

The Local Public Health System Assessment of MAPP/The National Public Health Performance Standards Local Tool: A Community-based, Public Health Practice and Academic Collaborative Approach to Implementation

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The Local Public Health System Assessment (LPHSA) in Mobilizing for Action through Planning and Partnerships (MAPP), and the Local Tool of the National Public Health Performance Standards Program (LT/NPHPSP)—which are one in the same—attempt to assess the capacity to provide the essential public health services. Both tools have been utilized in various public health practice settings; however, users have been challenged with the complexity of the tools and time and human resource investment necessary to complete them. The recent *Journal of Public Health Management and Practice* issue focus on MAPP provided several examples of LPHSA implementation, both as a component of MAPP and as a stand-alone activity in the context of performance standards. The uniqueness in our approach involved a collaborative between a community-based organization, a public health academic program, and a governmental public health agency which conducted the LPHSA in a manner that did not require actual modification of the tool itself, was practical and feasible, and was of benefit and value to all partners.

KEY WORDS: assessment, MAPP, performance standards, public health systems

The Local Public Health System Assessment (LPHSA) in Mobilizing for Action through Planning and Partnerships (MAPP)¹ and the Local Tool of the

National Public Health Performance Standards Program (hereafter, simply the Local Tool)² are one and the same. In MAPP—a systems approach to health improvement—the LPHSA is but one of four assessments that inform the overall strategic planning process. In the Performance Standards, the Local Tool is one of three tools that make up the overall performance measurement process. Both the LPHSA and the Local Tool seek to determine the capacity of the local public health system—all entities, agencies, and organizations that impact the health of the public—to provide the essential public health services.³

Over the past several years, both assessments have gone through various stages of pilot testing, demonstration site implementation, and even statewide use. With one coauthor (P.C.E.) who was a part of the work group that developed this tool and who later served as chair of the National Association of County and City Health Officials' MAPP Work Group, and one (S.W.) who currently serves as chair of the MAPP Work Group, we have had the opportunity to hear firsthand how

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communities have struggled with implementing the tool—either as the LPHSA or as the Local Tool. Many have complained at the length, the complexity and detail, and the requisite time to conduct, and as a result, many communities have opted to modify—sometimes radically—the tool itself.

The November 2005 *Journal of Public Health Management and Practice (JPHMP)* issue focus on MAPP provided several examples of LPHSA implementation, both as a component of MAPP and as a stand-alone activity in the context of performance standards.⁴ The work described in this article took place in the spring of 2005, as the November issue was being prepared for publication. Our focus was to learn how this tool could be implemented, accomplishing the following goals: (1) utilizing the tool as is, without significant modification; (2) ensuring minimal time commitments from community volunteers; (3) rendering the process manageable for health department staff to facilitate; and still (4) providing results that have value. Our involvement with the MAPP Work Group allowed us to hear from communities that were reluctant to implement the LPHSA because of the perception that these goals were unattainable. The uniqueness in our approach to implementing the LPHSA involved a collaborative among a community-based organization, a public health academic program, and a governmental public health agency.

● The setting and context

Jefferson County, population 44,294 (US Census 2000), located just east of Knoxville, Tennessee, is a county in the midst of change—from one in the folds of Appalachia, with poverty rates typically higher than nationwide figures, to a county that is rapidly becoming a bedroom community to Knoxville for an upwardly mobile middle class. Since 1996, the Jefferson County Health Council—a volunteer, community-based group of local citizens, concerned about and interested in health and healthcare issues—has been working through a locally implemented health assessment and planning process. After close to 10 years of efforts, resulting in the initiation and evaluation of programs that addressed priority concerns such as diabetes and tobacco use, the Health Council asked themselves, what's next? Where do we go from here?

Throughout this time period, the East Tennessee Regional Health Office (ETRHO) had provided staff support for facilitation and advocacy, and acted as a link to funding opportunities. Having facilitated local health assessment and planning processes throughout the region of 15 counties, the ETRHO had begun facilitating

MAPP in a few counties that were at an appropriate readiness stage.

To address the need for public health staff time, the ETRHO turned to one of its significant public health partners—the MPH program at the University of Tennessee. Over the past 4 years, during each spring semester, staff from ETRHO have worked with the MPH Health Planning class to provide opportunities for students and faculty to become involved in specific public health practice activities.*

The timing for conducting the LPHSA, therefore, came into alignment: the community wanted to refocus its priorities, the ETRHO sought to develop a practical approach to implementing the LPHSA, and the 2005 spring semester for the MPH Health Planning course—with a class of eight students—was about to begin and was in need of a field-based project.

