

North Dakota's Governance Assessment Story

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INTRODUCTION

North Dakota is a rural state with 642,200 residents widely dispersed over a large geographic area with only a few larger population centers. The public health system is decentralized with 28 independent public health units working in partnership with the North Dakota Department of Health. The 28 local public health units are organized into single or multi-county health districts, city/county health departments or city/county health districts.

There are limited state laws defining public health in North Dakota. State law requires that all counties be within a health unit jurisdiction and that a health unit have an established board of health and an appointed health officer licensed to practice medicine in North Dakota. The North Dakota Department of Health also is required to have a State Health Council whose members are appointed by the Governor. There are no state laws establishing minimum functions or expectations for public health delivery.

Both local health boards and the State Health Council have a broad range of authority in ensuring that essential and equitable public health services are provided at the local or state level or collaboratively. Local boards of health may make, establish and enforce rules for the protection of public health and safety in their jurisdiction. Whereas, the State Health Council shall establish standards, rules and regulations that are found necessary for the maintenance of public health in the state, including sanitation and disease control. Neither board has fully utilized its authority, and this authority may be the necessary tool for enhancing our state's public health infrastructure, especially in the light of new and emerging public health issues. Both the state and local health boards have governing authority but tend to serve more of an advisory role in most situations.

Therefore, to ensure the delivery of essential and equitable public health service to the people of North Dakota, the North Dakota Department of Health began the process of assessing the role and performance of local boards of health and the State Health Council. The department used the governance assessment tool from the National Public Health Performance Standards Program (NPHPSP), an initiative developed by national partners and led by the U.S. Centers for Disease Control and Prevention. The governance assessment process was coordinated by the public health liaison for the North Dakota Department of Health. Seven local boards of health completed the assessment from November 2006 to April 2007. The State Health Council then completed the assessment process in August 2008.

LOCAL BOARDS OF HEALTH **PREASSESSMENT PHASE**

Prior to the assessment process, all local public health unit administrators and board members were invited to participate in a one-hour orientation. Because the purpose of the presentation was to inform them about the assessment process and to create buy-in, we wanted to make participation as accessible as possible. Therefore, the orientation was held by videoconference and webcast and also archived for later viewing. The presentation included information about the three core functions of public health and the ten essential public health services; benefits of the

National Public Health Performance Standards Program; the purpose of the governance assessment; key steps in the governance assessment; the structure of the assessment; how to determine responses, and the report of results. The state health officer, also presented information about the new paradigm and future challenges of public health.

Local boards of health were then invited to participate in the assessment process and offered a \$330 stipend. Once participation interest was confirmed, the local public health unit administrator signed a contract agreement and then led the coordination of the assessment process. The administrators received an instruction sheet informing them how to prepare for the assessment. They were asked to encourage participation from all boards of health members since most boards consist of only five members. (State law requires local boards of health to have at least five members.) It also was suggested to invite other governing body members, such as county or city commissioners and city council members, the local health officer, and representatives from the local public health unit. The state field medical officer and state public health liaison were available to facilitate, if requested. The boards could choose from three structure options: (1) a one-day retreat, (2) a series of meetings or (3) board members complete the assessment individually.

DURING THE ASSESSMENT

Four local boards of health completed the assessment in a one-day retreat, two local boards of health completed it in a two-day meeting and one board completed it individually. Five of the local boards of health requested state facilitators. The other board assessment was facilitated by the local public health unit administrator. The individually completed assessment question response scores were weighted and averaged to determine the submitted response.

The format for the meetings that had a state facilitator consisted of an orientation, completion of the assessment tool and completion of the priority questionnaire. Participants received packets consisting of the public health century codes, the assessment tool and an orientation PowerPoint presentation.

