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STRENGTHENING THE PERFORMANCE AND EFFECTIVENESS OF THE PUBLIC HEALTH SYSTEM

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FOREWORD

As part of its continuing mission to serve trustees and staff of health foundations and corporate giving programs, Grantmakers In Health (GIH) convened a group of grantmakers and public health stakeholders on May 13, 2008, for an informative discussion about the nation's public health infrastructure. The program focused on strengthening the performance and effectiveness of the public health system.

This Issue Brief synthesizes key points from the day's discussion with a background paper previously prepared for Issue Dialogue participants. It includes information describing the challenges the public health system faces and provides examples of how health funders are addressing these problems.

Special thanks are due to those who participated in the Issue Dialogue, but especially to the presenters and discussants: Thomas Aschenbrenner, Northwest Health Foundation; Leslie Beitsch, Florida State University; Bobbie Berkowitz, University of Washington School of Nursing; Ronald Dendas, The Dorothy Rider Pool Health Care Trust; Alan Hinman, Public Health Informatics Institute; Paul Jarris, Association of State and Territorial Health Officials; Patrick Libbey, National Association

of County and City Health Officials; Linda Kay McGowan, CDC Foundation; Bruce Miyahara, Kansas Health Foundation; Pamela Russo, Robert Wood Johnson Foundation; and Mary Vallier-Kaplan, Endowment for Health.

Lauren LeRoy, president and CEO of GIH, moderated the Issue Dialogue. Kate Treanor, senior program associate at GIH, planned the program, wrote the background paper, and synthesized key points from the Issue Dialogue into this report. Additional support was provided by Eileen Salinsky, program advisor at GIH. Editorial assistance was provided by Faith Mitchell, vice president at GIH.

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EXECUTIVE SUMMARY

STRENGTHENING THE PERFORMANCE AND EFFECTIVENESS OF THE PUBLIC HEALTH SYSTEM

H *health funders at the national, state, and local levels have made substantial commitments to improve the functionality of the public health system. Using a variety of approaches, they have sought to develop the capabilities, services, and competencies that enhance public health practice. These efforts include developing the operational capacity of public health agencies and raising performance expectations for governmental public health organizations.*

Governmental agencies, such as state and local health departments, serve as the “load-bearing walls” of the nation’s public health system. The strength and effectiveness of these governmental agencies dictate the impact and sustainability of broader public health strategies. Ample documentation suggests, however, that the existing governmental public health infrastructure is inadequate to address health challenges currently facing the nation. Expert assessments have identified numerous pervasive deficiencies in resources and operating capabilities that both compromise agencies’ ability to fulfill traditional roles and responsibilities and undermine efforts to adapt to emerging health threats. Events over the last several years—the appearance of SARS, anthrax attacks, the devastation caused by Hurricanes Katrina and Rita, major recalls of foods and other consumer products, the looming potential of an influenza pandemic, and the growing obesity

epidemic—have underscored the serious, and sometimes tragic, consequences of failing to address these systemic weaknesses.

Such highly visible public health emergencies have resulted in a significant increase in federal public health spending, yet at state and local levels, resources devoted to public health have too often remained stagnant. Cuts in state and local budgets and increasing demands for public health care safety net services have frequently offset increases in federal public health dollars, resulting in little overall progress. Furthermore, federal funding streams for public health largely concentrate on emergency preparedness and other categorical obligations; as a result, federal support for some core services has diminished while other funding streams have increased.

Strengthening the Public Health System: Opportunities for Foundation Engagement

Many opportunities exist for health foundations to broaden the reach and enhance the effectiveness of governmental public health agencies. Such work has potential to yield tremendous returns although the investments require long-term commitments and tolerance for incremental change. They require employing a variety of strategies such as providing leadership, acting as neutral conveners, providing technical assistance, supporting research and assessments, and awarding grants directly to public health agencies.

While funders can pursue a variety of approaches to strengthen the public health system, many have sought to develop capabilities, services, and competencies that truly push the envelope in enhancing public health practice. These philanthropic efforts can be divided into two broad categories: developing the operational capacity of public health agencies and raising performance expectations for governmental public health organizations. Some health funders see these as mutually reinforcing strategies and support both.

Some regions in the country historically have not had any local public health authority, or the existing authorities were extremely limited in nature. Foundations have many opportunities to help build public health capacity in these communities. For example, they can help formalize the role of nongovernmental organizations in providing public health services and strengthen the capacity of local government to partner with nongovernmental organizations and state agencies. This can be done by supporting feasibility studies, disseminating the results, and providing technical assistance. Foundations can also harness momentum and build public will for increased public health capacity by awarding grants for regional convenings and public awareness campaigns.

The effective delivery of public health services depends on timely and reliable information and data. Public health information systems have historically been built

using a silo approach, resulting in a variety of different systems that cannot communicate with each other. A major challenge is to build integrated information systems that get the right information to the right people when they need it.

Foundations can provide considerable resources for public health departments to purchase, update, and utilize information and communications technology. They can also support programs to collect community health information and train public health professionals and others on how to use data to improve knowledge and service delivery.

Another critical issue facing public health is its workforce. Problems include an inadequate number of workers, unevenly prepared and trained professionals, a large number of workers retiring in the near future, and the need for dynamic leaders in the field. These challenges are exacerbated by the fact that the public health system is being asked to take on more responsibilities and be prepared for new and emerging health problems with fewer resources. Education and training are critical in building a strong public health workforce. From scholarships for continuing education programs to initiatives developing new schools and training programs, foundations of all sizes can support opportunities for public health professionals to increase their knowledge and skills.

Throughout the country, performance assessment and quality improvement efforts are being ramped up as public health agencies explore ways to increase efficiency and performance. New programs are helping document how resources are being used as well as generating a better understanding of what public health does among policymakers and the public. Performance assessment and accreditation efforts are two examples. Foundations can support these activities in a variety of ways. They can help local health departments become accreditation ready through self-assessments and promotion of quality improvement programs to remedy areas that need improvement. Technical assistance as well as support for training, consultants, convening, and exchange of

practices are specific activities foundations can fund. They can also support health department participation in beta pilot testing for the national accreditation process. Finally, foundations can support the evaluation

of accreditation and quality improvement efforts and then disseminate results to other health departments, the public, and policymakers.

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INTRODUCTION

Governmental public health agencies serve as the “load-bearing walls” of the public health system. Both public and private sectors make important contributions to improve the public’s health. Federal, state, and local health departments, however, have historically provided the critical infrastructure around which charitable, educational, religious, and commercial organizations typically build their efforts. The strength and effectiveness of these governmental entities often dictate the impact and sustainability of broader public health strategies. Significant erosions in public capacity jeopardize the structural integrity of the entire public health system.

“The health of Americans is compromised by the lack of consistent, high-quality public health services that can protect the safety of our air, water, and food supply; prevent chronic diseases; and be ready to deal with the next major health emergency.”

—Pamela Russo, Robert
Wood Johnson Foundation

Ample documentation suggests that the existing governmental public health infrastructure is inadequate to address health challenges currently facing the population. Expert assessments conducted by the Institute of Medicine (IOM), the Governmental Accountability Office, Trust for America’s Health (TFAH), and others have identified numerous pervasive deficiencies in resources and operating capabilities that both compromise agencies’ ability to fulfill traditional roles and responsibilities and undermine efforts to adapt to emerging health threats (IOM 1988; IOM 2003; Heinrich 2004; TFAH 2007). Events over the last several years—the appearance of SARS, anthrax attacks, the devastation caused by Hurricanes Katrina and Rita, major recalls of foods and other consumer products, the looming potential of an influenza pandemic, and the growing obesity epidemic—have underscored serious, and sometimes tragic, consequences of failing to address these systemic weaknesses.

Highly visible public health emergencies have resulted in a significant increase in federal public health spending, yet at state and local levels, resources devoted to public health have often remained stagnant. Cuts in state and local budgets and increasing demands for public health care safety net services have frequently offset increases in federal public health dollars, resulting in little overall progress. Furthermore, federal funding streams for public health largely concentrate on emergency preparedness and other categorical obligations. While federal support for some core services has increased in recent years, others have diminished. In fact only 20 percent of funds supporting local public health come from a federal source (Libbey 2008).