● Methods

Preparation

To initiate community engagement in the process, ETRHO Community Development staff first met with the Chair of the Health Council to discuss the potential for conducting the LPHSA as the appropriate next step for the council. The discussion focused on what the LPHSA could provide (and what it could not); the likely time investment for the Health Council members; the roles and responsibilities of the students; and the potential next steps for what would happen after the LPHSA was completed.

At a regular monthly meeting of the Health Council, ETRHO staff spent 30 minutes in open discussion regarding the essential public health services. Health Council members were oriented to the LPHSA by having members list each of the essential services on a separate flip chart, and answer, “Who or what agencies or organizations contribute to this essential service in Jefferson County?” This brought a visual realization of what is meant by the “Local Public Health System.” For each of the organizations listed, Health Council members then provided names of individuals who were key members of those community organizations, and who would later be invited to participate in completing the LPHSA.†

*This public health practice-academic linkage has garnered recognition at the national level (second place award in 2002 from The Council on Linkages between Academia and Public Health Practice), and the experiences of this collaborative between 2002 and 2004 are described in the special issue of the *JPHMP* focusing on MAPP.⁵

†A similar exercise was used in the classroom with the students to develop their breadth of understanding.

Collaborative planning, involving all partners, led to the decision to complete the LPHSA in two stages. In the first stage, a half-day facilitated retreat was held for a broad range of community participants, generating conversation and consensus around the major indicators for each performance standard. Retreat participants identified potential key informants who could be contacted for stage 2, follow-up interviews to answer the detailed questions for each essential public health service.

Prior to the half-day retreat, ETRHO staff reviewed the confirmed list of attendees and assigned each participant to two essential public health services based on the likely connection of that individual's organization to the specific service. In addition, five ETRHO staff members were provided with materials and 2 hours of training in preparation for facilitating at the retreat.

Implementation

After a welcome by the Health Council, and an overview of the essential public health services and the LPHSA by ETRHO staff, participants were seated at one of five tables, each with a facilitator and at least one MPH student to take detailed notes. There were two roundtable sessions, each lasting 30 minutes, with each participant contributing input to the LPHSA on two essential public health services. This 30-minute focused roundtable discussion was followed by further open discussion involving all tables and participants.

The LPHSA document lists each essential public health service, describes the optimum or "model standard," and then lists 2 to 5 "indicators" for each service. Each indicator is followed by a series of detailed questions and subquestions with answers of "yes," "no," or "don't know" for each. For this retreat, each facilitator was provided the basic description of the essential public health services, the model standard, and the "stem" questions for each indicator. The facilitator shared the description of the essential service, summarized the model standard, and then asked for a consensus response from the 5 to 10 community participants for the indicator stem questions. At the end of each roundtable session, the facilitator asked the table participants to identify individuals in the community who had detailed knowledge or information pertaining to that essential public health service and who would be good choices to serve as key informants for the detailed questions. Following the individual roundtable discussions, each table reported back to the full group. Further open discussion took place regarding the degree to which the model standard was being met, and who or what agencies contributed to each of the essential public health services. The retreat ended with participants being given an outline of next steps and dates for a follow-up meeting.

Telephone contact was made with each key informant, and a time was arranged for the MPH students to interview this person. These interviews, each conducted by at least two students, lasted between 45 and 75 minutes, with the average taking approximately 1 hour. During the interviews, the students asked all of the detailed questions under each indicator stem question, and noted responses as yes, no, or do not know. Each student participated in one or two individual interviews.

Data based on responses at the retreat and responses from the key informants were entered on-line into the data entry format provided by the Centers for Disease Control and Prevention (CDC) (<http://www.phppo.cdc.gov/takesurvey>). Results were returned from the CDC within 48 hours of data entry.

With these results in hand, students developed a final presentation to give back to the Health Council and a presentation of results took place during their regular monthly (1½ hours) meeting. Summary data were provided, showing overall scores for each essential public health service, and more detailed scores (by indicator) for the low-scoring and high-scoring indicators. Students reported the results and did not attempt to analyze or interpret the data.

Following the data presentation, participants broke out into three roundtables to discuss their overall reactions to the data and to formulate preliminary responses to three questions. The questions were as follows: (1) What stands out to you—both positive and negative? (2) What questions does the report raise for you? and (3) In what ways can this report be made more meaningful to you? At the same time, students, MPH faculty, and ETRHO formed their own roundtable to give students an opportunity to discuss these same questions.

After 30 minutes of roundtable discussion, the group came back together to report and openly discuss the three questions posed. Participants were generally appreciative of the work, but had concerns especially regarding low scores on three of the essential public health services. Staff from ETRHO stressed that these scores were not based on measurements, but rather the input from roundtable and key informant interviews. Thus, one could rightfully ask, does the low score reflect insufficient capacity for these essential services, or lack of awareness of the capacity, or a mixture of the two? The presentation ended with a suggestion for possible next steps.

