Can You Hear Me Now?

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EXECUTIVE SUMMARY

Our Kentucky Public Health Leadership Institute Team sought to determine the perceptions of local health department directors and state public health staff regarding state-local communications in Kentucky's public health system. A survey sent to directors and state staff showed a majority of the directors who responded to the survey rated communication between local health departments (LHDs) and Department for Public Health (DPH) as fair; no director rated communication as "excellent." The majority of DPH staff who responded rated LHD-DPH communications as "good." Both directors and state staff cited specific examples of excellent and poor communications and made recommendations for improvement.

In order to research possible remedies and give definite guidance for improving state-local communications, we did case studies on the communication philosophies and mechanisms in four states. These states have public health systems that resemble Kentucky's, and their communication models were recommended as exemplary by Kentucky Public Health Leadership Institute (KPHLI) faculty and mentors. These states included Washington, North Carolina, Wisconsin, and Iowa. Research for case studies was based on interviews with certain key staff from each of these states and analysis of documents from state public health websites. Local health department directors in these states were not consulted or interviewed.

While we acknowledge that efforts are currently underway at the local and state level to improve communications, we believe LHDs and DPH could adopt certain "best practices" from these four states to effectively correct the problems with communications identified in our survey. Recommended best practices include: (1) making effective, responsive and timely state-local communication a core value for Kentucky's public health system, (2) establishing liaison positions at the local level on a regionalized basis or assigning these duties to a staff member in each division at DPH, and (3) improving electronic communications through better state website design and enhanced use of existing technology such as the Health Alert Network, TRAIN, and the Distance Learning Center.

Our proposal to the Department for Public Health is one we believe to be realistic in achieving our goals. Its adoption can signal a new beginning for effective and efficient communication between both organizations leading to a strong and equally supportive relationship.

INTRODUCTION

"Skill in the art of communication is crucial to a leader's success. He can accomplish nothing unless he can communicate effectively." Norman Allen

According to Louis Rowitz, author of *Public Health Leadership*, "communication is the transfer of information, and it has become even more important over the last decades-the start of the so-called information age-than it was previously. Information makes situations orderly, promotes change and growth, and defines reality."

The purpose of this change master's project was to address the critical need for optimum communication between local health departments, local Boards of Health and the Kentucky Department for Public Health (DPH). The vision for the project was to develop an efficient and effective communication plan that would strengthen the public health infrastructure throughout the Commonwealth.

Why is communication between local health departments and the DPH important? The administrative reference developed by the DPH is a document that serves to give direction to local health departments in the form of protocols and procedures as it pertains to all programs and services. This reference is massive in size as it encompasses all areas of the local health department service delivery system. As in any delivery system, questions arise regarding specific programs and procedures. Without answers and clarification health departments cannot deliver the services in a professional and knowledgeable manner. There must be an open and accessible communication process established in order for an effective exchange of information between both organizations.

The process for the project began by researching communication models in other states. We sought and received guidance from the branch manager of the DPH training division, the director of the Kentucky Public Health Leadership Institute and our mentor in choosing which states would provide information regarding their infrastructure and relationship to their State department. The states we selected to examine were somewhat similar in their public health infrastructure to Kentucky's. Our examination of communication practices/models from the other states revealed various approaches to communication**.** Each of the states; Iowa, North Carolina, Washington and Wisconsin have made communication a top priority within their Department for Public Health and their partnership with the local health departments.

We also surveyed health department directors and management staff of the Department for Public Health to determine their opinion of the current communication status between both entities. Based on the results of the survey, it was apparent that there is a need for improved communication and the development of a realistic communication model could strengthen the current relationship and resolve misunderstandings and frustration.

The project provides a dynamic document that can be embraced by local health departments and the Department for Public Health. Implementing our recommendations will support values that determine the standard of excellence that both organizations must adopt to be successful.

PROBLEM STATEMENT

Disconnect between local health departments, local boards of health, and Department of Public Health relative to fundamental communications.

OBJECTIVES

1. Research communication models in other states.
2. Develop a survey tool, which provides quantitative and qualitative data to assist in implementation of the appropriate communication model.
3. Create a dynamic guidance document to be utilized by all stakeholders.
    a. share survey results and research on communication models in other states;
    b. set forth recommendations for improving state and local communications; and
    c. provide a constructive basis for exchange of ideas and opinions and the development of action plans by all stakeholders to resolve communication issues.

VISION

Efficient and effective communication model which strengthens the public health infrastructure throughout the Commonwealth.

Essential Public Health Services

Assure a competent public health workforce.

METHODOLOGY

Case Studies:

The communication methods of Washington, Wisconsin, North Carolina, and Iowa were used as models.

Washington: where "effective, responsive, and timely communication" is a core value.