The scope and capacity of governmental public health vary substantially across states and communities. Although performance concerns are widespread, investments and policy decisions made at state and local levels clearly influence the magnitude of these problems. The constitu-

tional framework of the United States vests state governments with primary authority over public health interventions. State policies create the fundamental legal framework, including the powers, resources, and intergovernmental relationships, which can be pivotal in determining the nature and structure of public health services. Local funding levels are also a strong predictor of the breadth and depth of governmental public health services. Extreme variation in the availability and intensity of services across jurisdictions allows for flexibility in responding to local needs and priorities, but such variation also complicates attempts to develop common practice standards and performance expectations.

Private foundations seeking to improve health at global, national, state, or local levels face a difficult question in deciding whether to invest in improvements to the governmental public health infrastructure. Broadening the reach and enhancing the effectiveness of governmental agencies have the potential to yield tremendous returns, but such investments require a long-term commitment and tolerance for incremental change. Some approaches to improve population health will not require active engagement of the public system. Many private funders have determined that their resources are best spent on supporting and mobilizing nongovernment organizations that can act in tandem with public sector assets. In some communities with particularly weak public infrastructures, funders may feel that available private resources

are insufficient to have a meaningful impact on public sector capacity and consciously choose to support private sector surrogates. Others provide grant funds to public health agencies through competitive processes that allow for simultaneous assessment of prospective grantees from both public and private sectors. Still others have explicitly elected to commit resources and programs to develop public sector capacity and have played a catalytic role in renewing governmental public health.

This issue brief highlights efforts of national, state, and local funders that have made substantial commitments to improve the functionality of public health agencies. While these funders have pursued a wide variety of approaches to achieve this goal, most have sought to develop capabilities, services, and competencies that truly “push the envelope” in enhancing public health practice. Private philanthropic organizations have generally been careful to avoid taking responsibility for “business-as-usual” activities that agencies have historically funded with public revenues. These philanthropic efforts can be divided into two broad categories: developing the operational capacity of public health agencies and raising performance expectations for governmental public health organizations. Some health funders see these as mutually reinforcing strategies and support both, but this brief will describe each approach separately in order to clarify unique challenges and opportunities.

Foundation investments in the public health infrastructure require long-term commitment and tolerance for incremental change.

DEVELOPING THE FUNCTIONAL CAPACITY OF GOVERNMENTAL PUBLIC HEALTH AGENCIES

The government's role in public health encompasses three core functions: assessment, policy development, and assurance. Assessment includes activities for evaluating health status and needs, such as surveillance; collecting and interpreting data; conducting research; and evaluating outcomes. Policy development involves determining the best ways to address problems, setting goals, identifying steps (and in some cases laws and regulations) needed to reach those goals, and appropriating resources to act on those goals. The assurance function seeks to guarantee that appropriate health care services and population-based interventions are available and accessible through either public or private mechanisms. The activities of federal, state, and local public health agencies overlap in the performance of these core governmental functions, with the exact contribution of each player varying across jurisdictions and activities (IOM 2003).

The Ten Essential Public Health Services, developed in 1994 by the Public Health Functions Steering Committee of the National Public Health Performance Standards Program, expand upon these core functions and provide a conceptual framework for defining components of public health that should be manifest in all communities. The essential services framework did not seek to define the respective roles and responsibilities of federal, state, and local governments and expressly recognized the importance of the private sector in providing these services. In fact more than 90 percent of local health departments (LHDs) partner with schools, emergency responders, media, health care providers, and community organizations. As Patrick Libbey, former executive director of the National Association of County and City Health Officials, suggested

at the Issue Dialogue, “Government cannot be and never will be the sole provider of these essential services... everyone else’s engagement at the end of the day ultimately is voluntary, and we rely on that contribution.”

The public health infrastructure is commonly defined as the network of people, systems, and organizations that provides the 10 essential services necessary to safeguard and maintain the public’s health. *Healthy People 2010* identifies three key dimensions of the public health infrastructure—organizational capacity, data and information systems, and workforce capacity—that provide useful categories for characterizing foundations’ investments in developing the governmental public health infrastructure.

TEN ESSENTIAL PUBLIC HEALTH SERVICES

- 1) Monitor health status to identify community health problems.
- 2) Diagnose and investigate health problems and health hazards in the community.
- 3) Inform, educate, and empower people about health issues.
- 4) Mobilize community partnerships to identify and solve health problems.
- 5) Develop policies and plans that support individual and community health efforts.
- 6) Enforce laws and regulations that protect health and ensure safety.
- 7) Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- 8) Assure a competent public health and personal health care workforce.
- 9) Evaluate effectiveness, accessibility, and quality of person- and population-based health services.
- 10) Research new insights and innovative solutions to health problems.

Source: National Public Health Performance Standards Program 1994

Building Organizational Capacity

The organizational capacity of a governmental public health agency to perform the 10 essential services of public health is typically determined by (1) the legal framework guiding its mission, authorities, obligations, and organizational structures; (2) financial resources allocated to fund agency staffing and capital investments; and (3) administrative policies adopted to regulate operating processes and procedures.

The governmental public health system represents a complex and diverse array of organizational models, and the evidence base identifying preferred governance structures and funding levels is extremely limited.

There are more than 50 state and territorial health departments and over 2,800 local public health agencies in the United States. While their organization and authority vary substantially across the country, most states have adopted a decentralized public health system, meaning that each county, township, or local unit of government maintains its own public health department under the authorities granted by the state. At the local level about three-quarters of LHDs serve a county or combined city-county jurisdiction. About 62 percent of LHDs serve districts of less than 50,000 residents or about 10 percent of the total population. Conversely, 6 percent of LHDs serve districts with more than 500,000 residents (NACCHO 2006). Public health

OPERATIONAL DEFINITION OF A FUNCTIONAL LOCAL PUBLIC HEALTH DEPARTMENT

In 2006 the National Association of County and City Health Officials (NACCHO) published a set of standards, based on the Ten Essential Public Health Services, to describe what everyone, regardless of where they live, should expect from their local health department. The standards include:

- Monitor health status and understand health issues facing the community.
- Protect people from health problems and health hazards.
- Give people information they need to make healthy choices.
- Engage the community to identify and solve health problems.
- Develop public health policies and plans.
- Enforce public health laws and regulations.
- Help people receive health services.
- Maintain a competent public health workforce.
- Evaluate and improve programs and interventions.
- Contribute to and apply the evidence base of public health.

Source: NACCHO 2005a

agency budgets vary greatly as well. About half of LHDs have budgets of less than \$1 million; 20 percent have budgets of over \$5 million. At the Issue Dialogue, Patrick Libbey pointed out, “We’ve got some LHDs operating with budgets of less than \$10,000 per year up to Los Angeles County and New York City health departments that have budgets of well over \$1 billion.”

Variation in state and local authority, responsibilities, and services makes it “more complicated to frame and pursue a coherent national agenda concerning changes and

improvements in the governmental public health infrastructure” (IOM 2003). A number of strategies are being implemented to develop public health capacity, where none has existed before, to consolidate resources to improve functioning and achieve economies of scale or to enhance organizational capabilities or competencies.

Health foundations can provide critical support for strengthening public health agencies at state and local levels. Grants to implement pilot programs in LHDs or for analyses of health needs within a community can

FOLLOW THE \$\$\$

It is estimated that state and local governments finance more than two-thirds of all funding for essential public health services (Turnock and Atchison 2002). In 2004 governmental spending for public health activities was about \$56.1 billion, which represents about 3 percent of total U.S. health care expenditures. Of this, just \$9.1 billion can be attributed to federal public health activities. The remaining \$47 billion came from state and local governments (Sensening 2007).

The Centers for Disease Control and Prevention (CDC) is a major federal source of funding for state and local public health departments. While CDC funds increased from about \$4 billion in 2000, to \$7.7 billion in 2003, to \$8.4 billion in 2006, much of this gain can be attributed to monies for terrorism preparedness in the wake of 9/11 (Levi et al. 2007). Support for the CDC's Strategic National Stockpile, for example, increased 735 percent between 2001 and 2006. Federal spending for core public health functions, however, diminished during the same period. For example, funding for general infectious disease control decreased almost 2 percent, funding for injury prevention decreased 8.5 percent, and HIV/AIDS funding decreased 21 percent (Levi et al. 2007).

Because most CDC funds are redistributed to states and other partners to support categorical services and programs, they cannot be used to support more broadly defined public health capacities. The siloed nature of public health funding makes it difficult for government agencies to respond to unexpected events such as emerging infectious disease or weather-related emergencies.

