

# Making the Connection

*An Exploration of Accreditation and Quality Improvement  
through the Multi-State Learning Collaborative*

Dear Sarah,

As the 2007 year is winding down, the Multi-State Learning Collaborative II (MLC-2) is gearing up for its final meeting and the year ahead. The final meeting for all grantees and partners will be held in New Orleans in January. The meeting will provide an opportunity to share the work that has been accomplished and key lessons learned, as well as engage in solution-oriented discussion around issues such as state agency accreditation.



The MLC-2 is also happy to release the first of four "Topical Briefs." Each brief will examine a particular issue or theme that has emerged throughout the course of the MLC states' work. The first [MLC Topical Brief](#) explores workforce development for quality improvement.

Finally, pending approval by the Robert Wood Johnson Foundation (RWJF) Board of Trustees, the National Network of Public Health Institutes (NNPHI) and the Public Health Leadership Society (PHLS) will manage a third phase of the Multi-State Learning Collaborative for Performance Assessment and Accreditation of Public Health Departments (MLC). [More information...](#)

We hope you enjoy this issue of *Making the Connection*, in which the work of Missouri and New Hampshire are highlighted, and we wish you all a happy New Year!

Sincerely,  
National Network of Public Health Institutes

## In This Issue

[Multi-State Accreditation: A Heartland Partnership](#)

[New Hampshire, Building Public Health from the Ground Up](#)

## Announcements

[PHAB Job Opening](#)

[PHAB Call for Nominees](#)

[New Paper on Regionalization on NACCHO Website](#)

## Invitation to Apply

...for Lead States in Quality Improvement: MLC-3. [Click here for more information.](#)

## MLC Topical Brief

[Preparing the Public Health Workforce for Quality Improvement](#)

## Multi-State Accreditation: A Heartland Partnership

*by Kathleen Wojciehowski and Janet Canavese, Missouri Institute for Community Health*

Partnerships are important not only for current projects but also for the future. A case in point emerged during the Heartland Centers for Public Health and Community Capacity Development (Heartland) of St. Louis University School of Public Health's Annual Retreat. At the retreat, public health representatives from Missouri, Oklahoma, Kentucky and Kansas meet to discuss workforce and emergency preparedness issues, how they are addressed in their states and how resources can be leveraged among the states. The Missouri Institute for Community Health (MICH) gives an update on its voluntary accreditation program, and as a result of these updates, MICH was invited to Kansas to speak at the Association of Public Health Nurses annual meeting as well as Oklahoma and Kentucky to talk to public health officials about accreditation

After these presentations, Oklahoma and Kansas public health officials decided to continue discussions about accreditation programs within their states. Each state agreed independently to work on a multi-state accreditation program in order to leverage resources and to shorten their journey towards accreditation and workforce certification. After conferring this summer and at the Heartland retreat in September, Missouri, Kansas and Oklahoma agreed in principle to the formation of a multi-state institute. Its first product will be a regional accreditation program followed by workforce certification. Oklahoma researched the Missouri standards and found they were applicable in Oklahoma and use of them would not expose agencies to any additional risk. Tulsa City/County Health Department volunteered to be the pilot if an independent accrediting agency/institute is established.

Kansas is working on regionalizing services in the rural areas and developing a public health workforce certification program. Workforce certification is the key to a competent workforce, and Missouri and Oklahoma are very interested in studying Kansas' system to see if it would be applicable with their workforce.

Initially, we discussed forming a committee under the Heartland umbrella. There would be some infrastructure support available from St. Louis University. MICH was started with assistance from the Missouri Department of Health and Senior Services (MDHSS) to provide a forum for academic, professional healthcare associations and governmental partners to meet together in a neutral setting to work on projects such as the voluntary accreditation program. When the organization was incorporated, it was completely independent from MDHSS. Each of the states felt a neutral platform was necessary for the new organization. Heartland was tied to one academic institution; the Missouri Institute for Community Health is Missouri focused. Therefore, a new corporation with a board of directors chosen from the participating states was the most viable option.

