
DESIGNING
THE FUTURE
OF
PUBLIC HEALTH
Missouri
Model
Agency
Project
Executive Summary

DESIGNING THE FUTURE OF PUBLIC HEALTH

MISSOURI MODEL AGENCY PROJECT

A collaborative effort of:

Cole County Health Department
Kansas City Health Department
Missouri Department of Health
Newton County Health Department
Phelps/Maries County Health Department
Springfield-Greene County Public Health Center
St. Louis County Department of Health
Taney County Health Department

MAY 2001

This document was funded in part by the Turning Point Grant from the Robert Wood Johnson Foundation.

Acknowledgements

One hundred and forty people worked on this project. Without their individual and group efforts, this planning phase would never have been completed.

Special thanks are extended to:

Dr. Rex Archer, Director, Kansas City Health Department,
Harold Bengsch , Director, Springfield-Greene County Public Health Center,
James Berry, Administrator, Taney County Health Department,
Ivah Scott Braun, Director, Cole County Health Department,
Daryel Brock, former Administrator, Newton County Health Department
Chris Deem, Administrator, Newton County Health Department,
Dr. Paula Livingston, Director, St. Louis County Department of Health,
Shirley Rutz, former Administrator, Phelps/Maries County Health Department, and
Jodi Waltman, Administrator, Phelps/Maries County Health Department

for having the vision to commit their agencies to this project and for committing staff resources to work on committees throughout the planning process.

***Dr. Maureen Dempsey,* Director, Missouri Department of Health (MDOH) for encouraging the initial vision for the grant and providing staff and resources to support that vision.**

The *Agency Selection Committee* for identifying the ten model components, establishing the criteria, and evaluating the sites:

Suzanne Alewine, MDOH
Harold Bengsch, Springfield-Greene County Public Health Center
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Dr. Paula Livingston, St. Louis County Department of Health
Owen Smith, MDOH
Pamela Rice Walker, MDOH
Lorna Wilson, MoALPHA
Elizabeth Woodyard, MDOH

Acknowledgements

The committee co-chairs for leading the ten component committees through the planning process and overseeing the report writing for their committee:

Suzanne Alewine, MDOH
Joan Bialczak, St. Louis County Department of Health
Caryl Collier, MDOH
Steve Fine, St. Louis County Department of Health
Angela Ford, MDOH
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Veronica Stillwell-Fisher, Taney County Health Department
Frank Thompson, Kansas City Health Department
Charles Williams, MDOH
Janet Williams, St. Louis County Department of Health

The editing team for assembling the individual reports into one document and producing the executive summary:

Janet Canavese, MDOH
Hilda Eichholz, MDOH
Lyn Konstant, MDOH
Veronica Stillwell-Fisher, Taney County Health Department
Christine Trainor, Kansas City Health Department

The graphic design team at the State Printing Center for their creativity and innovation:

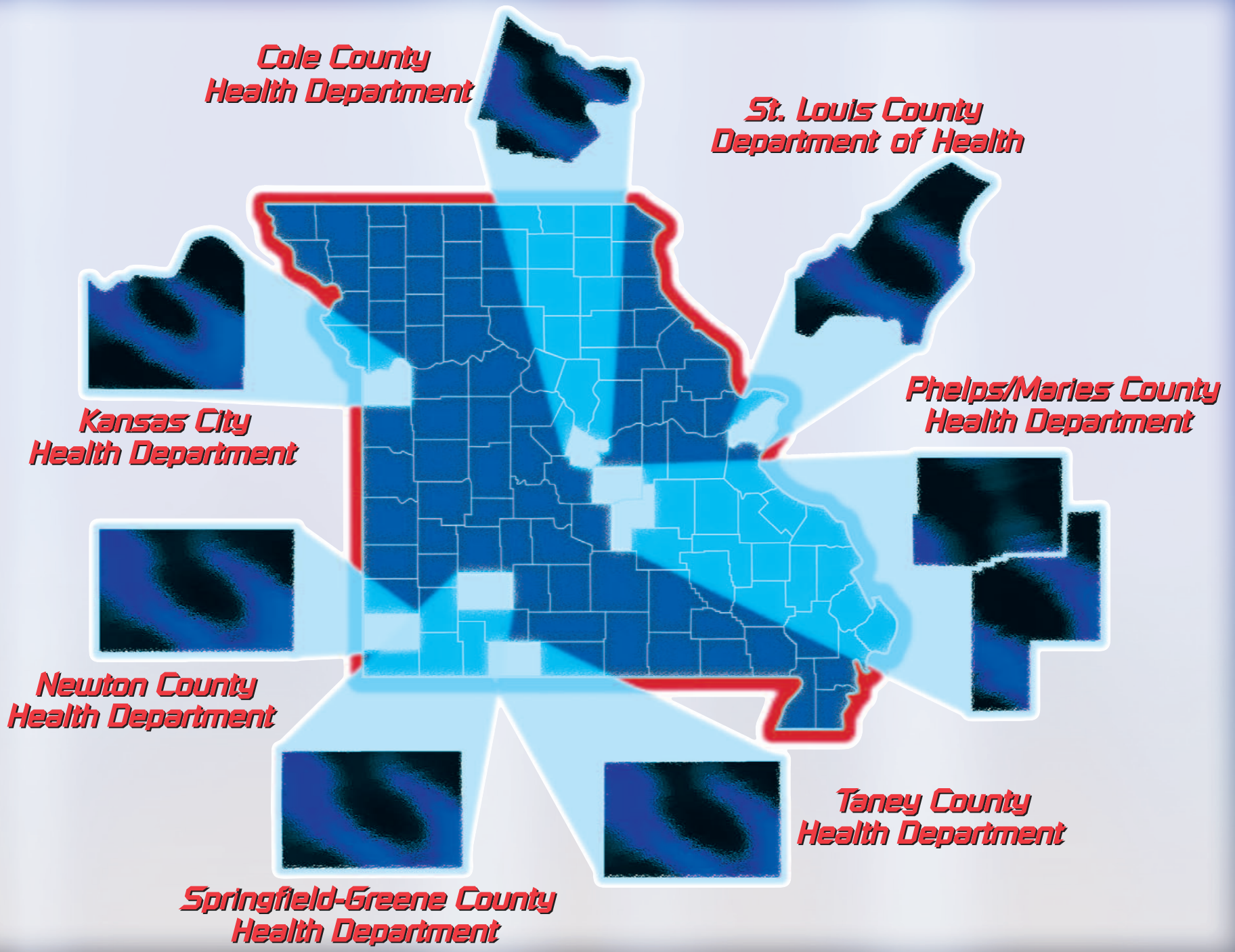
Shea Bryant, Graphic Designer, Creative Services
Gene Gillispie, Printing Services Representative

And finally, the MDOH support team for all the committees and the total project—the glue that kept us together and kept everyone in touch through the intranet site and e-mail, arranged committee meetings and conferences, kept minutes for the committee meetings and provided research and guidance to the committees:

Brenda Buschjost
Janet Canavese
Cindy Leuthen
Michelle Nienhuis
Tracy Ray
Cindy Woodcock

Thank you one and all.