Commenting on the financial resources poured into health in the United States, Paul Jarris (2008), executive director of the Association of State and Territorial Health Officials said, "It will take a fundamental relook at the allocation of health resources in our nation from a place where only 3 percent goes into public health and 97 percent goes into health care, to something a little more balanced."

greatly help public health agencies with limited budgets. Foundations can also act as neutral conveners, bringing together public health stakeholders to identify and address public health needs, and can take leadership positions on advisory committees or other bodies seeking to create change. Significant organizational reform is a daunting undertaking for most government agencies, and foundation support, in the form of financial

support and community leadership, can prove pivotal in moving these efforts forward.

Piloting Regionalization

Some states are testing regionalization as a strategy for identifying and leveraging resources within a defined geographic area to improve the provision of public health services. Sharing resources, along with the

Without a well-functioning public health system, broader health improvement efforts do not have a firm foundation.

provision of services, across city, county, or state lines can improve infrastructure, improve coordination of services, and save money. Essential to this strategy is the recognition of the interconnectedness of jurisdictions and the need to build capacity across boundaries (NACCHO 2005b). A study of regionalization efforts in five states found that the efforts arose from a “combination of factors: a crisis or perceived need for a coordinated response, a need to build local public health capacity, and an effort to use federal preparedness funds efficiently” (California Health Policy Forum 2007). The growing interest in national accreditation has also created an interest in exploring the potential of regionalization. In fact regionalization efforts can help lay the groundwork for accreditation by identifying resources and developing the capacity required for public health agencies to become accredited.

In Kansas, which is a home rule state, counties have authority to conduct business and perform legislative and administrative functions. In terms of public health, this means that LHD governance is decentralized and health departments are units of local government. Public health activities and services are largely provided through a web of 101 county health departments and other governmental agencies. The health departments serve populations ranging from 2,000 to more than 50,000 Kansans.

Support for a strong public health system has been a priority for the Kansas Health Foundation since

1998. Much of its work has focused on strengthening and connecting critical components of the public health system. The foundation recognizes that without a well-functioning public health system, broader health improvement efforts do not have a firm foundation. One of the Kansas Health Foundation’s strategies to accomplish this work has been to fund strategic capacity development. The foundation has supported pilot activities focused on regionalization as well as supported emergency preparedness training and exercises on a regional basis.

Kansas is currently undertaking a grassroots regionalization effort in two regions: North Central Kansas and the Northeast Corner. Small LHDs often do not have the capacity to meet the operational definition of a functional LHD. Using the National Association of County and City Officials’ (NACCHO) operational definition of a functional local health department as a framework has helped ensure the provision of public health activities and services. The Kansas approach, called functional regionalization, is a bottom-up approach. At the Issue Dialogue, Bruce Miyahara, public health program manager for the Kansas Health Foundation, said, “By approaching it functionally, we’ve said we are not worried about the structure; we wanted the public health departments to focus on how they might benefit from working together.” Using functional regionalization allows LHDs to work together through formal interlocal agreements

to ensure that residents have access to basic public health services.

Kansas' work builds on past efforts to strengthen LHD capacity to respond to emergencies on a regional basis and to expand regional arrangements for public health services. The real opportunity to implement a regional approach came with bioterrorism funding. Once the LHDs were able to articulate their functions through the bioterrorism grant, "they realized that each individual health department did not have the capacity or capability to take on this work themselves" (Miyahara 2008). The 101 LHDs organized themselves into 16 regions, with all but two representing populations of 50,000 or more.

With funding from the Robert Wood Johnson Foundation, NACCHO is supporting this initiative, as well as one in Massachusetts, with technical assistance. The Kansas Health Foundation provided matching grants to LHDs for the project and funded a summit on regionalization for county commissioners and other leaders.

The foundation sees itself as the "glue" in the regionalization process. "State and local agencies, particularly in rural states, are not always singing from the same sheet of paper. An examination of the roles of and relationships between these agencies is necessary," said Bruce Miyahara at the Issue Dialogue. The Kansas Health Institute, with support from the Kansas Health Foundation, has played a critical role in looking at the public health functions needed within

the state and facilitated discussion and agreement among these stakeholders. "Including other actors, such as foundations or public health institutes, in the process allows for stakeholders to open up and provides a safer place for them to think about the actual system outputs" (Miyahara 2008).

The Kansas Health Foundation has also worked closely with the Kansas Association of Local Health Departments to organize LHDs to find common ground and activities. For example, the foundation funded the state public health association and the Association of Counties to put on a regionalization summit. The meeting brought together county commissioners, policymakers, and local public health department leaders to discuss common concerns and identify activities in which to partner. Regionalization efforts can be threatening to individual counties in strong home rule states such as Kansas. Providing a neutral environment for such discussions can help local leadership. As Bruce Miyahara noted at the Issue Dialogue, "We need to get county commissioners on board with the whole idea or it will be very difficult, if not impossible, to expand shared activities beyond bioterrorism or preparedness activities."

Today there are eleven states across the country exploring regionalization and sharing resources across jurisdictions. Foundations can play an important role in these efforts. Pamela Russo, a senior program officer at the Robert Wood Johnson Foundation, noted during the meeting that this work

Today there are eleven states across the country exploring regionalization and sharing resources across jurisdictions.

“requires convening, examining legal issues and financing streams, evaluating quality improvement efforts, and disseminating results. Foundations can help with any of these.”

Establishing a Local Public Health Authority

In some jurisdictions, efforts to regionalize local public health services are not hampered by pre-existing organizational models because these communities historically have not had any local public health authority, or the existing authorities were extremely limited in nature. New Hampshire stakeholders are building on past accomplishments to create a more cohesive public health system throughout the state.

The Endowment for Health, an independent foundation serving the state of New Hampshire, is working to leverage past public health achievements. Through grants for regional convenings and technical assistance, as well as a public awareness campaign, the foundation is harnessing momentum to strengthen public health capacity. The foundation’s leadership is also playing an active role, bringing their knowledge and experience to the table. According to Mary Vallier-Kaplan (2008), vice president and chief operations officer at the Endowment for Health, “The foundation looks at its public health work as an opportunity to build something from the ground up.” The foundation has invested close to \$2.5 million in public health issues, and its explicit strategy has been to

collaborate with government. “We acknowledged that government could be an entity we could fund. They could, in essence, be a grantee. But we also recognized the foundation could be a coleader with government,” said Vallier-Kaplan. The foundation chose to fund convenings, award operating grants, and fund public policy work rather than piloting large initiatives or demonstration programs.

New Hampshire is consistently rated as one of the healthiest states in the nation. Its fragmented local public health system, however, has resulted in a lack of cohesive disease control and surveillance, limited capacity to identify and leverage statewide public health assets, and a shortage of incoming federal public health resources. The state has only two city-based health departments, and its public health infrastructure is based on 300 health officers who often have limited training in health. In fact only six towns employ full-time health officers; the rest depend on part-time or volunteer workers. By default, police officers, firefighters, school nurses, nonprofit service providers, and others fill roles that are usually the responsibility of local public health departments.

It is against this backdrop that in the mid-1990s New Hampshire participated in Turning Point, a collaboration between the W.K. Kellogg Foundation and the Robert Wood Johnson Foundation. Turning Point was designed to strengthen state and local public health agencies through partnerships between public

health and its many stakeholders. The central activity of the state's Turning Point project was developing the New Hampshire Public Health Network, a system of regional community collaborative programs working to create a more effective and responsive local public health system. Key ingredients for improving the system included increasing coordination between state agencies, formalizing the traditional role of nongovernmental organizations in providing a range of public health services, and strengthening local government capacity to partner more fully with nongovernmental organizations and the state. Federal bioterrorism and related resources also helped focus attention on and build new partnerships for public health in the state (Turning Point 2004).

Turning Point also developed a comprehensive public health improvement plan. The plan contained specific action steps to improve the state's public health infrastructure among which was the development of an ad hoc advisory group to develop strategies for increased state agency coordination. The Public Health Improvement Action Plan Advisory Committee (PHIAP), convened in 2006, included members of the state departments of health and human services, education, and safety, as well as local public health leaders, legislators, academics, and the state public health association. The convening was underwritten by the Endowment for Health. Mary Vallier-Kaplan (2008) explained, "It was a \$35,000 grant. The state, quite

honestly, couldn't afford to bring everyone together."