At present, we are drafting by-laws and articles of incorporation and expect to have an operational virtual institute by spring 2008 organized for the purpose of accrediting local and state health departments.

## New Hampshire, Building Public Health from the Ground Up

*by Joan Ascheim, Bureau Chief, New Hampshire Department of Health and Human Services*

One of the goals of New Hampshire's MLC-2 project is focused on planning for a tiered approach to credentialing/accreditation for local public health professionals and agencies. As our MLC-2 project began to work on a tiered approach to accreditation, the New Hampshire Division of Public Health, in collaboration with a newly formed task force, the Public Health Regionalization Initiative, was undertaking a public health regionalization initiative in an effort to provide statewide public health coverage and to eliminate many diverse maps for varied services. These two initiatives merged and the task force took on the goal to develop a performance-based public health delivery system which

provides all ten essential public health services throughout New Hampshire. So while many states are looking to accredit existing health departments, New Hampshire is looking to create health departments that are prepared for accreditation and able to meet national standards such as the National Public Health Performance Standards or the National Association of County and City Health Officials (NACCHO) Operational Definition of a Functional Local Health Department.

### **A Brief Look Back**

To appreciate the importance of this goal, one has to understand the context of the public health environment in New Hampshire. Like other New England states, the role of county governments has been limited, particularly with regard to public health activities. Only two New Hampshire communities maintain comprehensive public health departments. A handful more has public health departments, whose work is generally centered on health inspection such as childcare facilities and septic systems. By law, all 234 cities and towns in New Hampshire are required to have a health officer. However, there are no specific credentials, educational or experiential requirements thus competencies vary greatly throughout the state. With some health officers serving very small communities, many receive only a small stipend while others may be volunteers.

New Hampshire began building its regional public health infrastructure with an influx of Turning Point funds in 1999. Four public health networks were developed at that time, with the intent of creating local capacity to deliver the ten essential services. Today fourteen networks exist and cover seventy percent of the population and fifty percent of towns, leaving half without a public health presence. Fast-forward to 2006 when additional funds for pandemic influenza preparedness were received and a new public health map was drawn to create all health hazard regions that covered the entire state. Yet we were still left without a statewide public health infrastructure that could deliver the same level and breadth of services to the residents of New Hampshire, and with the state and many non-governmental agencies providing a significant sub-set of the essential services.

### **Beginning with Assumptions**

We started with some basic assumptions. First, was that we would likely not have the resources, nor the need for comprehensive health departments throughout the state. This led us to the notion of two tiers of agencies: a primary agency which would have a fundamental public health presence in a region and deliver some level of the ten essential services and comprehensive fully functioning health departments located primarily in our largest cities.

Another assumption was that these public health agencies need to have a link to a governmental entity, be it town, city or county. It was also assumed that the state would continue to provide some services in some regions, such as disease investigation.

Finally, we set out to develop public health agencies and a system that would meet national standards and therefore be poised for accreditation.

### **Where to Begin?**

During our first few task force meetings, we raised as many questions as we answered. These are some of the key questions posed that have driven the process.

What does the ideal local or regional health department look like? What public health services should be carried out at the local and regional level and what is the ideal staffing mix to provide these services? What is the minimum number of people a public health agency should serve? How do you build a quality public health agency that will be ready for accreditation? Does a tiered approach towards credentialing/accreditation make sense for New Hampshire? What does it cost and how do you pay for it? To what level of government should a health department be attached?

How can we assure that our existing local health officers have necessary competencies?

To answer these questions, we are fortunate to have a vast array of resources and national experience to draw from such as the National Association of County and City Health Officials (NACCHO) Operational Definition of a Functional Local Health Department, Version 2 of the National Public Health Performance Standards Program (NPHPS) Assessment Instruments, and accreditation work of many of the MLC-2 states, such as Missouri's three-tiered system.