Mahree Skala, Project Director
Kathleen Wojciehowski, Co-Project Director


Cole County
Health Department
St. Louis County
Department of Health
Kansas City
Health Department
Phelps/Maries County
Health Department
Newton County
Health Department
Taney County
Health Department
Springfield-Greene County
Health Department

DESIGNING THE FUTURE OF PUBLIC HEALTH IN MISSOURI

In the past eight years the healthcare system in Missouri changed dramatically as managed care and the restructuring of Medicaid reimbursement affected the more populated areas of our state. There was a general fear among the public health system that our mission of environmental and population-based services was being lost and that critical clusters of people were falling between the ever-widening cracks of primary care.

These issues propelled the Missouri public health system to undertake an intensive self-examination and review of the basic foundation of public health and its role in the community. One of the vehicles chosen for this self-examination was the Missouri Model Agency Project (MOMAP) funded by Turning Point and Robert Wood Johnson.

The MOMAP Story

During the last two years, the Missouri Department of Health/Center for Local Public Health Services (MDOH), in conjunction with seven local public health agencies (model sites) worked collaboratively to design a model local public health agency in a community-based public health system. The seven participating local public health agencies are:

- **Cole County Health Department -** a mid-size county agency serving a population of 65,000, with environmental issues in the county seat addressed by the city of Jefferson Department of Public Works;
- **Kansas City Health Department -** a large city health department on the Kansas/Missouri border serving a diverse population;
- **Newton County Health Department -** a small rural county agency which shares jurisdiction with a city health department that is in Newton and Jasper Counties;
- **Phelps/Maries County Health Department -** a small rural health department serving two counties in mid-Missouri;
- **St. Louis County Department of Health -** the largest suburban county health department, adjacent to St. Louis City;
- **Springfield-Greene County Public Health Center -** a mid-size metropolitan city/county health department in southwest Missouri, gateway to the Ozarks; and
- **Taney County Health Department -** a small rural health department that shares jurisdiction with a city health department servicing a large tourist area in the greater Branson area.

Phase I

Initially, a selection committee, composed of representatives from local public health agencies and MDOH leadership, met to discuss the grant and decide on the criteria for applicants to be model sites. The committee identified ten components for a model agency in a community-based public health system:

1. Access
2. Attitude and Value
3. Community Planning
4. Consumer Protection
5. Cost Efficiency and Effectiveness
6. Customer Service
7. Emergency Response
8. Health Communications
9. Surveillance
10. Workforce Issues

Missouri's 114 local public health agencies were invited to apply to be model sites. Out of the competitive pool, seven agencies were chosen to participate in the project. These agencies had the strongest collaborative ties to their community, participated in a Community Health Assistance Resource Team (CHART) type community coalition and had strategic plans linked to Missouri Department of Health's integrated strategic plan. In addition, their governing bodies were committed to a strong public health infrastructure and the assurance of population-based public health services at the community level.

The ten component committees were formed at the November 1999 Kick-Off Conference. Leanne Kaiser Carlson, a national expert on organizational change, spoke to the group of 100 participants on change and innovation. The group then discussed the project and the ten components identified as essential for a local public health agency in a community based public health system. People emerged from the Kick-Off energized and committed, but unsure about what they would discover.

Representatives from each model site, along with MDOH staff with expertise in the area were included in each committee. All were co-chaired by MDOH representatives and leadership staff from the model sites. Committee size averaged about 15 people, with staff from the small agencies serving on multiple groups. Since November 2000, the number of individuals working on the project fluctuated between 140 and 110, due to job reassignments, new priorities, and other factors.

Each committee was to identify the framework for their component in a model local public health agency (LPHA). They were also charged with producing a written document supported by research and best practices from the model sites. Monthly meetings, along with ongoing research assignments required each participant to spend approximately 10 hours plus travel per month on the project. The project became a venue for breaking down barriers between state and LPHA points of view, developing strong working relationships among people who may not have worked together in the past, and creating an atmosphere of mutual trust and respect.

From the beginning, participants envisioned this project as a system approach for a local public health agency in a community-based public health system. The blueprint that emerged requires evidenced-based decision making, customer focus, strategic planning, leadership, and appropriately trained workforce. The ultimate outcome of the system approach is to improve the health status indicators for each community in the state.

Each committee's charge was to:

- Determine the infrastructure needed at the model sites and MDOH to assure the public's health is protected and improved;
- Determine the necessary relationships among public health, health care, other public agencies and the community to address public health needs;
- Identify resources, sources of funding and strategies that will adequately support the model public health system;
- Identify the local and state policy, ordinance and law changes needed to fulfill core public health responsibilities; and
- Document the model public health system so that it can be replicated throughout Missouri and the country.

A basic process was developed for the groups to use while completing their assignment. After the Kick-Off, committees used this process for dialoging, researching and writing their reports.

Step 1

Each committee had to define exactly what their component meant for LPHA at the community level. They needed to describe why their component was important to LPHA, and the value the LPHA derived from using the component structure. For example, Community Health Planning described why community assessment is important to local public health agencies and the value agencies receive by using the information they gather. From the beginning, this was very challenging, since the committees were given no parameters to limit their discussion and research, and all were expected to be creative and flexible.

Step 2

The committees conducted literature searches about their component. Accessing information from both published and unpublished sources was central to their research. Each committee spent many months collecting sources, reading articles and books, jotting down ideas, and discussing their topic with anyone who would listen. The committees made use of the MOMAP Intranet site where search engines and useful web sites were listed. The Intranet site was also used to share documents, ideas, and discussions with other members of MOMAP.

The committees needed to identify what each model site was doing that related to the component they were designing. To determine this, each committee developed a survey tool. Administration of the surveys varied by committee. Some did in-person interviews, some surveyed by e-mail, others did telephone interviews and some did a combination of methods.

Step 3

The committees then discussed the best practices they identified. Surveys were tabulated, then the research and survey results were discussed. Strengths and weaknesses of the surveys were reviewed and some questions were asked in another way.

Step 4

Each of the committees analyzed their research. Throughout this step, the committees supported their findings with specific evidence: descriptions, statistics, testimony, or examples from their personal experience.

The MOMAP group process fostered an environment that allowed agencies to share what they identified as their strengths and weaknesses. Strategic conversations centered on ways to adapt and adopt best practices and challenged participants to explore alternatives for the future.

Step 5

By using the research results, the committees attempted to identify the tools and approaches needed to implement a component. Varying sizes of communities, differing levels of funding, demographics, geographic location, etc., were considered. The committees then endeavored to document the cost to LPHA to initiate and maintain the recommended approaches and tools.

Oftentimes, the committees discovered their reports could not address all areas of their component. Further work was needed on LPHA/state roles and the determination of cost for recommended changes. Time was a major factor; more was needed. In addition, urgent agency priorities often had to usurp group priorities. The committees highlighted those areas requiring further investigation or research.

