation for accomplishment (practice measure) has been developed for each of the 10 practices; the

performance indicators provide the information needed to determine whether each measure has been achieved. The 10 practices and their practice measures and performance indicators are shown in the second accompanying box on page 482.

Both the practice measures and their corresponding indicators will be refined further, subsequent to obtaining input from a 10-percent sample of the nation's LHDs. The national sample of LHDs will report on fulfilling the 10 practice measures, to establish a baseline for objective 8.14.

Two other CDC-sponsored surveillance projects have successfully incorporated aspects of the 10 practices into their design. They include revisiting 15 LHDs that were the subject of case studies in the early 1980s by researchers at the University of North Carolina at Chapel Hill, School of Public Health *(2,12)* and a series of studies at the University of South Florida, School of Public Health, designed to link LHDs resource and personnel allocation to the core functions of public health *(13)*. While the efforts of three schools of public health are insufficient to test the validity of the 10-practice construct, they demonstrate that it can provide a useful framework for measuring the activities of LHDs.

Public health practices as standards for LHDs. The IOM report and its related developments have stimulated some States to examine their capabilities to address the core functions of public health. Such a capacity building effort began in Illinois as early as 1983 with the development of what is known as the Roadmap Principles. The Roadmap Principles were further conceptualized in "The Road to Better Health for All Illinois," which outlined some 29 capacity building recommendations *(14)*. Several of the 29 recommendations focused on the structure and operation of State and local public health programs and services, specifically the organization, provision, and delegation of public health responsibilities.

Project Health began in 1990 as a concerted campaign by the five statewide public health organizations (Illinois Department of Public Health, Illinois Public Health Association, Illinois Association of Public Health Administrators, Illinois Association of Boards of Health, and UIC-SPH) to implement the 29 recommendations, including those calling for a redesign of the structure and organization of public health responsibilities within the State-local system *(14)*.

The intent of the Project Health partner organizations was to define a LHD based on the three core functions of public health and to establish standards for Illinois LHDs that would be based on the 10 practices, rather than specific categorical programs or services. The practice measures being developed through the UIC-SPH surveillance project with CDC (second box) were used as a starting point for developing practice standards that would apply to all LHDs seeking certification by the State.

The participating organizations viewed the 10 practices as a more rational and appropriate framework for defining local public health responsibilities than previously. That framework had required 10 specific categorical programs (including environmental and personal health programs) for a LHD to be certified by the State health agency. The new approach was approved by the board overseeing Project Health in early 1993. Rules to implement the changes, as well as other important aspects of Project Health, were formally promulgated by the State health department in July 1993. The differences between the two approaches are characterized in the third accompanying box on page 484.

The Illinois experience suggests that the 10 practices, together with performance expectations that can be developed for each, represent an acceptable and rational framework for defining and certifying LHDs in collaborative statewide public health networks. However, time is required for determining whether fulfilling the 10 practices is equivalent to LHD effectiveness.

Public health practices in leadership development. Enhancing public health leadership has been a major priority of CDC's capacity building activities in recent years *(10)*. CDC has funded a National Public Health Leadership Institute and several State and local programs to provide leadership development for public health workers. One program was funded in Illinois at UIC-SPH to provide leadership training and skills to State and local public health agency staff. While incorporating an appropriate emphasis on developing leadership skills, the Illinois program sought to build its Public Health Leadership Institute around the core functions and 10 practices.

The program was developed to foster leadership skills, but to do so with the goal of improving organizational effectiveness to address the core functions and practices within communities. Leaders come from all levels within an organization, enabling the entire organization to be more successful in achieving its mission through the 10 organizational practices. Organizational leadership affords leaders both internal and external means (through the 10 practices) to address the organization's mission.

The 10 practices were used as the basis for identifying needs for leadership development among

Local Health Department Organizational Practices, Practice Measures, and Performance Indicators, from the Surveillance Project, University of Illinois at Chicago, School of Public Health, 1993

1. Assess the health needs of the community.

A community health needs assessment process is in place that systematically describes the prevailing health status and health needs of the community.

- A community health needs assessment planning process is in place
- Needs assessment includes community input
- Morbidity and mortality data obtained from vital records
- Morbidity and mortality data obtained from other sources
- Behavioral risk factors included in community needs assessment

2. Investigate the occurrence of adverse health events and health hazards in the community.

Timely investigations are conducted on an ongoing basis of the occurrence of adverse health events and health hazards in the community.

- Epidemiologic surveillance systems are functioning
- No preventable mortality or morbidity as result of delay in surveillance

3. Analyze the determinants of identified health needs.

Health needs identified in a community health needs assessment are analyzed to establish their determinants, contributing factors, adequacy of existing health resources, and the population groups most impacted in the community.

- Health needs from needs assessment are analyzed
- Determinants and contributing factors are identified
- Health needs of population groups are analyzed
- Existing health resources are analyzed

4. Advocate public health, build constituencies, and identify resources in the community.

A public review and discussion is conducted at least every 5 years of mission and role, short- and long-term public health goals, accomplishments, past activities, and plans in relation to community health.