### **Form Versus Function**

Many of the questions raised drove us to a discussion of form versus function. We decided we needed to know what a local/regional health agency was expected to do, before we could determine the necessary staff and structure. Because the state Division of Public Health Services has traditionally provided many services at the local level, we needed to be clear on what services would continue at the state level versus those to be transferred to the regions and how this might be different at a primary level agency versus a comprehensive one.

To determine the respective functions of the state and local agencies, we methodically reviewed each essential public health service using the NPHPS instrument for both state and local public health systems. For each service we defined what the state and local responsibility (both primary and comprehensive) would be. For example, it was decided that the primary responsibility for disease investigation would remain with the state, with assistance from the local agencies and a higher level of assistance or autonomy for this role at comprehensive agencies. The current restaurant inspectors, who are employed by the state would continue to work around the state but be co-located in local/regional public health agencies. Comprehensive health departments employ their own inspectors and would continue to do so.

Once we determined the functions of local entities, we could begin to define the staff. We did this only for primary agencies; our current comprehensive health departments have a full complement of public health staff. As we reviewed the function of a primary agency by essential service, we determined the staff needed to carry out that function and developed the following for proposed staffing patterns at the local and regional level.

| <b>Proposed Primary Public Health Agency Staff</b> | <b>Proposed Shared Regional Staff</b> |
|--|---------------------------------------|
| Qualified Administrator                            | Epidemiologist                        |
| Support Staff                                      | Financial Manager                     |
| Health Educator/Marketing Staff                    | Emergency Preparedness Coordinator    |
| Nurse (?)  | IT Support                            |
| Environmental Health Specialist                    | Medical Consultant                    |

The proposed primary public health agency staff comprise what we saw as core staff. The proposed shared regional staff are those that we thought could be shared across regions for maximum efficiency. Consensus on the absolute need for a public health nurse could not be reached after lengthy debate.

### **Next Steps**

Our task force working on this effort, the Public Health Regionalization Initiative is now tasked with drawing the map to determine the public health regions going forward. Each region will have to determine how they will link to local government. Will it be county, town, or a newly created regional district? We need to determine resources needed or those that could be redeployed. We will need to analyze existing public health statutes and adapt them to reflect proposed new systems.

At the same time, we are beginning to look at workforce competencies and credentialing. We are beginning this process by defining competencies and subsequent credentials and training for two levels of health officers, part-time and full-time since in some towns this is the only public health infrastructure we currently have. In time, we envision more regional full-time health officers who can integrate into the proposed public health infrastructure. In the near future, we plan to develop a competency-based system for all public health staff.

### **Lessons Learned**

Engineering a new regional, tiered public health system is, at the same time, exciting and an enormous undertaking. Involving key partners from around the state in the design phase, has been extremely valuable and will be instrumental to the success of the initiative. Beginning the process with a set of assumptions was key. While partners want to contribute to the development of a new public health system, they do look to the Division of Public Health to lay out the parameters. We will utilize the NACCHO Operational Definition of a Functional Local Health Department and accompanying metrics and work coming out of the Public Health Accreditation Board as quality cornerstones as we shape our system in New Hampshire.

## Our Partners

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|---|--|
| <a href="#"><u>American Public Health Association</u></a>                       | <a href="#"><u>Public Health Accreditation Board</u></a>   |
| <a href="#"><u>Association of State and Territorial Health Officials</u></a>    | <a href="#"><u>Public Health Foundation</u></a>            |
| <a href="#"><u>Centers for Disease Control and Prevention</u></a>               | <a href="#"><u>Public Health Informatics Institute</u></a> |
| <a href="#"><u>National Association of County and City Health Officials</u></a> | <a href="#"><u>Robert Wood Johnson Foundation</u></a>      |
| <a href="#"><u>National Association of Local Boards of Health</u></a>           |  |

If you have any comments, questions or suggestions regarding *Making the Connection*, please contact Liz Tagle at [etagle@nnphi.org](mailto:etagle@nnphi.org).

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