In addition the foundation took a leadership role in development of the state's public health plan. PHIAP was co-chaired by the director of the Division of Public Health Services and the president of the Endowment for Health, James Squires. Dr. Squires had previously served in the New Hampshire Senate where he chaired the Public Institutions, Health, and Human Services Committee. His leadership at the foundation and in the state legislature helped bring visibility to the committee and its work.

PHIAP was responsible for providing oversight of a performance improvement planning process based on the results of the National Public Health Performance Standards Assessment. In June 2007 the committee was replaced by the Public Health Improvement Services Council, which will continue oversight of the public health improvement efforts begun under PHIAP. The Endowment for Health's vice president of program sits on the council.

As the council moved forward with its work, the Endowment for Health sought the public's support for public health in the state. To do this, the foundation turned to the New Hampshire Public Health Association. The foundation awarded an operating grant of \$100,000 per year over five years to build the association's capacity from a volunteer entity to an organization with a full-time

public policy director. The operating grant “provides the association with needed flexibility,” according to Vallier-Kaplan (2008). An additional \$100,000 grant was awarded for a statewide awareness campaign designed to communicate the value and importance of public health to key audiences. The work piggybacks on the national Association of State and Territorial Health Officials (ASTHO) public health campaign.

The Endowment for Health also sought support from state policy-makers in New Hampshire, which has 425 legislators and holds elections every two years. To this end, it supported the state public health association to develop and implement Public Health 101, an annual one-day class on public health designed for legislators. “No one is allowed in the room except the presenters and the legislators so that they can be as open and curious as they want,” explained Mary Vallier-Kaplan at the Issue Dialogue. The program draws about 100 legislators each year. “This was a small grant – only \$3,000. Not a lot of money for a big impact,” Vallier-Kaplan commented.

In the state of Pennsylvania, stakeholders are working to create a new multicounty health department in the Lehigh Valley to serve a geographic area that has historically had only limited coverage by a local public health authority. The Dorothy Rider Pool Health Care Trust (Pool Trust) is using its leadership position to move the Lehigh Valley toward a regional health department model. The state

has 67 counties, but only six have their own LHDs. Four of the states’ cities have health departments. The remaining areas are covered by the State Department of Health.

The Lehigh Valley, which spreads across Northampton and Lehigh counties, has a population of approximately 600,000 and is the fastest growing region in the state. The valley has two major cities: Allentown and Bethlehem. Each city has a health department, but they serve less than a third of the population. Suburban communities outside the cities’ jurisdictions do not receive health department services such as restaurant or water well inspections. According to Ronald Dendas, a program officer at the Pool Trust, outside Allentown and Bethlehem cities, county residents are served by 1.5 full-time public health nurses. “That’s our public health infrastructure,” he said at the Issue Dialogue and added that because of this, “provision of much public health services falls on the shoulders of our community hospitals.”

In the mid-1990s The Rider-Pool Foundation, a second foundation endowed by the same donors as the Pool Trust, funded a project dedicated to the revitalization of Allentown. A significant outcome was identifying the need for a regional health department—one that served people living outside city limits. Shortly thereafter the mayor of Bethlehem raised the issue of a regional health department, largely because of having had three different health directors in three years. In 2000 the Pool Trust

awarded a \$29,000 grant to study the feasibility of a regional health department in Lehigh Valley. The study revealed that while stakeholders throughout the valley were in favor of the concept, there was skepticism about its feasibility. The cost of setting up and sustaining a regional health department, as well as the issue of who would pay for it, stalled further action. With support for the idea but questions about implementation and cost, foundation staff decided to fund the development of a report outlining potential models for a regional health department.

In 2004 and 2006 the Pool Trust and Two Rivers Health and Wellness Foundation cofunded analyses of three service models: minimum services, maintaining the current level of services, and increasing current services proportionally throughout the region. In 2006 the analysis expanded into a regional or bicounty model to address questions regarding the cost of a regional health department model. The first time around, there was limited interest in the project among county officials, but in 2006 Northampton County leadership was willing to collaborate on the development of a regional health department and offered to contribute \$500,000 annually for its operations. Pennsylvania public health state law, however, posed a challenge. The antiquated statute needed updating and a few tweaks.

Throughout 2006 and 2007 the Pool Trust used its leadership position to further advance the movement toward a regional health department.

For example, Northampton County wanted to create a board of health to continue exploration of a health department. Pennsylvania public health law, however, considers a board of health to be the equivalent of a health department. If the plan for a health department did not materialize, the only way to dissolve the board would be to put it on the ballot and have county residents vote to disband it. Stakeholders turned to the Pool Trust for guidance. Foundation staff met with local legislators and worked to draft—and pass—legislation allowing counties to create boards of health without establishing health departments. During this time the foundation also awarded a small, \$15,000 grant to Renew Lehigh Valley, a local nonprofit promoting smart growth and smart governance to revitalize communities in the region. The grant was used for community organizing and a campaign to build citizen support for public health.

Financing of the proposed health department became another sticking point. Pennsylvania law required a dollar-for-dollar match to any public health dollars invested. But the proposed regional health department would not be financed through county dollars. Foundation staff “went through the books with a fine-tooth comb and found only \$140,000 worth of public health services for the region,” said Ronald Dendas at the meeting. The foundation also drew on its strong relationship with area hospitals. “We started looking at a model that allowed the hospitals to build their charitable care contributions into the public

health funding,” Dendas explained. Including health services provided by the hospitals would allow a health department to draw down more state funds and require less local funding. This financial model allowed the foundation to build additional support for the project.

Finally the foundation sought to “seal the deal” and offered a \$1 million challenge grant if the two counties could pass ordinances creating a regional board of health by December 31, 2007. The funding would cover start-up costs. “That got their attention,” said Dendas (2008).

The challenge now is to build integrated information systems that get the right information to the right people when they need it.

While the valley still does not have a regional health department, the Lehigh County Commissioners and Northampton County Council agreed in December 2007 to create a Lehigh Valley Board of Health. The five-member body will create a staffing plan, service model, and budget for a regional health department. Appointments to the board of health are expected to be made in 2008. The regional health department plan is ultimately subject to final approval by the Pennsylvania Department of Health as well as Lehigh and Northampton counties.

In reflecting on the lessons learned during this nine-year process, Ronald Dendas (2008) said the foundation was “constantly going to its toolbox and pulling out different strategies. Are we using convening today? Are we pulling out facilitating? Are we pulling out public policy work? Grantmaking? Leveraging? Partnering? Innovation?”

He also suggested that this type of work requires a long-term commitment from foundations. “Pace yourself because this won’t be over in a couple of minutes—or a couple of years.”

Advancing Information Technology

The effective delivery of public health services depends on timely and reliable information and data. Public health information systems have historically been built using a silo approach resulting in a variety of different systems for different programs that cannot communicate with each other (NACCHO 2008). The challenge now is to build integrated information systems that get the right information to the right people when they need it.

State and local public health agency staffs need information systems to effectively perform their job functions, particularly in the areas of surveillance and monitoring. Biosurveillance, for example, has become an important aspect of public health work in a post-9/11 world. Biosurveillance systems provide real-time disease detection by analyzing streams of data from sources like hospitals and emergency rooms, poison control centers, and environmental agencies (ASTHO 2006). Information technology can also enhance an agency’s ability to collaborate with other health departments, private clinicians, and patients. Shortfalls in information infrastructure are troubling on a day-to-day basis but can be deadly in emergencies.

In order for information systems to be effective, individuals must know how to use them. Public health informatics is the systematic application of information and computer science and technology to public health practice, research, and learning (IOM 2003). Informatics differs from information technology in that it “seeks to understand current technologies and the potential application of technologies to meet public health needs” (ASTHO 2006). It also seeks to use information resources to satisfy the business requirements of public health. The IOM recommends that informatics should be incorporated in public health training programs (IOM 2003).