MOMAP's Blueprint for a Model Local Public Health Agency in a Missouri Community-Based Public Health System

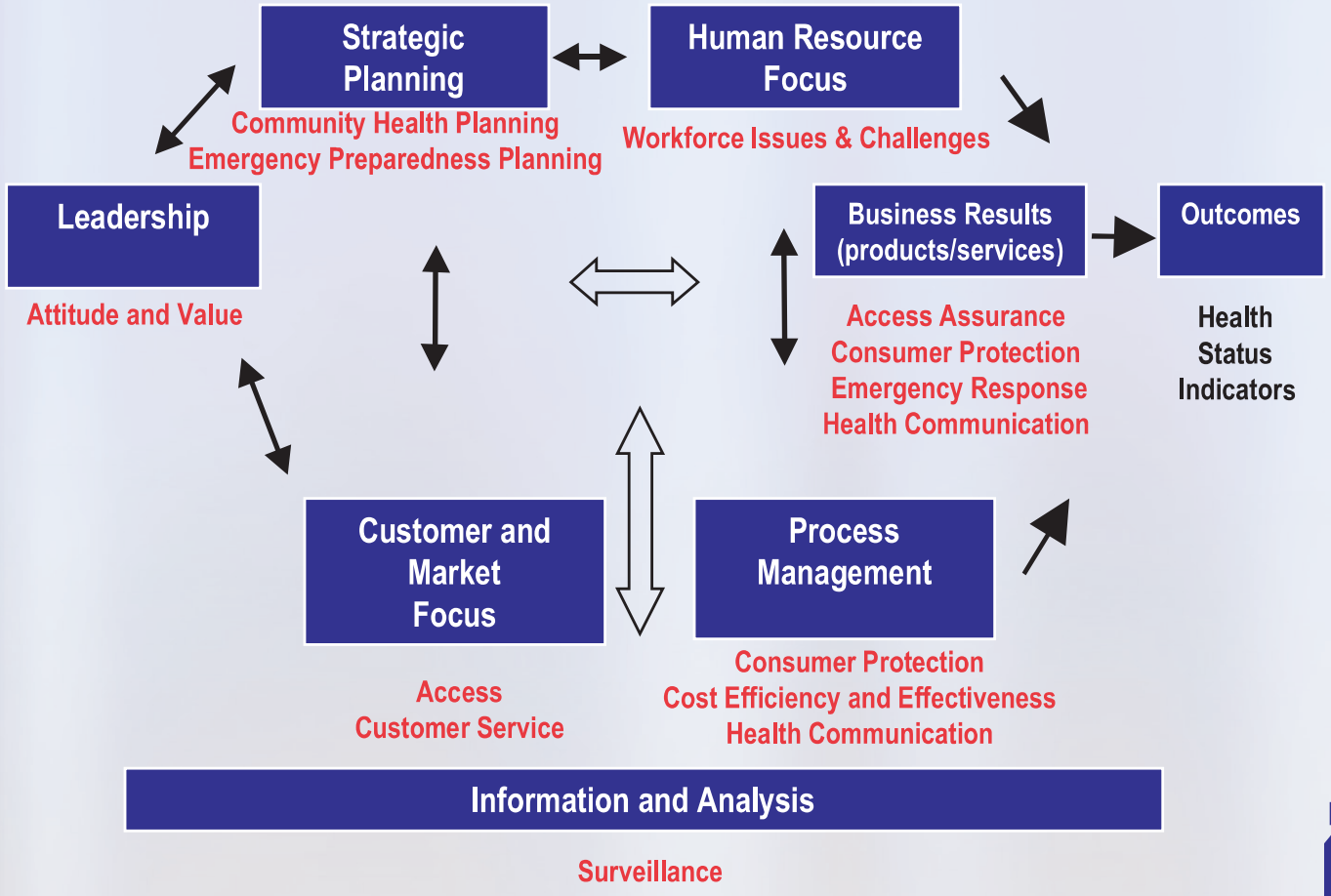


Diagram adapted from the Excellence in Missouri Foundation's Missouri Quality Award system approach for an organization.

Cole County Health Department

Kansas City Health Department

Mo. Department of Health

Newton County Health Department

Phelps/Maries County Health Department

St. Louis County Department of Health

Springfield-Greene County Public Health Center

Taney County Health Department

130 people from these agencies are participating in the project.

MISSOURI DEPARTMENT OF HEALTH

During each of these steps, consultants worked with individual committees. In addition, large group working meetings were held in tandem with two statewide Local Public Health Agency Administrators' meetings. National speakers discussed developing a customer focus for LPHA products, changing mental models and continuous quality improvement approaches. MOMAP participants incorporated these ideas into their work. "What's our product?" and "Who is our customer?" became common refrains at meetings. In addition, MOMAP model sites began sharing their expertise with each other. Kansas City Health Department, which has been on a leadership journey since the mid-1990's, provided quality improvement training at MDOH and Cole County Health Department. St. Louis County Department of Health's environmentalists consulted with Newton County Health Department's environmentalists on a water issue. Peer mentoring became an accepted practice for individuals who had not worked together in the past. Finally, three of the sites participated in the APEX-CPH tabletop exercise, and Taney County Health Department was asked to be a pilot for Mobilizing Action Through Planning and Partnership (MAPP).

Phase II

A Summit meeting was held on November 22, 2000, to brainstorm and identify the direction of the project for the implementation phase. The model site administrators and committee members participated in the Summit. This large group discussed 40 priorities identified by the model site administrators and committee co-chairs prior to the meeting. From the day long process emerged four priorities to focus on in implementation:

1. Workforce Development;
2. Marketing plan for public health, including Health Communication;
3. Community Health Planning; and
4. Community Protection.

Common themes emerged:

- The work of public health is to protect the community by educating and promoting healthy choices.
- The public health workforce is changing and present leaders need to address the changing expectations and learning needs of this work force.
- We in public health are searching for our brand to give us an identity to market to our communities throughout the state.
- Public health at the community level needs to be messaged consistently by all staff.

Workforce was then discussed further. Although the Missouri Department of Health, through its training programs and the collaborative Public Health Leadership Institute at St. Louis University School of Public Health, provides programs for administrators and specialized programmatic training such as epidemiology, no single entity provides comprehensive educational opportunities for the public health workforce. The primary goal for the institutes of higher education, with programs in public health, is to attract masters' candidates for their curriculum. As a result, each local public health agency in the state has had to develop its own approach to training its workforce. While some excellent programs are emerging, such as the Kansas City Health Department's three-part

curriculum for personal mastery, leadership and quality improvement, most local public health agencies don't have the resources or expertise to develop programs. As a result, training is spotty and inadequate. Even in Kansas City, there are serious funding issues, resulting in the Training Institute being an inadequately funded lower priority.