- Meets with health related organizations
- Public health issues are disseminated to the community on a regular basis
- Information is provided to local media on a regular basis
- Public review is made of the LHD mission

5. Set priorities among health needs.

Community health problems, identified from a community health needs assessment conducted within the past 5 years, are ordered and classified, based on the size and seriousness of the problem and the acceptability, economic feasibility, and effectiveness of interventions.

- Community health needs are prioritized, based on size and seriousness
- Community health needs are prioritized, based on interventions
- Community health needs are prioritized, with community input

6. Develop plans and policies to address priority health needs.

A community health action plan that includes the current year and addresses priority community health needs has been developed with the participation of constituents and other groups.

- Community health action plan addresses priority health needs
- Community health action plan incorporates public participation
- Community health action plan incorporates policy analyses
- Long range strategic plan of LHD is linked to community action plan

7. Manage resources and organizational structure.

An organizational self-assessment and agency capacity building plan is completed at least once every 5 years.

- Organizational chart includes all functional elements of the LHD
- Self-assessment and plan to identify capacity needs is completed
- Written job descriptions and qualifications for staff are included
- Funds to address priority health needs are identified

8. Implement programs.

Priority health needs are effectively addressed in the community through implementation of mandated programs and services, other priority services are either provided or available, and all programs and services are provided in compliance with applicable professional and regulatory standards.

- LHD-mandated programs are being addressed
- Services are being provided for priority health needs

9. Evaluate programs and provide quality assurance.

Program's impact and effectiveness standards exist for each program, are monitored on a regular basis, and are utilized to redirect programs and resources as appropriate.

- LHD demonstrates compliance with professional and regulatory standards
- Monitors programs to assess compliance with standards and objectives
- Program changes are based on evaluation and quality assurance activities

10. Inform and educate the public.

The public is informed and educated about current health status, health care needs, positive health behaviors, and important health care policy issues.

- Public is informed about health status, behaviors, and policy issues

LHD = local health department.
SOURCE: Reference *11*.

the public health worker group identified for the institute (senior and middle management of State and LHDs). A training needs assessment sought input as to the importance of the practices, of the respondent's role in addressing that practice within their organization, and of facilitators and inhibitors in effectively addressing each practice. The 3-day workshop held in the fall of 1992 initiated the year-long leadership training program focused on the 10 practices in plenary presentations as well as in intensive case studies developed around the assessment, policy development, and assurance themes. The understandability and acceptability of the 10 practices as a virtual "job description" for public health agencies were apparent in the conference evaluations, demonstrating that the 10 practices are seen as a useful tool by public health practitioners. The second year of the leadership training institute addressed those practices in even greater depth. Future plans call for offering the leadership development program to community health agency staff and community board members.

Comment

Golfing folklore includes some unconventional wisdom, attributed to one of its anonymous legends, that golf is nothing more than a "game of luck." The old pro would immediately add that the more he practiced, the luckier he got. Unfortunately the elements of the organizational practice of public health are not as well understood by public health professionals as those for the practice of golf were to the famous golf professional.

The difficulties and pitfalls of attempting to characterize the organizational practices of public health are considerable. It is a bit daunting to even attempt to describe the central processes of an enterprise as dynamic and complex as public health. Yet this must be done if public health is to become better understood by both its practitioners and its external constituencies, namely the public it serves. The need for practice guidelines for medical practice has been acknowledged and addressed by the Public Health Service's Agency for Health Care Policy and Research. CDC and the national practice organizations should exercise the national leadership necessary for the establishment of consensus guidelines for organizational practice to guide the work and assessment of local public health agencies. Those would serve to complement preventive practice guidelines that may be developed for particular preventive interventions. Schools of public health and other academic and training programs should examine the congruence of organizational practices with the knowledge and competencies imparted to public health students and workers. The 10 organizational practices could provide a sound basis for the development of criteria and practice guidelines to be applied in any voluntary accreditation program for LHDs.

Although extensive external examination and validation of CDC's framework using 10 organizational practices is called for, early applications of this framework have been promising for capacity building purposes. They include the use of the practices to characterize and measure LHD effectiveness, to establish basic certification standards within a State-local public health system, and to focus on the effectiveness of organizations in developing public health leadership.

The model and its applications are small but important steps in the right direction. Continuous examination and revisiting of the model will be necessary to assure that its applications rise to the

Activities Required for Certification of Local Health Departments in Illinois, Before and After July 1993

Before July 1993

1. Food sanitation
2. Potable water
3. Maternal health and family planning
4. Child health
5. Communicable disease control
6. Private sewage
7. Solid waste
8. Nuisance control
9. Chronic disease
10. Administration

July 1993 and later

1. Assess the health needs of the community
2. Investigate health effects and hazards
3. Advocate and build constituencies
4. Develop plans and policies to address needs (includes analyzing for determinants and setting priorities)
5. Manage resources
6. Implement programs
7. Evaluate and provide quality assurance
8. Inform and educate the public

SOURCE: Reference *15*.

challenges presented in "The Future of Public Health" *(1)*:

> No citizen from any community, no matter how small or remote, should be without identifiable and realistic access to the benefits of public health protection which is possible through a local component of the public health delivery system.

Amid major changes in the organization and financing of the health care system, the challenge is to describe and measure the practice of public health better, so that its values can be made a more integral part of the new system.

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