One federal initiative to enhance public health information systems is the Centers for Disease Control and Prevention’s (CDC) Public Health Information Network (PHIN). It seeks to improve the capacity of public health agencies to use and exchange information electronically by promoting the use of standards as well as defining functional and technical requirements. PHIN is also working to enhance research and practice through best practices related to efficient, effective, and interoperable public health information systems (CDC 2008a). To do this, PHIN is supporting the exchange of critical health information between public health and health care organizations; collaboratively developing and promulgating system requirements, standards, specifications, and architecture; monitoring the capability of state and local health

departments to exchange information; advancing public policies to support public health departments in this area; providing technical assistance; and facilitating communication and information sharing (CDC 2008a). The CDC’s Health Alert Network (HAN) now functions as PHIN’s health alert component. This includes working with federal, state, and local partners to develop protocols and strengthen relationships to develop an interoperable platform for rapid exchange of public health information. HAN’s messaging system transmits health alerts, advisories, and updates to over 1 million public health professionals (CDC 2008b).

Foundations can provide considerable resources for public health departments to purchase, update, and utilize information and communications technology. They can also support programs to collect community health information and train public health professionals and others on how to use data to improve knowledge and service delivery.

Acquiring 21st Century Tools

The Missouri Foundation for Health recently provided \$13 million in funding to 84 local health departments in Missouri to help agencies make significant capital investments. At a time when Missouri’s health departments were struggling with reduced funding and with annual budgets barely covering the cost of meeting critical community health responsibilities, the foundation designed this one-time grant initiative for infra-

Foundations can provide considerable resources for public health departments to purchase, update, and utilize information and communications technology.

structure improvements specifically to enhance and modernize local health departments' delivery of services, rather than simply sustain existing activities. Grantees could use funds to purchase equipment for information technology, communications services, transportation improvements, and health-related educational programs or to finance building renovations related to improvements in client services. Grants could not be used for operational, staffing, or travel expenses or other overhead costs. Although the funding initiative did not limit grantees to information technology-related investments, many of the eligible health departments used funds to support development of more sophisticated information management and telecommunications systems, suggesting the pervasiveness of this type of capital development need.

Each health department was eligible for a base grant of \$50,000 plus at least \$2 per area resident based on 2005 population data. The individual department grants ranged from about \$58,000 to more than \$2 million. Missouri Foundation for Health noted that most public funding available to local health departments is linked to specific public health activities and does not address basic equipment needs. It reasoned that health departments can quickly find themselves with outdated computers, telephones, and diagnostic equipment; worn-out transportation vehicles; and offices and examination rooms in disrepair, and with no way to address those problems except to redirect funds

from health care services. Foundation funds would provide a unique opportunity for health departments to enhance their services through acquisition of up-to-date equipment.

James R. Kimmey, president and CEO of the Missouri Foundation for Health, said, "With the foundation's one-time grant, health departments can address infrastructure problems so that available government funding can continue to be spent where it is needed most—providing services to area residents" (Missouri Foundation for Health 2007).

Building an Accessible Information Resource

As part of its ongoing work to build public health system capacity in New Hampshire, the Endowment for Health provided funding for a community health data system. Between 2001 and 2004 the foundation invested more than \$500,000 in the Empowering Communities project. The project, based at the University of New Hampshire, supports efforts to facilitate access to health data, as well as to build skills among public health professionals and stakeholders to engage in evidence-based health improvement processes. Data are accessible through an interactive Web site, essentially creating one-stop shopping for health information. Users can drill down from state to zip code level. Using the available data, public health professionals and others can better understand and manage the health of the communities they serve.

In 2001 the foundation made its first investment in Empowering Communities. The University of New Hampshire was awarded the first grant to develop a business plan, budget, and fundraising strategy. In addition 10 community meetings were held around the state to seek input on community data needs. A second grant was awarded in 2002, and these funds supported development of the New Hampshire Health Data Inventory, which provides information on health data sources and reports as well as links to organizations that manage the data. They also supported development of a query-based system on the Web. The system is a “bottom-up health information system that provides people in communities with the information they need” (Vallier-Kaplan 2008).

A second component of Empowering Communities has been the effort to build knowledge of data and its uses among public health and other professionals throughout the state. A significant challenge in this work has been the fact that even when data are available, they are underutilized because people do not know how to access or use it (Vallier-Kaplan 2008). The Empowering Communities project has provided trainings on community-specific topics; technical assistance; and tools, such as resource sheets, to support evidence-based public health practice. The Endowment for Health’s support for these activities has been used to develop and implement an on-line survey to identify current community

health improvement training needs and to create, carry out, and evaluate new and existing training programs.

Integrating Public Health Information Systems

Recognizing that information technology and data management are central to providing quality public health services, the Kansas Health Foundation has supported the development and installation of the Kansas Integrated Public Health System (KIPHS). This comprehensive health information system is designed to enhance the quality, effectiveness, and efficiency of public health practice. It assists state and local health departments in obtaining accurate data on health issues and integrating data from multiple sources. The system is connected to the CDC’s national surveillance system.

Ten years ago the Kansas Health Foundation began working with the Wichita/Sedgwick County Health Department to develop software that would help local health departments and clinics manage, track, and organize their services. The foundation’s grant support totaled approximately \$1.8 million for development and implementation and resulted in KIPHS software. The software has since been installed in several of the state’s LHDs. A central data clearinghouse was established as well as an office within the Kansas Department of Health and the Environment. The Kansas Health Institute administers the grant, and the CDC provides additional support.

The Kansas Health Institute owns the intellectual property rights to the KIPHS software and exclusively licenses it to KIPHS, Inc., a separate company headquartered in Wichita. KIPHS, Inc. has expanded its line of information solutions into a suite of software products provided exclusively for public health.

Facilitating Collaborative Learning

The Robert Wood Johnson Foundation views collaboration as a key to developing information system requirements that support the work of public health agencies. To that end, the foundation developed Common Ground, a three-year, \$15 million national initiative designed to help state and local public health agencies respond better to health threats by improving their use of information systems. The program's overarching principle is that public health agencies across the country do essentially the same kind of work in similar ways. Common Ground is helping agencies share their experiences and best practices, address common approaches to problems, and develop common business processes. As Alan Hinman (2008), senior public health scientist at the Public Health Informatics Institute, put it, "Public health enterprise can be successful only if it works together to define our common goals and our common ground."

In December 2006 the foundation awarded grants to 31 public health agencies throughout the country. The Public Health Informatics Institute,

Common Ground's national program office, provides management and technical support to the grantees. The initiative's goal is to support collaboration among state and local public health agencies in the analysis and redesign of public health business processes and in collaboratively defining a set of information system requirements for technology to strengthen public health agencies. At the Issue Dialogue, Hinman suggested that there is a growing movement to agree on standards. "If you don't have agreement on standards, how can systems talk to one another and how can you exchange information?" he posited.

The foundation awarded 15 informatics capacity grants of up to \$30,000 to analyze agencies' business processes related to a specific public health problem. For example, in the state of Utah the Summit County Board of Health is conducting a business process analysis of interactions among food-borne illness, disease surveillance, restaurant inspection, and case management. Oregon's Multnomah County Health Department is working to decentralize public health data into an integrated system for communicable disease investigation and control.

Another 16 grants of up to \$600,000 were awarded for application of a proven methodology to analyze business processes and define future system requirements. These grantees focus their work in one of two areas: chronic disease prevention and control or public health preparedness.

In Massachusetts, for example, the Children’s Hospital Corporation is collaborating with state and local government to develop a system to more effectively manage inventory, track patients, and build capacity within local and state health authorities. The Metropolitan Government of Nashville and Davidson County in Tennessee is developing incident command informatics to strengthen the region’s emergency response capacity. The work includes defining business processes, examining work flow, and identifying information technology requirements.

The Public Health Informatics Institute’s guiding principle throughout its involvement in Common Ground and other projects was: systems must support performance (Hinman 2008). Public health professionals need to think before they start building, engage all stakeholders, and plan for interoperability. “We have to be thinking about how systems are going to relate to one another and look for ways to improve business processes and add value” (Hinman 2008).

Strengthening the Public Health Workforce

A critical issue facing public health is its workforce; problems include an inadequate number of workers, unevenly prepared and trained professionals, a large number of workers retiring in the near future, and the need for dynamic leaders in the field. These challenges are further

compounded by the fact that the public health system is being asked to take on more responsibilities and be prepared for new and emerging health problems with fewer resources (Perlino 2006). As Paul Jarris, executive director of ASTHO, stated at the Issue Dialogue, “Overall, this is a tremendously challenging issue for all of us in public health.”