The Kansas City/Cole County mentoring experience was the starting point for a conversation about peer mentoring with sister agencies and sharing of resources. Although the group was aware of present training from MDOH, they felt the need to inventory training opportunities and areas of expertise in their sister agencies in order to provide the foundation for a peer-mentoring program. Since retention of staff and career ladders are issues which every agency faces, the group felt the development of a unified approach to workforce development would help all agencies. A highly skilled staff, understanding public health and messaging it consistently to the community, will hopefully take pride in its work and the value it contributes to the community. The use of a consistent message may also assist the public in understanding the role of public health in their community. The group also reexamined the ten components of the model and concluded the best way to begin implementation was to provide learning opportunities for all levels of the workforce on each component.

From the work of the ten committees and the Summit Meeting, the Center for Excellence in Public Health (CEPH) emerged as our next step. This is a concept based on collaboration rather than an actual building. Stakeholders from the community, higher education, health care, the business sector, and public health will be brought together to discuss the future of public health, workforce issues, and identified and needed learning opportunities to support the future of public health at the community level. Key in this discussion is a marketing plan to assure public awareness of the essential role of public health in promoting and protecting the health of people in the communities of Missouri. The stakeholders will design a framework that will:

- Provide a forum to discuss public health best practices prior to implementation;
- Develop a unified public health marketing plan;
- Engage the model site community partners in strategic conversations related to improving health status indicators;
- Provide sounding boards for emerging issues in public health; and
- Provide a forum for the local public health agencies to identify and discuss common issues, needs, and challenges related to the model components.

At the February 2001, Local Public Health Administrators' meeting, each of the ten committees gave an overview of their work. What emerged were some common themes:

- All of the reports are interrelated and reflect a system approach;
- Marketing of public health is a desperate need;
- A Center for Excellence in Public Health will engage the whole state public health system; and
- Sustainability of the public health system is a major concern.

MOMAP Accomplishments

Enhancing relationships:

- Local public health and state staff engaged in collaborative research and strategic conversations to define the essential components of a model public health agency in a community based public health system.
- Staff from local agencies who did not normally work together established relationships and shared knowledge and expertise informally both with their peers and state staff.
- There have been attitudinal shifts within the MDOH. MDOH is re-examining its relationships with LPHA, recognizing that MDOH can learn from LPHAs.
- Model sites have begun to think about regionalization of environmental and surveillance services for economy of scale, whereas before, this subject was rarely discussed.
- Board member involvement from the board governed model sites has made the agencies stronger.
- The MOMAP process has increased pride in public health.

Products resulting from MOMAP:

- The committees developed a survey tool for each of the components of the model and field-tested them.
- A "blueprint" of the interrelationships of the model components was adapted from the Excellence in Missouri Foundation's Missouri Quality Award system approach for an organization. This system is based on the Baldridge national system for excellence and is a model for achieving excellence in an organization.
- A peer mentoring and cross-training process among the model agencies and at the local public administrators' meeting was begun.
- MOMAP established an Intranet site for sharing of information and posting for meetings.
- The model sites piloted video conferencing with MDOH.
- MOMAP model site staff piloted the expansion of the quarterly state Local Public Health Administrators' meetings into a training forum for LPHA leadership staff.
- All LPHA and state staff were updated on MOMAP's progress through the quarterly state LPHA meetings, Friday FAX and district meetings for local administrators.

Catalysts for change:

- The model identified potential changes in public health "business practices" needed to integrate a strong community focus.
- Each model agency is re-examining how they do business in terms of each component, such as Health Communications, Consumer Protection, Emergency Preparedness, etc., to focus on their customers and produce appropriate products and services.
- Model sites decided that they are accountable for their own training rather than relying on MDOH to provide all training.
- LPHA and state staff have a much broader concept of public health and how the 10 essential services and core functions fit together.
- MOMAP has raised the bar in our respective agencies' journeys to excellence. As the Center for Excellence is implemented, there should be increased awareness statewide of the benefits of staff training and the need to address customer needs and expectations.

The MOMAP System Linkages

The Missouri Model Agency Project is a system approach to public health at the community level. A system is based on linkages and common areas. MOMAP is no exception. Leadership and staff in the organization are focused on the community health status indicators and the products/services they can deliver to impact those health status outcomes. A system is function rather than program based. Staff is cross-trained and operates across traditional program lines. The focus is on the community's needs and producing the most beneficial products and services to influence the community's health status indicators in a positive way. Funding is sought only if a grant or contract will enhance the mission of the organization with the focus on health status indicators.

A system has no beginning or ending point. Rather than a linear structure, the system focus revolves around the customer - the community. The **Customer Focus** committee considered why LPHAs exist and what are the products produced. Basic questions addressed included:

- Who are my agency's customers?
- What are their needs?
- What are their expectations?
- What are the agency's products and services?
- How do they meet the customers' needs and expectations?
- How can the agency better serve its customers?

A customer-focused organization empowers employees to assume as much responsibility as possible to provide the best service.

The **Access** Committee addressed community access issues. Two broad categories were identified:

- The public's access to medical/clinical care and services; and
- The LPHA's access to the community to provide education on prevention, healthy lifestyles/behaviors and safety.

Local public health agencies need to interact with community stakeholders to discuss how to prevent diseases and to represent the voiceless stakeholder. The LPHA and the community need to consider availability, affordability, appropriateness, accommodation and acceptability in their discussions on access.

The quality of products and services, and the extent of the community's access to health care and public health interventions, are directly related to the leadership provided internally and to the community by the LPHA. The **Attitude and Value** Committee addressed leadership issues. Now, more than ever, local public health agencies must proactively and strategically plan how to position themselves for the coming years. LPHAs must explore their reason for being and characterize their vision in relationship to the larger community, as well as forge clear statements of mission and goals. Integrity, openness, accountability and helpfulness are key values for an organization serving the public and seeking to have the public value it. These are values all staff need to embrace and model to others.

In the final analysis, the value of public health rests with the timeliness and relevance of its programs, the expertise of its personnel, and its adherence to a mission the community can understand and support. Public health leaders are learning they must demonstrate to the public the inherent value of what they do. For the community to understand and support the LPHA, community members need to be involved in the agency's strategic planning and product/services determinations, as well as in the broader process of community health planning.

Community Health Planning is necessary for sustainability of the public health system. The community health planning process is generally constructed around a cyclical model and is closely linked with the general practices of community development. The emphasis is placed on the use of data to drive decisions and priority setting at both the state and local levels. Community involvement is integral to the success of the process: the focus is on the customer. Community health planning is a continual process of systematically examining and communicating the prevailing health status, assets, needs, perceptions, resources and health system(s) of a community. The components of community planning include organization, assessment, prioritization, program design and implementation, and evaluation. This planning process develops the blueprint for the future of the organization, including the marketing plan for products and services and affirming the mission of the agency.

Another essential community planning process is **Emergency Preparedness** planning. Emergency preparedness always has a customer focus. Planning is the foundation for dealing with an emergency. A solid plan that includes preparedness, mitigation, response and recovery elements must be developed and updated on a regular basis to be effective and useful. The LPHA needs to develop an all hazard plan rather than reacting to one type of emergency at a time. Evaluation is key to the success of the plan. The LPHA needs to consider the community, available resources inside and outside the agency and the potential for disasters.