Background

Washington State was the first state we researched for our project. Through the good offices of Cynthia Lamberth, Executive Director of the Kentucky Public Health Leadership Institute (KPHLI), we were put in touch with Marie Flake. Ms. Flake, who holds an MPH and BSN degrees, is the Local Health Liaison at the Washington State Department of Public Health (DOH). We had two telephone conversations with Ms. Flake in August 2004 to discuss the communication mechanisms used in by the local health jurisdictions (LHJs), the equivalent of our Local Health Departments (LHDs) and DOH. Discussions about attitudes and values figured frequently into our conversations. Ms. Flake supplemented our conversations with pertinent documents she emailed to us.

Additionally, we obtained considerable information on state-local organization and the statutory underpinnings of public health in Washington State from DOH's website, http://www.doh.wa.gov/about.htm. Finally, we researched the Washington State Board of Health (SBOH), a governing body that has no equivalent in Kentucky's public health structure. We found that SBOH, too, does much to foster good state-local communications in Washington State.

Structures

According to DOH's website, Washington State's "public health services are population-based, focusing on improving the health status of the population, rather than simply treating individuals." This mission is shared by WSDOH, which derives its statutory authority from Revised Code of Washington 43.70.020, and thirty-five mostly county-based LHJs that serve the state's thirty-nine counties. Similar to Kentucky, these thirty-five LHJs are part of local government, not satellite affiliates of WSDOH or the State Board of Health.

Nineteen local health departments serve about sixty percent of the state's population. Of these, seventeen are single-county departments where the county commissioners serve as the local board of health. Two large metropolitan areas, Seattle-King County and Tacoma-Pierce County, have combined city-county departments, with local boards of health organized under inter-local agreement. Fourteen local health districts serve the rest of the state's population. These districts are political subdivisions distinct from the other offices of county government. Their local boards of health include county and city representation. Four districts combine more than one county, including Northeast Tri-County, Chelan-Douglas, Benton-Franklin, and Southwest Washington.

Marie Flake stressed the strong "local autonomy" of the LHJs. Each LHJ is a separate legal authority that operates according to local rules for all of its administrative functions and can pass and enforce local ordinances, as Kentucky's LHDs do. Each LHJ has a director who is its chief executive and is responsible for day-to-day operations. Each LHJ has a public health nursing director, an environmental health director, and a physician health officer, who, in smaller LHJs, may be only a part-time contract employee. LHJs range in size from six to twelve hundred employees. There are three thousand local public health workers in the state's total local workforce.

Local health department employees in Washington State have their own equivalents of Kentucky's various professional organizations. The umbrella organization is Washington State Association of Local Public Health Officials (WSALPHO). Under WSALPHO can be found the Public Health Executive Leadership Forum (PHELF) and the Environmental Health Directors (EHD), the counterparts of Kentucky's KHDA and KAMFES. There is also a group for Public Health Nursing Directors. Each affiliate uses several communication modalities, including regular meetings, list serves, conference calls, and so on.

WSALPHO's organizational chart identifies "communication" happening not just through meetings and technology, but through DOH assistant secretaries and DOH contact persons as well. This stresses DOH staff's responsibility for communication. As a local liaison, Marie Flake is the DOH contact for PHELF and one of the contacts for WSALPHO. She described this role

and that of other state staff is being a "guest" of WSALPHO and its affiliates. She said she attempts to "work out problems" and ensure that the state-association communications "stay positive." More details of Ms. Flake's role in state-local communications are discussed later in this case study.

In terms of state structure, DOH was formed in 1989 as the state's agency responsible for preserving public health; monitoring health care costs; maintaining minimal standards for quality health care delivery; and planning activities related to the health of its citizens. The Department's mission, from its web site, reads:

The Department of Health works to protect and improve the health of people in Washington State.
We envision a future for Washington citizens where we:

- begin as children born healthy, and wanted by healthy families;
- are free of preventable conditions, anticipating long and healthy lives;
- are able to make educated choices about preserving our health;
- enjoy access to quality health and illness care, when needed;
- have the opportunity to live as independently and with as much dignity as we are able; and
- live in a physical environment that nurtures good health.

DOH is a Cabinet within Washington State's executive branch and is headed by a Secretary appointed by the governor. The organizational chart from its website shows Mary Selecky as the Secretary of Health. She oversees all DOH divisions: Community and Family Health, Environmental Health, Epidemiology, Health Statistics and Public Health Laboratory, Health Systems Quality Assurance and Administrative Services. There is a Deputy Secretary, Bill White, whose role deals mostly with DOH's administrative functions and health policy development. An assistant secretary heads each of DOPH's four divisions--Community and Family Health, Environmental Health, Epidemiology Health Preparedness and Public Health, and Health Systems Quality Assurance.