There are currently more than 500,000 individuals in the public health workforce, including nurses, epidemiologists, laboratory scientists and technicians, health educators, nutritionists, physicians, occupational and safety specialists, sanitarians, environmental professionals, and many others (Center for State and Local Government Excellence 2008). These workers come into public health with a range of backgrounds and educational experiences. In fact only 20 percent of the graduates of schools of public health enter governmental public health. “The schools really aren’t the source of our workforce,” noted Paul Jarris (2008). “Our workers need to come out of the informatics profession, the nursing profession, out of places other than schools of public health.” Courses such as epidemiology, emerging diseases, and other public health classes, however, are becoming more popular at the undergraduate level. According to the Association of American Colleges and Universities, 16 percent of its members offer majors or minors in public health. The uptick in enrollment is reflective of media reports full of global health

“You’ve got to use the information you’ve got, even if it’s not perfect. The more you use it, the better it will become.”

—Alan Hinman, Public Health Informatics Institute

news and the recognition that health gains in the 21st century will largely be global (Brown 2008).

Recruitment and retention, however, are particular challenges. Federal and state budget cuts to public health have resulted in a large number of vacancies being left unfilled as workers retire or leave their positions (Perlino 2006). In fact NACCHO's *2005 National Profile of Local Health Departments* notes that 16 percent of LHDs report an inability to fill open positions because of budgetary restrictions. Limited budgets also affect the recruitment of workers because they cannot compete with more competitive private-sector salaries. Twenty-nine percent of LHD respondents in the NACCHO survey report this as a problem in hiring.

Another imminent challenge facing the public health workforce is the retirement of current workers. The average age of a public health worker in state government is 47 years old, and the average age of a new hire is 40 years old (ASTHO 2008). At the meeting Paul Jarris suggested that this indicates that people are entering governmental public health at a second career stage. ASTHO research also finds that 29 percent of current health agency staff are eligible for retirement in 2008. This is up from 24 percent in 2003. More importantly, about 50 percent of the leadership in health agencies are at retirement age. The good news are that only 16 percent of those eligible to retire are retiring (Jarris 2008).

The number of individuals prepared to fill public health vacancies is also shrinking, especially in the areas of public health nursing, epidemiology, and environmental health. For example, 59 percent of LHDs anticipate having problems hiring qualified nurses in 2008, and 38 percent anticipate problems hiring qualified epidemiologists (Center for State and Local Government Excellence 2008).

Education and training are critical in building a strong public health workforce. From scholarships for continuing education programs to initiatives developing new schools and training programs, foundations of all sizes can support opportunities for public health professionals to increase their knowledge and skills.

Public Health Professional Development

One strategy of The Duke Endowment is to strengthen organizational infrastructure for health and health care organizations. By improving health care facilities, systems, management, and operations, the foundation sees an opportunity for long-term impact on the health of North Carolinians.

In 2006 The Duke Endowment awarded the North Carolina Institute for Public Health (NCIPH), an arm of the School of Public Health at the University of North Carolina at Chapel Hill, a \$291,000 grant to develop the North Carolina Public Health Academy. The U.S. Health Resources and Services

“We need to make sure that we recruit the public health workforce of tomorrow and not the workforce we had in the last century.”

—Paul Jarris, Association of State and Territorial Health Officials

Administration provided additional support through the Southeast Public Health Training Center.

The academy is essentially a school without walls for public health professionals. It is organized around competency-based learning for specific professional categories as well as general public health training needs. To accomplish this work, NCIPH has partnered with Area Health Education Centers (AHECs) throughout North Carolina to provide professional development opportunities and experiences. The academy also maintains a comprehensive Web site, which acts as a “virtual academy.” The Web site provides a variety of learning opportunities, such as on-line modules, and links to training and professional development opportunities throughout the state and nation. It also offers workers information on professional competencies and self-assessment tools.

The CDC Foundation also structures learning opportunities for community-based public health practitioners. For example, each year the Price Fellowships for HIV Prevention brings three leaders of HIV prevention programs to the CDC to spend a month working side-by-side with scientists to learn about HIV prevention at the national level and to exchange ideas about important HIV/AIDS prevention issues. The program, funded by the Price Foundation, allows community practitioners to learn new skills and build relationships with leading HIV researchers.

Establishing a School of Public Health

The Colorado Health Foundation supports programs that lead to lasting improvement in the health of Coloradans. The foundation views long-term health improvement through multiyear funding and collaboration as part of its mission. Educating public health professionals is a natural fit for the foundation’s work.

There is no school of public health in Colorado or the surrounding eight-state region to help support the demands public health threats place on the region’s health care and state and local public health infrastructure. An accredited school of public health would help the region better meet these increased demands as well as make the state more competitive for federal training and research dollars. The school would also provide state and local public health professionals with increased education and training opportunities, expand numbers and expertise of faculty participating in education and research, and provide access to a pool of potential public health workers. In July 2006 The Colorado Health Foundation issued a challenge for the development of a state school of public health.

The Colorado School of Public Health is a collaborative effort of the University of Colorado, Colorado State University, and the University of Northern Colorado. The new school, which will serve the Rocky Mountain region, will incorporate public health graduate

degree programs at each of the three institutions with distance learning, continuing education, community outreach, and public health research.

Through the challenge grant, The Colorado Health Foundation committed \$1.25 million in exchange for demonstrated university and community support. In response, the three universities pledged a combined total of \$1.2 million, while an additional \$750,000 has been targeted as the private and corporate fundraising goal. The Caring for Colorado Foundation, Rose Community Foundation, Colorado Public Health Association, the Hill Foundation, Great West Life, and numerous individual donors have contributed. Additionally the Colorado Department of Public Health and Environment, the CDC's National Institute for Occupational Safety and Health, and Colorado's AHEC have awarded contracts for projects within the proposed school.

The state of Oregon also does not currently have a school of public health. The Oregon Master of Public Health Program (OMPH), however, is a unique statewide degree program offered collectively by Oregon Health and Science University, Oregon State University, and Portland State University. Students enrolled in the OMPH program can take courses at any of the three campuses and interact with faculty from the three universities. The Northwest Health Foundation has funded a project to examine the feasibility of establishing a school of public health at one of the

state's universities. The foundation also helped create a public health certificate program in Oregon.

The 18-month program is open to public health officials who have not met the state-mandated education requirements for their position, according to Thomas Aschenbrener (2008), president of the Northwest Health Foundation. The foundation also provides scholarships to local health directors who want to participate in the program. "There are little things that foundations can do that can make a big difference," said Aschenbrener.

Attracting Clinicians to Public Health Practice

One of the focus areas of the CDC Foundation is educating and training the public health workforce. The foundation partners with private sector organizations to develop innovative learning opportunities for health care and public health professionals. With funding from the Pfizer Foundation, for example, the CDC Foundation is facilitating opportunities for medical students to have hands-on experience in epidemiology and public health. The competitive fellowships are awarded to eight, third- and fourth-year medical students to spend a full year at the CDC. Working side-by-side with CDC epidemiologists, the fellows conduct epidemiologic analyses in areas such as birth defects, chronic disease, infectious disease, environmental health, and health disparities. Training and work assignments provide opportunities to perform

"There are little things that foundations can do that can make a big difference."

— Thomas Aschenbrener,
Northwest Health
Foundation

epidemiologic analyses and research, design public health interventions, assist in public health field experiences, and report on findings through written and oral presentations. The program serves to provide students with a unique perspective of the role epidemiology plays in protecting the public's health and safety. Fellows also leave the program better prepared to pursue careers in medicine, epidemiology, health services research, preventive medicine, and public health.

The O.C. Hubert Student Fellowship in International Health program provides funding for third- and fourth-year medical and veterinary students to work on priority public health problems in developing countries. Founded in 1999 and endowed by the O.C. Hubert Charitable Trust, the program is designed to encourage students to think of public health in a global context. It is also designed to

engage young people in public health before they set their career paths, suggested Linda Kay McGowan, senior liaison with the CDC Foundation, at the Issue Dialogue. Fellows spend 6 to 12 weeks in a developing country working with CDC staff and other national and international health agencies. Since its inception the program has awarded 52 fellowships to students from 35 universities. Examples of past fellowships include an outcome evaluation of various home drinking water treatment and storage methods in Guatemala; a review of antiretroviral therapy in private practices in Kenya; and development of surveillance systems for surgical site infections, antimicrobial use, and antimicrobial resistance in a tertiary surgical center in Vietnam. McGowan noted that several of fellows applied for positions within the CDC upon completion of their schooling.