Good planning processes and community preparedness depend upon accurate, timely information about the community's health status and potential threats to the public's health. **Surveillance** is the primary means of acquiring public health data, and is the foundation for decision making by the agency. It is essential to every component of the model, and allows the agency to have a community focus to spot new and reemerging diseases. Smaller agencies may find it helpful to share surveillance activities with other agencies in order to improve their data collection and analysis. Larger agencies may require staff to be cross-trained to do surveillance and preventive activities. A critical element is a central statewide repository of information with access by the entire public health workforce. The Internet is rapidly making this a reality. Not only will the LPHA be gathering data, but even more importantly, the data can be used by the public health workforce and the community to make evidence-based decisions to protect the consumer and meet community needs and expectations.

The use of new technology and the ability to use data for decisionmaking are just two of the many challenges facing the public health **Workforce.** Perhaps the greatest challenge is for the workforce to engage effectively with the community and provide leadership. The public health workforce has to understand what public health is, what it does, and how it achieves its mission. Workers need the skills that allow them to cut across all dimensions of public health practice, requiring both technical knowledge and technological skills. The worker needs always to be planning for the future and sharing those planning skills, especially those relating to sustainability, with the community. The workforce needs to be uniformly trained on marketing and delivering consistent public health messages to the community.

Health Communications is the vehicle for public health messages. A systematic emphasis on health communications provides the opportunity to plan approaches for routine and crisis communication activities. The public health workforce requires training in the core competencies of health education (assessment, design, implementation and evaluation) applied to health messages, public awareness campaigns, and media strategies.

To sustain health communications and other critical public health products and services requires the LPHA to move program evaluation and economic analysis from the periphery into the mainstream of public health operations. Economic analysis alone does not fulfill the need to make evidence-based decisions regarding the allocation of resources and setting of policy priorities; program evaluation must be included in order to be **Cost Efficient and Effective.**

A comprehensive program evaluation includes a statement of purpose, program goals and objectives. Program evaluations demonstrate broader impacts than can be measured annually and can improve an agency's understanding of performance. They are most effective when coupled with process evaluation, which permits a snapshot of the program to be considered. Cost-effectiveness analysis is the most useful tool for LPHAs to measure the effectiveness of a program, since it compares the costs and consequences of alternative approaches to attaining a goal. The workforce requires training in the use and application of these tools. Planning for the future of the agency requires economic analysis and evaluation of existing and projected activities.

The system approach, which began with the customer as the focus, culminates in **Consumer Protection.** Consumer protection includes proactive prevention efforts, providing accurate health information, enforcing environmental and other public health laws, improving the quality of health care delivery, and reducing the sources of illness and premature death. Consumer protection is only possible with effective teamwork among different professions, the creation of strong collaborative relationships with community and health partners, the training of staff for new roles, expanding electronic transfer of information and creating mechanisms for sustainability, especially financial stability.

Consumer protection, as a product of the LPHA, is only as strong as the other components. With strong consumer protection mechanisms in place, public health agencies can and will be the voice of public health in their communities. They will be seen and heard at the most crucial meetings for policy development in their communities, demonstrating their worth through the provision of evidence-based information, the sound evaluation of products and services and their responsiveness to the needs and expectations of their respective publics - consumers and customers of public health functions.

MOMAP
A FOCUS ON THE COMMUNITY

Customer Focus

A customer-focused organization empowers employees to assume as much responsibility as possible to provide the best service. The quality of products and services delivered directly relates to the leadership provided internally and to the community, and the values demonstrated by the public health workforce.

Consumer Protection

Consumer protection includes proactive prevention efforts, providing accurate health information, improving the quality of healthcare delivery and reducing the causes of illness and premature death. Consumer protection, as a product, is only as strong as the other components. With strong consumer protection mechanisms in place, public health agencies can and will be the voice of public health in their communities.

Access

Public health agencies and their community need to consider: availability, affordability, appropriateness, accommodation and acceptability in their discussions on access. They need to plan for the future together.

Cost Efficiency & Effectiveness

Sustainability requires the agency to move program evaluation and economic analysis into the mainstream of public health operations. Planning for the future requires economic analysis and the evaluation of existing and projected activities.

Attitude & Values

The value of public health rests with the timeliness and relevance of its programs, the expertise of its personnel, and its adherence to a mission the community can understand and support. For the community to understand and support its public health agency, the community needs to be involved in the agency's strategic planning and products/services determinations.

COMMUNITY

With these ten components in place, public health agencies can and will be the voice of public health in their communities. They will be seen and heard at the most crucial policy development meetings in their communities - demonstrating their worth through the provision of evidence-based information, the sound evaluation of products and services and their responsiveness to the needs and expectations of their consumers and customers.

Health Communications

Health communication is the vehicle for public health messages. It is the opportunity to plan approaches for crisis communication activities. Health communication targets the public, the media, and the funding bodies.

Community Health Planning

Community needs and expectations are building blocks the public health workforce needs to incorporate into all activities and programs.

Workforce Issues & Challenges

The public health workforce needs to be engaged with the community and provide leadership on public health issues. The workforce needs to be uniformly trained on marketing and delivering a consistent public health message to the community.

Surveillance

Surveillance is the means for acquiring data and is the foundation for all decision making by the agency. It is essential to every component and allows the agency to have a community focus to spot new and reemerging diseases. Not only will the agency be gathering data, but even more importantly, using it to make sound evidence-based decisions to protect the consumer and meet community needs and expectations.

Emergency Preparedness

The agency and its partners need to consider the community, available resources and the potentials for disasters. The existing public health surveillance system will provide important data to use in the planning process. Evaluation is key to the success of an all hazard plan.

Committee Recommendations

Committee

Recommendation

For organizations reporting success in achieving customer satisfaction and delivering service quality, five key areas emerged.

1. **Customer Focus:** Clearly identifying outcomes, what is to be provided, and who the customers are.
2. **Organizational Commitment:** If decision makers understand the customer, they will be able to make management decisions that will better meet the needs the customer expressed.
3. **Measurements important to customers:** The committee makes the case for using customer-centered measures rather than exclusively using cost-accounting performance measures. Performance data collected from customer groups might include the timeliness and quality of the service, its cycle time, the defect rate, and the perceived customer-service orientation of the employees.
4. **Cross-functional coordination (One Stop Shopping):** Putting aside the "silos" of the past where programs don't interact with one another, or actually compete with each other, leaving the customer confused and frustrated.
5. **Quality Improvement:** A quality improvement process provides the mechanism for agencies to assess value for customers as well as receive value from customers.

1. **Establishing and nurturing community collaboratives.** The state and local agencies must continue to build trusting relationships and partnerships to further address the access issues.
2. **Decision-making through application of core functions.** Successful gains in access require utilization of all three core functions of public health - assessment, policy development/planning, and assurance.
3. **Strong and flexible leadership that fosters a dynamic learning organization.** Leadership should provide an environment that encourages and rewards positive change, staff training, and staff education.
4. **Adequate funding mechanisms for sustainability.** Adequate funding mechanisms must be in place to ensure quality access and sustainability of effort.
5. **Realigning the organization - role clarification and delineation.** In order to address access issues, a local public health agency requires realigning the organization and changing staff roles from traditional service/program delivery to promotion of health behaviors, e.g. health education, outreach, case management, coalition building, etc.