The brief orientation included a review of meeting logistics, assessment tool, voting process and determining responses. The facilitator started the process by reading the first tiered question and then engaged the group in discussion. The facilitator then read the stem questions and conducted a group vote. The question response was determined by the majority vote. The group voted by raising their hands for the response option. Each stem question was answered first and then the first tiered question last. During the discussion, the board members relied heavily on the local public health unit staff to provide information relating to the model standard. All participants, even the local public health unit staff, were included in the votes. The health unit staff were more critical and felt they could be doing more with more support from the board so tended to score lower than the board members. The board members, on the other hand, commented that the health unit is doing the best with the resources that they have and therefore, scored higher. The facilitators continually redirected the members to rate how the board was performing – not the health unit. The state facilitators were very familiar with the assessment tool so the glossary was not used and the discussion toolboxes were occasionally reviewed when the group needed more clarification. Each participant completed the priority questionnaire so the responses were averaged to determine the response score. The assessment coordinator collected and submitted

assessment and priority response scores for all the health boards and then distributed the reports to the local public health units to share with the board members and other participants.

Overall, board members felt the assessment process was beneficial as an educational tool. Board members felt that the orientation at the start of the meeting was very helpful, especially the review of board member authority and responsibilities outlined in state statute. It became more apparent from the comments and discussion that larger health units and those that have been longer in existence had more active and knowledgeable boards of health. Single county health departments whose board members were county commissioners were much less active and knowledgeable about public health issues.

POST-ASSESSMENT PHASE

State facilitators were available to present the results if requested; however, none of the boards requested state facilitators. It was assumed that the local public health units presented the assessment results. Three of the health boards have pursued strategic planning and have implemented performance improvement activities while the others have just used the results as a resource. A gap identified in all the assessments is that boards were lacking formal orientation for new members. This has been priority area of improvement for the boards.

STATE HEALTH COUNCIL PREASSESSMENT PHASE

The state public health liaison coordinated and facilitated the state governance assessment. The public health liaison presented the purpose and value of the assessment at a council meeting and asked for each member's commitment to participate. The State Health Council decided to complete the assessment in a one-day retreat. The council did not receive a stipend, but members were paid for their time and reimbursed for travel.

DURING THE ASSESSMENT

The assessment format was similar to the local boards assessment conducted by state facilitators. An assistant attorney general provided an overview of the council's authority defined in state statute. Completion of the assessment tool was facilitated the same as with the local boards. All 13 board members participated in the assessment. The state health officer participated by providing information but did not vote. Before starting the process, council members were informed that that they are the governing body or the board of health that has the responsibility to ensure that the state health department and its partners have the necessary legal authority, resources and policies to provide essential services. Therefore, council members were asked to rate their performance in fulfilling this responsibility. They also were informed that the word "community" in the assessment is referring to all North Dakotans or the whole state. Similar to the locals, the assessment was scored using a combination of voting and consensus. Again, it was challenging to score the assessment because it was hard to determine the council's performance rather than the Department of Health's performance concerning the noted activities. Scoring also appeared to be influenced by the veteran members' perspective.

The State Health Council also used the optional questionnaire to rate the priority of each model standard. Unlike the local process, a nominal group voting process was used to determine priority areas. Each member was provided three stickers and asked to vote for the three model

standards they considered to have the highest importance to the public health system. Using a scale of 1 to 10, the standard with the most votes received a 10 and so on in descending order.

The assessment process has been valuable in educating North Dakota's State Health Council about its statutory authority and responsibility. The council members have become more active and engaged. During the assessment process, the council members commented that the council doesn't formally assess or review, but rather trusts and relies on state health department staff to provide information and bring concerns to their attention. The council's goal now is to be proactive and better informed when making decisions.

POST-ASSESSMENT PHASE

The state public health liaison presented the results to the council and has facilitated a performance improvement process. Priority areas to address in the performance improvement phase were determined by the indicators of higher importance and weaker performance scores. As a result, the council has identified the areas of improvement as (1) ensure a competent public and personal health-care workforce, (2) monitor health status to identify community health status monitoring and (3) link people to needed personal health services and ensure the provision of health care when otherwise unavailable. In the next stages, the council will identify key strategies as they relate to policy and advocacy for each of the priority areas.