RAISING PERFORMANCE EXPECTATIONS

The nation's public health system is in disarray (IOM 2003). How can it be improved and strengthened? What tools are available to enable this stressed system to do more with its limited resources?

Performance assessment and quality improvement efforts are going on throughout the country as agencies seek to “increase efficiency and performance, decrease waste, and improve health outcomes” (Russo 2007). Such programs also help document how resources are used, as well as facilitate a better understanding of what public health does among policymakers and the public. A number of different approaches have been pursued to assess capacity, identify areas for improvement, and validate their impact for policymakers and the public. Some rely on consistent assessment protocols implemented by neutral third-party evaluators to support comparative analysis, while other approaches focus on internal-focused management practices and quality improvement tools.

“Accreditation is a means, not an end unto itself. It’s a strategy to improve performance and, thus, improve impact.”

— Pamela Russo, Robert Wood Johnson Foundation

Accreditation of Public Health Agencies

Accreditation of public health agencies “sets a benchmark of consistent standards for public health services that should be met in every community across the country” (Russo 2007). It also creates a level playing field for quality improvement. At the Issue Dialogue Bobbie Berkowitz, professor of nursing at the University of Washington, suggested that accreditation is a “huge opportunity for public health.” She continued, “Think about how health care has leveraged its work in accountability and how it has increased the public’s opinion in many areas about how well the health care system is performing using tools of accreditation. Public health has the opportunity to do the same thing.”

Performance assessment and accreditation efforts at the state and local levels have been ongoing for many years. Several recent factors, however, have contributed to a comprehensive exploration of a national voluntary accreditation program. These include the Institute of Medicine’s *The Future of the Public’s Health*, which recommended establishing a steering committee to examine the benefits of accrediting governmental public health departments, and the Center for Disease Control and Prevention’s (CDC) Futures Initiative, which identified accreditation as a critical tool for strengthening the public health infrastructure.

In 2004 the Robert Wood Johnson Foundation convened a meeting of public health stakeholders to build on this momentum and discuss whether a voluntary accreditation program

BUILDING BLOCKS OF ASSESSMENT AND ACCREDITATION

- Ten Essential Public Health Services (developed in 1994)
- Mobilizing for Action through Planning and Partnerships (developed 1996-2001)
- National Public Health Performance Standards Program (developed 1998-2002)
- Operational Definition of a Local Public Health Department (developed 2003-2005)
- Exploring Accreditation (developed 2005-2007)
- Understanding State Public Health (developed 2006-present)
- Public Health Accreditations Board (developed 2007-present)

Source: NACCHO 2007

should be pursued. The foundation also commissioned two background reports to support deliberations of this exploratory meeting. *Exploring Public Health Experience with Standards and Accreditation* reviewed positions that major public health organizations had taken on performance assessment programs and accreditation. The report also examined agency accreditation programs in eight states. The second report *Can Accreditation Work in Public Health? Lessons from Other Service Industries* reviewed literature on experiences and outcomes of accreditation programs in the health and social service fields (Russo 2007). Based on information provided in these background documents and interactive group discussions, this initial stakeholder discussion led to the development of the Exploring Accreditation project.

Exploring Accreditation began in 2005 with funding from the CDC

and the Robert Wood Johnson Foundation. A planning committee of the executive directors from the American Public Health Association, Association of State and Territorial Health Officials, National Association of County and City Health Officials, and National Association of Local Boards of Health—who had also been involved in the CDC’s National Public Health Performance Standards Program—provided oversight. They established a 25-member steering committee in September 2005, comprising representatives from public health organizations at the federal, state, and local levels to lead the exploration process.

To inform the process, workgroups on governance and implementation, standards development, financing and incentives, and research and evolution examined issues related to developing a voluntary accreditation program. The workgroups developed

reports indicating consensus recommendations and a rationale for each as well as alternatives considered. Their findings were then reported to the steering committee. The steering committee met in April 2006 to consider all the information and to develop a proposed model, which was vetted through public health officials. Comments were solicited via the Exploring Accreditation Web site and public meetings. The committee concluded, “Establishment of a voluntary national accreditation program is desirable for many reasons. Chief among them is the opportunity to advance the quality, accountability, and credibility of governmental public health departments, and to do so in a proactive manner” (Exploring Accreditation 2006). *Exploring Accreditation’s Final Recommendations for a Voluntary National Accreditation Program for State and Local Public Health Departments* was released in September 2006. As Pamela Russo explained at the Issue Dialogue, “The goal of accreditation is to be an agent of change, to focus on capacity and process, but with an eye toward the goal of improving health outcomes.”

The Public Health Accreditation Board (PHAB), which is funded by the Robert Wood Johnson Foundation, was an outgrowth of a recommendation from the Exploring Accreditation steering committee to move forward with implementation of a voluntary national accreditation program. The committee served as the PHAB board of incorporators and oversaw the initial implementation

of the new national program. The PHAB draws on a rich programmatic history, including NACCHO’s Operational Definition of a Local Health Department, the National Public Health Performance Standards Program, Exploring Accreditation, and the Multi-State Learning Collaborative.

In October 2006 board members began to develop a system for the voluntary accreditation of local and state health departments. PHAB formed several workgroups made up of state and local health officials to develop all aspects of the new accreditation program. The program development phase will be informed by workgroup findings and recommendations. For example, the standards development workgroup is developing accreditation standards for state and local health departments, and the assessment process workgroup is determining how to evaluate whether a health department has achieved accreditation status and how health departments can appeal decisions (PHAB 2008).

During a discussion of standards at the Issue Dialogue, a participant asked if the standards being developed would be set as a minimum floor for health departments rather than best practices. In response, Leslie Beitsch, director of the Center on Medicine and Public Health at Florida State University, explained, “Setting standards for accreditation is an iterative process, an evolutionary process in the sense that as the floor actually rises and performance improves,

EXISTING PERFORMANCE ASSESSMENT TOOLS

Efforts to develop an accreditation program to validate performance levels and functional capabilities of governmental public health agencies build on a number of existing tools designed to guide public health agencies in assessing their own performance. Since 1998 the National Public Health Performance Standards Program (NPHPSP) has developed National Public Health Performance Standards for state and local public health agencies and for governing bodies such as boards of health. The standards were developed collaboratively by seven national public health organizations including the Centers for Disease Control and Prevention (CDC), American Public Health Association, Association of State and Territorial Health Officials, National Association of County and City Health Officials (NACCHO), National Association of Local Boards of Health, National Network of Public Health Institutes, and the Public Health Foundation.

NPHPSP is a tool to assist public health agencies in identifying areas for system improvement, strengthening state and local partnerships, and assuring that a strong system is in place for effective response to day-to-day public health issues and public health emergencies (CDC 2008c). Its goals are to provide performance standards for public health systems, improve quality and accountability of public health practice, conduct systematic collection and analysis of performance data, and develop a science base for public health practice improvement (CDC 2008c).

The initiative's standards are grounded in the Ten Essential Public Health Services. The standards are primarily designed to guide agency self-assessments by defining an optimal-level of performance to which all public health systems can aspire (CDC 2008c). The first version of standards was released in 2002, and by 2007 more than 30 states had used the tool. A second version of the standards has since been developed. The lack of uniform, concrete metrics to rate performance, however, has limited the utility of the standards for comparative assessments across agencies.

Mobilizing for Action through Planning and Partnerships (MAPP) is a strategic planning approach to community health improvement developed by NACCHO. It helps local health departments and communities improve health and quality of life through communitywide strategic planning. It also helps assure the provision of essential public health services in the community. MAPP helps communities identify and use resources wisely by taking into account their unique characteristics and needs, and it helps establish partnerships for strategic action. MAPP was developed prior to NPHPSP, and although it reflects many of the same performance domains included in NPHPSP, MAPP is a more intensive, process-oriented tool to guide the development of best practices.

then the standards themselves would also be raised to reflect improving performance.” PHAB expects that applications for accreditation will be accepted beginning in 2011.

Pamela Russo (2008) emphasized the Robert Wood Johnson Foundation’s commitment to accreditation:

The foundation believes that a national accreditation system for local and state health departments will establish standards and benchmarks for providing the essential public health services, make agencies accountable to the communities that they service, and provide the impetus for widespread quality improvement in public health—all with the goal of improving the health of communities.