Committee Recommendations

Committee

Recommendation

1. **Develop and foster community partnerships.** Successful agencies are ones that have worked with their community to define shared goals and are able to mobilize community organizations around those goals.
2. **Build shared leadership capacity.** Strong, visionary, effective local public health leadership is a key ingredient in success. Such leaders create strong organizations and promote strong community alliances.
3. **Create strategies for other organizations to assist with funding public health activities.** As the community becomes more involved and increases its understanding of how public health can make a difference in the health of the citizens, the community will also appreciate the agency's need for resources.
4. **Promote a comprehensive public marketing campaign.** This committee found through their surveys the need for public relations campaigns and social marketing of public health, emphasizing in campaigns that public health is for the entire population.
5. **Create and allow for enhancement of a learning organization.** To succeed in shaping its future, an organization must be able to learn well, efficiently, and constantly.
6. **Establish a dynamic strategic planning process.** Developing statements of the organization's vision, values, and mission, is a necessary first step in determining the infrastructure and programs that are needed so the local public health agency can fulfill community needs.
7. **Establish an accreditation process.** Today public health's accountability has increased. The accreditation of health departments must be part of the process of building accountability and credibility.
8. **Center For Excellence in Public Health.** This Center should coordinate learning resources for all the local public health agencies.

1. **Use the 7 essential ingredients:** Clear vision & mission, action planning, leadership, resources for community mobilization, documentation and feed back on changes, technical assistance, and making outcomes matter.
2. **Well thought out communications plan.** Communication is critical from the outset of any community health planning process. Communication helps build trust and breaks down barriers.
3. **The foundation of community health planning is sustainability.** Because sustainability is so critical, it is important to recognize at the outset the six primary elements that sustain an initiative long-term. They are structure, money, people, vision, relationships, and focus.

Committee Recommendations

Committee

Recommendation

1. **View emergency preparedness in four phases of Preparedness, Mitigation, Response, and Recovery.** Planning is the most important aspect in preparing a local public health agency for a public health disaster. The LPHA needs to be part of the integrated emergency management system in the community.
2. **Use an All-Hazards Plan.** The causes of public heath emergencies can vary greatly, but the effects do not. When designing and writing the LPHA plan, the concept of the "all hazards" plan should be used as a general guide. The all hazards concept is the basis for all federal and state planning.
3. **Training public health staff in Emergency Response.** After development of the plan, it is crucial to exercise it on a yearly basis. In addition to exercising a plan, LPHAs should also assign staff to attend training sessions related to emergency management.
4. **Written Memoranda of Understanding, i.e. mutual aid agreements.** In times of emergency, the LPHA may have the need to supplement resources. The MOU allows for supplementation of resources and is necessary to document requests for reimbursement.
5. **Integration of All-Hazards Plan with county, city, state, federal plans.** The LPHA may coordinate public health emergency planning but should never prepare a plan in isolation. The LPHA plan must be included in the Local Emergency Planning Council plan that is shared with community and state partners.

1. **Multi-county collaboration and resource sharing.** Due to the size and staffing in some of the smaller local public health agencies, multi-county collaboration and resource sharing would be necessary to develop efficient and effective surveillance systems.
2. **Improve funding and sustainability.** Funding for a model surveillance system must cover personnel, training, computers, software, and other identified equipment.
3. **Enhance basic training.** State level agencies should adopt training modules that assure local access to basic surveillance training for current and new local agency employees who are assigned surveillance responsibilities.
4. **Dedicated FTE/employees.** Recommendations for staffing reflect the minimum requirements for effective surveillance systems.
5. **Critical components of a surveillance system:** The Essential Public Health Services, Missouri Health Strategic Architectures Information Cooperative (MOHSAIC) and infrastructure development at both the local and state level.
6. **Database development of a library of model ordinances.** This database would allow local decision-makers throughout the state to see how other communities have addressed public health issues.

Committee Recommendations

Committee

Recommendation

1. **Establish a Learning Institute.** The Institute would develop a framework for evaluation and develop standards and guidelines to consistently evaluate training and continuing education of the public health workforce at the individual, program/curricula, and learning system level.
2. **Training and mentoring, career mapping, portfolio development.** Training and retraining in the public and private sectors are needed to prepare the workforce for new challenges and responsibilities. For partnerships and collaborations to function both efficiently and effectively, the future public health worker will require critical thinking skills, as well as ongoing public health education and training.
3. **Accreditation/Certification.** One way to assure that new and current public health professionals meet the core competencies needed is through a process of certification. Certification constitutes recognition that the professional has the knowledge and skills essential to provide leadership for the public health workforce in the future.
4. **The public health workforce at both the state and local level should have basic core competencies and capacities.** These would include skills in assessment, strategic planning, critical thinking, technology, health communication and being able to convey the value of public health.

All of these recommendations support the development of a **Center for Excellence in Public Health.**

1. Planning and implementing a comprehensive and integrated **health communications plan.**
2. **Employee and staff training** to effectively provide public education for the community and media.
3. Formal **evaluation** of health messages, public awareness campaigns, and media strategies.
4. Identify and initiate requisite processes for health communication **funding.**

Committee Recommendations

Committee

Recommendation

1. **Local public health agencies must begin to move program evaluation and economic analysis from the periphery into the mainstream of public health operations.** By engaging in formalized, integrated, and comprehensive economic evaluation process, the LPHA proactively prepares for this challenge.
2. **Economic analysis alone does not fulfill the need to make evidence-based decisions regarding the allocation of resources and setting of policy priorities.** In addition to costs, there are other factors that must be considered when setting policy or determining modes of intervention for different populations.
3. **Having the critical components of a comprehensive evaluation model in place can serve as a tool for dealing with unanticipated challenges.** A primary benefit to engaging in program evaluation is the intimate awareness it creates of internal weaknesses, as well as strengths.
4. **A shared evaluation/economic analysis team.** It is clear that neither the state, nor the local public health agencies possess the resources to implement a comprehensive evaluation and economic analysis program. A model that included a shared evaluation/economic analysis team would be required to move these issues from the periphery of public health practice into the mainstream.

1. **Staffing.** Agencies need to make staffing decisions based on the size of the agency and the area served. Smaller agencies need to consider regional staffing.
2. **Training.** Cross training is necessary to enable staff to recognize the needs of their clients and educate them on the available services.
3. **Infrastructure.** The committee made specific infrastructure recommendations based on agency size.
4. **Technology.** Electronic transfer of communicable disease data is critical for tracking, analysis and generating reports.
5. **Public Heath Policies.** Policies need to be drafted which will impact community health status indicators. The committee delineated necessary areas of expertise.
6. **Quality Improvement.** It is important to know and understand consumer protection functions.
7. **Sustainability.** LPHAs need to explore funding sources for communicable disease prevention and control. The committee supports the use of economic evaluation to determine the most effective methodology.
8. **Community Collaboration.** Collaboration needs to occur among agencies and organizations at the community level. LPHA leadership needs to profile consumer protection to existing and potential partners.
9. **Public Health Marketing.** The public health workforce needs to provide technical assistance and market the benefits of mandated reporting to the health care community.