DOH differs from DPH in two significant ways. First, because it is a Cabinet and not a department, DOH has other, broader mandates than DPH. Three of its four divisions appear largely comparable to and handle the same or similar public health programs as DPH's Divisions of Maternal and Child Health Improvement, Public Health Protection and Safety, Laboratory, and Epidemiology and Health Planning. However, DOH's Division of Health Systems Quality Improvement oversees licensure and regulation of facilities and services, professional licensure, and medical and trauma systems, functions not under DPH's purview. Its Division of Environmental Health also has a wider span of authority. Certain programs of that division, such as regulation of drinking water, pesticide incident management, and school health and safety, would not even fall under Kentucky's Cabinet for Health and Family Services but instead would be regulated by other cabinets.

Second, DOH is not headed by a physician commissioner, as DPH is. It does have a state health officer, Dr. Maxine Hayes, who also serves as chief spokesperson on medical issues. Secretary Mary Selecky was appointed to her position by Governor Gary Locke in March 1999 and has a degree in political science. She served as Acting Secretary beginning in October 1998 and helped start DOH. Prior to this, she had twenty-year tenure as administrator of the Northeast Tri-County Health District in Colville, Washington. Ms. Selecky's long years of services at the LHJ level, as

may be one reason why state-local communications are so valued and effective in Washington State.

Finally, public health in Washington State has one significant structural difference from Kentucky: an independent State Board of Health (SBOH). Kentucky has no comparable governing body for public health, though there was a state board of health in the past. SBOH was established under Article XX of the State Constitution of 1889. It consists of ten members, who serve three-year terms, with the qualifications of its membership are set in statute; nine members are appointed by the governor, and the tenth member is the Secretary of Health or a designee. SBOH is a means for Washington State residents to have input in the development of public health policy. This input is sought through citizen surveys, monthly Board meetings at various locations across the state, and public forums.

One of the Board's primary responsibilities is to prepare the biennial *Washington State Public Health Report*, which "reports on the people's health status," lists the State's Priority Health Goals, and recommended Action Strategies that are used in to prepare budgets and set forth requests for legislation. The Board has regulatory authority in certain public health areas, including drinking water, immunizations, school safety, and food handling. This authority consists of promulgating regulations, issuing waivers and exemptions to rules and regulations in response to citizen inquires, and advising the legislature.

SBOH has a professional staff of six, including an executive director and two health policy advisors. Its staff is assigned to certain projects termed as "priority projects" by the Board. One of these, which we shall explore in more detail below, focuses on strengthening ties with local boards of health.

Attitudes and Philosophy towards Communications

The emphasis that DOH places on communication is demonstrated most fundamentally in its Statement of Values. This, statement, which is posted on its web site, enshrines communication—communications that are "effective, responsive, and timely"--as one of its core values. The Statement reads as follows:

EMPLOYEES
We recognize that our employees are our most valuable resource; we trust them to be innovative; challenge existing processes; and make the best decisions.
DIVERSITY
We seek diversity in our employees and recognize the value diversity brings in understanding and serving the people of Washington State.
RESPECT
We value and respect our employees, partners, and people in the communities we serve.
TRUST
We value the public's trust and believe in a proactive and responsive public health system accountable to those we serve.
COMMUNICATION
We value effective, responsive, and timely communications and our role as a trusted source of health information.
TEAMWORK
We value working as a team with each other, local communities, and our partners in health.

The importance given to communication at DOH is more than lip service. Marie Flake was emphatic in noting that Secretary Mary Selecky, because of her work history at the local level, values and expects state-local communications. One way Ms. Selecky puts communication into practice is by visiting LHJs regularly. Ms. Flake said she travels to all thirty-nine LHJs in the state every year. In reviewing these itineraries, it is obvious that Ms. Selecky is interested in each health department as an individual entity, because her visits deal with local issues and involve local staff, local people, and local media.

A briefing for DOH's Assistant Secretaries shows that concern for "effective, responsive, and timely" communication penetrates below Secretary Selecky's level. This document, the text of an overhead presentation forwarded by Ms. Flake, is dated September 2003. It gives an overview of local-state operations and relationships and pressing issues and must have been used as talking points at the meetings where it was shared. What is notable throughout the briefing, however, is its respectful, relational, and communications-oriented emphasis and content. For instance, in the section "State and Local Partnership" the following statement is made:

"We cannot do our job without LHJs-nor can they do their job without us. We are mutually responsible for public health protection-and mutually accountable to the citizens we serve."