Foundations can support accreditation in a variety of ways. They can help local health departments become accreditation ready through self-assessments and the promotion of quality improvement programs to remedy areas that need improvement. Technical assistance, as well as support for training, consultants, convening, and exchange of practices, are specific activities foundations can fund. They can also support health department participation in beta pilot testing for the national accreditation process. Pamela Russo (2008) suggested that “particular attention be paid to those agencies that serve the poorest communities because they are likely to have the lowest level of local revenue.” Foundations can also support the evaluation of accreditation and quality improvement efforts and then disseminate results to other

health departments, the public, and policymakers.

Some foundations cannot award grants directly to governmental agencies. Alternative opportunities to support performance improvement may include funding intermediary organizations such as state associations of county and city health officials, state associations of local boards of health, public health institutes, or other community-based organizations. These organizations often work directly with health departments and are well positioned to move work forward. Foundations can look into their toolboxes and consider support for convenings, collaboration, or communication activities. Pamela Russo recommended, however, to always engage the local health department in such activities. “Make sure they have some sort of role in developing projects and concurrence about how funds might be used—even if they are not the direct recipient of grant funds” (Russo 2008).

Multi-State Learning Collaborative

In 2005, to support Exploring Accreditation and provide empirical information on existing public health accreditation programs, the Robert Wood Johnson Foundation developed and funded the Multi-State Learning Collaborative (MLC-1), which is managed by the National Network of Public Health Institutes and the Public Health Leadership Society. Through a competitive application

process, five states (Illinois, Michigan, Missouri, North Carolina, and Washington) already involved in performance assessment and accreditation were selected to be grantees. A peer network facilitated the exchange of ideas and strategies among participating states, interested stakeholders, and members of the public health practice community. The program was designed to advance existing public health assessment or accreditation activities in the grantee states and to provide opportunities for representatives of each state to share experiences and learn from one another (Beitsch et al. 2007). Additionally MLC-1 synthesized and disseminated information to local and state public health agencies and other stakeholders.

In 2006 the Robert Wood Johnson Foundation supported the Multi-State Learning Collaborative II: Quality Improvement in the Context of Assessment and Accreditation Programs (MLC-2). This phase of the initiative focused on quality improvement in the context of assessment or accreditation. Ten states (Florida, Illinois, Kansas, Michigan, Minnesota, Missouri, New Hampshire, North Carolina, Ohio, and Washington) were selected from 21 applicants to assess quality improvement strategies to enhance the work of public health departments. MLC-2 also expanded the peer network with teleconferences, face-to-face meetings, and site visits. In Kansas, for example, the concept of functional regionalization, which

includes regional trainings, pilot projects, and development of a model for regional application of core public health competencies, was introduced. Kansas is also using quality improvement practices to identify areas of need and solutions.

States participating in MLC-1 and MLC-2 received grants of \$150,000 from the Robert Wood Johnson Foundation. One of the most successful strategies used by MLC-2 states has been referred to as the “plan, do, act cycle” (Beitsch 2008). This includes setting goals and targets, communicating expectations, determining action plans, collecting and analyzing data, and reporting progress.

The third phase of the Multi-State Learning Collaborative (MLC-3) is focused on using quality improvement to achieve measurable impacts. Currently 16 states participate in MLC-3. As in the previous phases, states received \$150,000 non-categorical grant dollars. At the Issue Dialogue Leslie Beitsch noted, “The fact that these dollars are flexible, that they can be spent at the state or local level, is very important.” Florida is using its flexible funds to increase peer review capacity. For example, environmental health professionals in one county might be peer reviewers for another county that has expressed need for environmental health technical assistance. These types of programs promote “cross-pollination” (Beitsch 2008).

CONCLUSION

Our public health system struggles to provide essential services and prepare for unknown future events. The challenges presented in this brief are significant but can be overcome.

An array of stakeholders, such as public health associations, nonprofit and advocacy groups, academia, and foundations, are developing and implementing programs to address the system's most pressing needs. Their strategies include conducting research and analysis to build public will, grants for public health agencies seeking to restructure their operations, and convening stakeholders to identify needs and devise collaborative

solutions. Such activities will greatly improve the public health system's ability to attain its vision of healthy people in healthy communities.

Foundations have a unique role to play as champions of public health, and they can build a constituency for public health. "No matter where they sit; no matter what their circumstances; whether they are focused on the local, state, or national level, foundations can take advantage of the many tools at their disposal," concluded Lauren LeRoy (2008), president and CEO of Grantmakers In Health, at the Issue Dialogue.

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ABOUT GIH

With a mission to help grantmakers improve the health of all people, Grantmakers In Health (GIH) seeks to build the knowledge and skills of health funders, strengthen organizational effectiveness, and connect grantmakers with peers and potential partners. We help funders learn about contemporary health issues, the implications of changes in the health sector and health policy, and how grantmakers can make a difference. We generate and disseminate information through meetings, publications, and on-line; provide training and technical assistance; offer strategic advice on programmatic and operational issues; and conduct studies of the field. As the professional home for health grantmakers, GIH looks at health issues through a philanthropic lens and takes on operational issues in ways that are meaningful to those in the health field.

Expertise on Health Issues

GIH's Resource Center on Health Philanthropy maintains descriptive data about foundations and corporate giving programs that fund in health and information on their grants and initiatives. Drawing on their expertise

in health and philanthropy, GIH staff advise grantmakers on key health issues and synthesizes lessons learned from their work. The Resource Center database, which contains information on thousands of grants and initiatives, is available on-line on a password-protected basis to GIH Funding Partners (health grantmaking organizations that provide annual financial support to the organization).

Advice on Foundation Operations

GIH focuses on operational issues confronting both new and established foundations through the work of its Support Center for Health Foundations. The Support Center offers an annual two-day meeting, The Art & Science of Health Grantmaking, with introductory and advanced courses on board development, grantmaking, evaluation, communications, and finance and investments. It also provides sessions focusing on operational issues at the GIH annual meeting, individualized technical assistance, and a frequently asked questions (FAQ) feature on the GIH Web site.

Connecting Health Funders

GIH creates opportunities to connect colleagues, experts, and practitioners to one another through its Annual Meeting on Health Philanthropy, the Fall Forum (which focuses on policy issues), and day-long Issue Dialogues, as well as several audioconference series for grantmakers working on issues such as access to care, obesity, public policy, racial and ethnic health disparities, and health care quality.

Fostering Partnerships

Grantmakers recognize both the value of collaboration and the challenges of working effectively with colleagues. Although successful collaborations cannot be forced, GIH works to facilitate those relationships where we see mutual interest. We bring together national funders with those working at the state and local levels, link with other affinity groups within philanthropy, and connect grantmakers to organizations that can help further their goals.

To bridge the worlds of health philanthropy and health policy, we help grantmakers understand the

importance of public policy to their work and the roles they can play in informing and shaping policy. We also work to help policymakers become more aware of the contributions made by health philanthropy. When there is synergy, we work to strengthen collaborative relationships between philanthropy and government.

Educating and Informing the Field

GIH publications inform funders through both in-depth reports and quick reads. Issue Briefs delve into a single health topic, providing the most recent data and sketching out roles funders can and do play. The GIH Bulletin, published 22 times each year, keeps funders up to date on new grants, studies, and people. GIH's Web site, www.gih.org, is a one-stop information resource for health grantmakers and those interested in the field. The site includes all of GIH's publications, the Resource Center database (available only to GIH Funding Partners), and the Support Center's FAQs. Key health issue pages provide grantmakers with quick access to new studies, GIH publications, information on audioconferences, and the work of their peers.

DIVERSITY STATEMENT

GIH is committed to promoting diversity and cultural competency in its programming, personnel and employment practices, and governance. It views diversity as a fundamental element of social justice and integral to its mission of helping grantmakers improve the health of all people. Diverse voices and viewpoints deepen our understanding of differences in health outcomes and health care

delivery, and strengthen our ability to fashion just solutions. GIH uses the term, diversity, broadly to encompass differences in the attributes of both individuals (such as race, ethnicity, age, gender, sexual orientation, physical ability, religion, and socioeconomic status) and organizations (foundations and giving programs of differing sizes, missions, geographic locations, and approaches to grantmaking).



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