Committee Best Practices

Committee	Best Practice	Description	Contact
	Building a Customer-Centered WIC Program, Cole County Health Department	In 1995, the Cole County WIC Program was one of 8 WIC and HUD collaborative projects in the nation. In 1999, the Program received an award of Excellence in Customer Service at the Missouri WIC Conference. The program was nominated for the 2000 Dan Glickman Pyramid of Excellence Award. Results over the last 4 years include: breastfeeding initiation rates have increased from 22% to 34%; nutrition education contacts increased by 45%; prenatal smoking rates have decreased from 41% to 28%; and low birth weight rates have decreased from 9% to 4%.	Ivah Scott-Braun, Administrator Cole County Health Department 1616 Industrial Drive Jefferson City, MO 65109 573/636-2181 scotti@lpha.health.state.mo.us
	Streamlining Customer Response, Springfield/Greene County Public Health Center	In 1994, health department and city officials in Springfield, MO became acutely aware that an increasing number of citizens were dissatisfied with the phone shuffle that occurred whenever they called. Whether it was to make a complaint, check on the progress of a complaint, or just to gather information, customers inevitably were transferred several times within or between departments. In response, the officials established work groups and developed a new central database with networked computers. As a result, management review of complaints and subsequent inspections found a decrease in response times from as much as 4 to 5 days to no more than 48 hours.	Harold Bengsch, Director Springfield-Greene County Public Health Center 227 E. Chestnut Expressway, Springfield, MO 65802 417/864-1657 harold_bengsch@ci.springfield.mo.us
	Measurements Important to Customers, St. Louis County Department of Health	The Health Promotion and Disease Prevention Division of the St. Louis County Department of Health uses community and asset assessments to improve customer service. Specific training has taught staff how to think and plan with citizens rather than for them. With many successful programs to their credit, the St. Louis County Department of Health plans to continue using the voice of the customer to design and improve program offerings.	Joan Bialczak St. Louis County Department of Health 111 S. Meramec, Clayton, MO 63105 314/615-0600 joan_bialczak@stlouisco.com

Committee Best Practices

Committee	Best Practice	Description	Contact
	Cross-functional Coordination, Phelps/Maries County Health Department	Previous to 1996, Phelps/Maries County Health Department (PCHD) used a system of client services that dictated specific services on specific days. To improve services to their clients, the PCHD implemented a number of action steps such as staff cross training, inclusive patient charts, electronic centralized appointment system, walk-in appointments, assigning a nurse on call, and improved patient flow to provide one stop service access to the clients.	Jodi Waltman Phelps/Maries County Health Department 200 N. Main, Suite G51 Rolla, MO 65401 573/364-3381 waltmj@lpha.health.state.mo.us
	Quality Improvement, Kansas City Health Department	The Kansas City Health Departments (KCHD) quality journey began when the director became convinced that the principles and tools from the quality improvement movement could improve customer satisfaction in the public domain. The mission was to develop a framework for a coordinated, departmental training initiative at four levels: individual, front line supervisor, program manager, and division head/senior manager level. The KCHD and the citizens it serves benefited from the quality improvement training. Staff now use structured problem-solving processes and cross-functional work teams to better meet their customers' expectations and needs.	Thomas Maddox, Deputy Director Kansas City Health Department 2400 Troost, Suite 4000 Kansas City, MO 64108 816/513-6008 Thomas_Maddox@KCMO.org
	WOW Program, Kansas City Health Department	Walkers on Watch is a community-based crime and safety initiative developed in conjunction with the Kansas City Police, Codes Enforcement, Community Builders of Kansas City (a community development corporation), the Kansas City Health Development and Residents of two Urban Core Neighborhoods. The program, which is in its second year, is entirely supported by the residents of the communities. They reduced code infractions, found a missing person, and have lost weight. The health department has now gained vocal advocates, based at the community level, supporting the initiatives of the health department.	Bill Snook Kansas City Health Department 2400 Troost, Suite 4000 Kansas City, MO 64108 816/513-6274 Bill_Snook@KCMO.org
	Agencies that have mission, vision & value statements	All MOMAP Agencies have developed a strategic plan with mission, vision and values statements unique to their community.	

Committee Best Practices

Committee	Best Practice	Description	Contact
	Using Mobilizing for Action through Planning & Partnership (MAPP)	Taney county is one of nine sites in the USA chosen to implement MAPP. The MAPP tool provides a strategic approach to conducting a community health improvement process. Enhancements that distinguish this tool are the four strategic assessments, community themes, local public health system assessments, community health status assessment, and forces of change.	Veronica Stillwell-Fisher Taney County Health Department 15379 U.S. Highway 160 P.O.Box 369 Forsyth, MO 65653 Fishev@lpha.health.state.mo.us
	Using PACE-EH: Protocol for Assessing Community Excellence in Environmental Health	PACE-EH offers local health officials guidance in conducting a community-based environmental health assessment and creating an accurate and verifiable profile of the community environmental health status. The process is designed to improve decision making by taking a collaborative community-based approach to generating an action plan that is based on a set of priorities that reflect both an accurate assessment of local environmental health status and an understanding of community values and priorities.	Kevin Gipson Springfield-Greene County Public Health Center 227 E. Chestnut Expy. Springfield, MO 65802 Kevin_gipson@ci.springfield.mo.us
	Forging Our Comprehensive Urban Strategy (FOCUS), Kansas City Health Department	FOCUS Kansas City, Kansas City's strategic and comprehensive plan recognizes that neighborhoods understand best how to direct their own futures. Kansas City is doing an assessment of each of the 154 neighborhoods of the greater Kansas City area. The first initiative in the FOCUS Neighborhood Prototypes Plan is a strategic assessment that enables a neighborhood to evaluate its strengths and needs. Through the assessment process, a neighborhood can direct its assets towards its most critical needs. This process is accomplished by completing questions about the neighborhood, identifying areas to improve, and then a reporting back to each neighborhood for planning purposes.	Frank Thompson Community Health Planner Kansas City Health Department 2400 Troost, Suite 4000 Kansas City, MO 64108 816/513-6008 Frank_Thompson@KCMO.org