● Results

Were the four goals as described in the introduction accomplished?

1. *Goal 1: Using the tool without modification—Yes.* All questions as written in the LPHSA were asked—no questions were altered in wording, and none were excluded. But, the approach we took in dividing the questions between the roundtable (indicator stem questions) and key informants (detailed, sub-questions) prevented participants from being overwhelmed at the breadth and depth of the LPHSA—the single greatest complaint other users have made.
2. *Goal 2: Ensuring minimal time commitments from community volunteers—Yes.* The retreat was conducted from noon until 4 PM; subsequent key informant interviews were completed within 1 hour on average; and the presentation of data and discussion lasted 1½ hours (during a regular Council meeting). With good staff preparation, we were better able to make efficient use of volunteers' time; for example, a very useful exercise for engaging Health Council members was in listing entities that contributed to each of the essential public health services, which was considered of great value in increasing comprehension of the "Local Public Health System." The determination of what was feasible was made subjectively by the Health Council members themselves, and validated by the level of attendance and participation at the meetings.
3. *Goal 3: Rendering the process manageable for health department staff to facilitate—Yes.* The ETRHO could not have completed this assessment with only its existing staff. Involving MPH students in the field provided ETRHO with the requisite human resources to complete the work. Moreover, it provided the students with the opportunity to apply theory to public health practice and it provided the community with a sense of pride in serving as the vehicle for students' learning.
4. *Goal 4: Producing results that have value to the community—Yes.* *Value* here is defined as meeting the needs of the community. After almost 10 years of work, the Health Council had asked—what's next? And how do we go about determining a new set of priorities? It is acknowledged, that, at best, the LPHSA is a semiquantitative assessment providing a rational and consistent scoring mechanism but based on subjective responses to questions. In the end, the Health Council had a completed assessment that described possible assets and deficiencies—or awareness of such—in their local public health system. For a tangible next step, given the results of the LPHSA, the suggestion was made to apply the assets described in the highest scoring essential public health service number 3 (inform, educate, and empower people about health issues, score 91/100) to exploring the low-scoring essential service number 1 (Monitor Health Status, score of 10/100). A po-

tentially productive outcome would be creating an annual community health report card. The presentation did not serve as an end, but rather, as a possible new beginning place for the Health Council, which is exactly what they had wanted.

● Discussion

The work described in this current article was being completed just prior to the publication of the *JPHMP* special issue focus on MAPP. Several of the articles described implementation of the LPHSA as a part of MAPP, most notably in Chicago, Northern Kentucky, and San Antonio.⁶⁻⁸ In addition, significant detail on conducting the LPHSA as part of the NPHPSP was provided from North Dakota; Clarendon County, South Carolina; and in Livingston County, New York.⁹⁻¹¹ This current work adds to that growing body of literature that describes the process of conducting the LPHSA in sufficient detail for other communities to adapt or adopt. The uniqueness of our work is in the collaborative relationship among a community-based organization, a public health academic program, and a governmental public health agency.

Several key factors contributed to the successful completion of the LPHSA in this setting, which may have significant implications for wider duplication of our approach:

1. *Previous and ongoing community participation:* The Jefferson County Health Council has been in existence for 10 years, and had previously gone through a community-based health assessment and planning process. Experience, a history of working with the ETRHO, and a foundation of trust were well established. Importantly, because trust did exist, an open discussion and true dialogue flourished—and this "process" was envisioned by the LPHSA developers as being equal if not more important than the eventual scoring. To repeatedly hear one community member say to another (community member or agency lead), "I didn't know you did that" as they worked through who contributes to the essential public health services, by itself speaks to the success of the work.
2. *Experience with collaborations:* The Academic-Public Health Practice collaborative had 3 years of previous experience in involving students in the field. Planning for the semester, staying within the academic calendar while being flexible to the community's "schedule," was much more efficient and effective because of having done it previously.
3. *Knowledge of the tool itself:* With our own involvement in building the LPHSA, and our ongoing work at the national level through the MAPP Work Group,

we were in a strong position of sensing how to present the LPHSA, what might and might not work.

A lesson learned: The roundtable session identifies a single key informant; contact is made with that key informant, and the detailed questions are sent in advance of the interview. On the basis of our experience, we recommend that the key informant be asked to consider two additional key informants who might provide information that the initial key informant could not; the interview would then be conducted with the three key informants at the same time to generate a consensus response.

In summary, through a collaborative effort involving community participants, academia, and public health practitioners, we learned that implementing the LPHSA is feasible and practical, and yields valuable results to all partners. The goal of understanding the capacity of the local public health system to provide essential public health services can be realized.

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