Committee Best Practices

Committee	Best Practice	Description	Contact
	TB at high school, Cole County Health Department	With a recent diagnosis of TB in an individual attending the largest high school in Missouri, the Cole County Health Department (CCHD) had potentially 2,403 students at risk. CCHD met with appropriate community partners, parents of potentially exposed students, school administration and the media to provide accurate and current descriptions of the TB issue.	Ivah Scott-Braun, Administrator Cole County Health Department 1616 Industrial Drive Jefferson City, MO 65109 573/636-2181 scotti@lpha.health.state.mo.us
	Hepatitis A, St. Louis County Department of Health	Mitigation in an emergency includes the ability to take a situation that has occurred and keep the situation from happening again. The St. Louis County Department of Health had a Hepatitis A outbreak. The disease investigation determined the illnesses were coming from local restaurants. After clientele follow-up, the St. Louis County Department of Health initiated the passage of a new ordinance requiring all restaurant workers to be vaccinated for Hepatitis A. The Health Department developed a database tracking system to assist restaurant workers and their employers in complying with the ordinance.	Steve Fine, Director, Public Health and Ancillary Services St. Louis County Department of Health 111 S. Meramec, Clayton, MO 63105 314/615-0600 steve_fine@stlouisco.com

Committee Best Practices

Committee	Best Practice	Description	Contact
	MOHSAIC/MOHSIS Missouri Department Of Health	The Missouri Health Strategic Architecture and Information Cooperative (MOHSAIC) project began analysis and development of an integrated surveillance system in 1992. In November 1996 the Missouri Health Surveillance Information System (MOHSIS) was formed. It is a transactional application that provides a centralized and integrated database for the entry, update, and retrieval of surveillance information about conditions of interest to public health.	Garland Land Director, CHIME Missouri Department of Health 920 Wildwood P.O. Box 570 Jefferson City, 65102 Landg@mail.health.state.mo.us
	Duty Officer System, Kansas City Health Department	The Kansas City Health Department initiated a 24-hour on-call Duty Officer system. Every week a different program manager is assigned to answer any calls made to the pager number which is made available to the health care system, media, restaurant owners and individuals. People can call to report a possible public health emergency.	Thomas Maddox, Deputy Director Kansas City Health Department 2400 Troost, Suite 4000 Kansas City, MO 64108 816/513-6008 Thomas_Maddox@KCMO.org
	Training Institute, Kansas City Health Department	The Kansas City Health Department's (KCHD) quality journey began when the Director became convinced that the principles and tools from the quality improvement movement could improve customer satisfaction in the public domain. The mission was to develop a framework for a coordinated, departmental training initiative at four levels: individual, front line supervisor, program manager, and division head/senior manager level. The KCHD and the citizens it serves have benefited from the quality improvement training, with structured problem-solving processes and cross-functional work teams.	Thomas Maddox, Deputy Director Kansas City Health Department 2400 Troost, Suite 4000 Kansas City, MO 64108 816/513-6008 Thomas_Maddox@KCMO.org

Committee Best Practices

Committee	Best Practice	Description	Contact
	TB Event, Cole County Health Department	With a recent diagnosis of TB in an individual attending the largest high school in Missouri, the Cole County Health Department (CCHD) had potentially 2,403 students at risk. CCHD met with appropriate community partners, parents of potentially exposed students, school administration and the media to provide accurate and current descriptions of the TB issue.	Ivah Scott-Braun, Administrator Cole County Health Department 1616 Industrial Drive Jefferson City, MO 65109 573/636-2181 scotti@lpha.health.state.mo.us
	Focus group, target population (tobacco prevention), Kansas City Health Department	KCHD used community focus groups to develop tobacco prevention messages that were culturally appropriate to the neighborhood, which were messaged on billboards and posters.	Christine Trainor Kansas City Health Department 2400 Troost, Suite 4000 Kansas City, MO 64108 816/513-6008 Christine_Trainor@KCMO.org
	Movie slides, Taney County Health Department	Taney County Health Department was not reaching the large tourist population by traditional health communication strategies. An outreach was initiated at the local theaters using a slide presentation. Messages focused on basic hygiene principles.	Veronica Stillwell-Fisher Taney County Health Department 15379 U.S. Highway 160 P.O. Box 369 Forsyth, MO 65653 Fishev@lpha.health.state.mo.us

Committee Best Practices

Committee	Best Practice	Description	Contact
	Thin Prep vs. Conventional pap smears, Cole County Health Department	This case study provides a real-life example of how the process of economic evaluation is an effective measuring tool that can gather information to be utilized by LPHAs to make decisions about the services they provide and the cost involved.	Ivah Scott-Braun, Administrator Cole County Health Department 1616 Industrial Drive Jefferson City, MO 65109 573/636-2181 scotti@lpha.health.state.mo.us
	Merging STD with Communicable Disease unit, Kansas City Health Department	Most STD programs are completely separate from the Communicable Disease programs and even farther from any chronic disease programs. In an effort to streamline services and train staff to recognize the more holistic needs of their clients, KCHD has made the effort to cross-train their staff. Now the Disease Intervention Specialists (DIS) are capable of not only STD/HIV disease intervention, but perform TB directly observed therapy, and educate patients regarding other communicable diseases and programs available through the KCHD.	Ron Griffin, Program Manager Kansas City Health Department 2400 Troost, Suite 4000 Kansas City, MO 64108 816/513-6008 Ron_Griffin@KCMO.org

Lessons Learned

- Creativity was enhanced; however, limiting assigned structure and guidance for the process by which the teams reached their conclusions hampered productivity.
- Elements initially identified and envisioned as necessary to the model could not be fully addressed within time and resources constraints.
- Day to day business of the model site agencies along with staff turnover, crisis situations, time and travel limitations, and other resource issues did not allow for a consistent level of focus by every site.
- Cost to implement the model, or any single component of the model, could not be established because cost data does not exist to analyze the business of public health.
- A more visionary product was created through the team process because members had diverse backgrounds, experiences, and strengths to bring to the table.
- Each model site agency took a risk by opening itself for scrutiny by all members of the MOMAP group.
- Other initiatives within the public health system such as accreditation, quality improvement, and coordinated professional development support the model agency concept and the teams' conclusions.
- Stakeholders from the health care system and the community need to be involved in implementation of the MOMAP model.

Conclusion

The planning phase of MOMAP has now concluded. The next step is the development of a Center for Excellence in Public Health (CEPH). This is a concept based on collaboration rather than an actual physical structure. Stakeholders from the community, higher education, health care, the business sector, and public health will be brought together to discuss the future of public health, workforce issues, and identified and needed learning opportunities to support the future of public health at the community level. Key in this discussion is a marketing plan to assure public awareness of the essential role of public health in promoting and protecting the health of people in the communities of Missouri. The stakeholders will design the framework to:

- Provide a forum to discuss public health best practices prior to implementation;
- Develop a unified public health marketing plan;
- Engage the model site community partners in strategic conversations related to improving health status indicators;
- Provide sounding boards for emerging issues in public health; and
- Provide a forum for the local public health agencies to identify and discuss common issues, needs, and challenges related to the model components.

The result of the CEPH work will be improved leadership, better systems, enhanced partnerships with state and local health professionals and most importantly, improved services for the clients and communities. The CEPH's long term goal is to support a strong public health system at the community level, which is customer focused.

MISSOURI DEPARTMENT OF HEALTH

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