The theme of communications is further developed in the next section, "Implications for DOH", which encourages the assistant secretaries to…"listen…the local perspective is different" and to "communicate well, and with respect." They are reminded that "we are creating a system—through collaborative action, over time—with people." State and local workers are characterized as "in constant communication" through visits, phone calls, reports, and so on. The role of the local health liaisons and their workgroup-- which will be discussed in more detail below—to "facilitate communications" is noted. Lastly, under the section, "Some Emerging Issues", two of the issues highlighted are "intentional, integrated communications" and the "need for 'non-silo' approaches." Obviously, DOH's assistant secretaries have their marching orders: communicate with the LHJs!

SBOH makes communication a priority, too. This is evidenced by its "priority projects," areas of special study, policy formation, and guidance taken on by the Board and its staff on an ongoing basis. One of these is a relatively new project to strengthen ties with local boards of health. In December 2003, SBOH met jointly in SeaTac with the Seattle-King County Board of Health. In March 2004, it met with the Thurston County Board of Health. The Board continues, according to SBOH's website, "its long-standing practice of holding its regular meetings in various local health jurisdictions so it can meet with other local boards." To further increase contact with local boards, SBOH also sent letters to all local boards asking to visit. The SBOH website says, "A state board member and a staff member plan to attend some 18 local board of health meetings each year to hear about local priorities and concerns." Again, improving communication is an active, ongoing process for Washington State's public health leadership.

Communication Mechanisms: Liaisons and Local Health Jurisdiction Workgroup

"Effective, responsive, and timely" communications between DOH and LHJs are institutionalized through positions called Local Health Liaisons. The liaisons, who are DOH staff, report directly to the assistant secretaries and office directors in DOH's divisions and

offices, though not all divisions have a liaison. Marie Flake is one of these liaisons; she reports to Joan Brewster, who is Office Director of Public Health System Planning and Development.

The very existence of the liaisons' positions reflects DOH's commitment to growing and maintaining relationships with the LHJs. In reviewing the liaison's job description it is evident their *raison d'etre* is to be interactive, hands-on, out in the field, and communicate with public health stakeholders. The scope of Ms. Flake's job is broad, yet it is succinctly summed up in the "Position Objective Section": "manages relations between…DOH and 35…LHJs throughout the state. Responsible for improving and strengthening relationships between DOH and local public health leaders statewide." She does this through all types of media (written, electronic, and phone) visits, teaching, meetings, consultation, and policy analysis to/with LHJs, local officials, and state associations. She is the voice of the Secretary for the LHJs.

Along with other DOH staff, the liaisons take part in a second mechanism to improve communication, the Local Health Jurisdiction (LHJ) Workgroup. Its existence seems to be collective means for DOH staff to reach out, to understand local culture, to share ideas, and to provide expertise for all LHJs. From reading the groups' charter, it seems respect for and collaboration with the LHJs is viewed as paramount to accomplishing public health goals in Washington State: without LHJs' success, DOH-LHJ common initiatives come to naught.

Conclusion

From the secretary to the director and public health field staff in the LHJs, "effective, responsive, and timely communication" is practiced and prized in Washington State's public health system. The values that support communication, the people who practice it, and the mechanisms that foster it are not unique to that state: they can readily be duplicated elsewhere. Kentucky could easily emulate Washington State's example.

North Carolina: Restructuring Public Health

Background

North Carolina was recommended for us to study because they are close to us geographically and demographically. Their local health departments' structure is similar to Kentucky.
Eula Spears suggested that we contact Joy Reed. She works in the Local Technical Assistance and Training Branch of Women's and Children's Health. She has been very helpful and shares our interest in improving communication.

We have accessed the North Carolina Division of Public Health website at www.ncpublichhealth.com and found a wealth of information. This provided us with the history of the division as well as current happenings in their state.

An interesting link on the website was discovered. A task force was formed in 2003 to put together a plan to study public health in North Carolina. The charge was given from the Secretary of Health and Human Services to "strengthen North Carolina's public health system, improve the health status for North Carolinians, and eliminate health disparities." In January 2005, this task force submitted "The North Carolina Public Health Improvement Plan" to the

legislature. This is published on their website. The report is divided into two (2) sections: core infrastructure and core service gaps. Some of the issues that are addressed are:

* Establish an accreditation system for local/district health departments.
* Fund local health departments to assess and document community health needs through community partnerships.
* Fund increased technology capacity at the local level to collect, compile, analyze, and report essential public health data.
* Eliminate funding gaps in critical public health services (such as Title VI compliance and immunizations).

The interesting part is that this began with a group of people who attended the Public Health Leadership Institute at the University of North Carolina. Their project has evolved into a statewide effort to restructure the public health system.

Structures

Local

Joy Reed described the local health departments of North Carolina as "autonomous, locally controlled units." There are one hundred (100) counties in the state with eighty-five (85) health departments. Funding is through consolidated agreements with state and federal money tied to program-specific requirements.

The services provided at the local health departments are stated on an attached list. There are many similarities in our clinics and environmental programs. A sliding fee is charged for most visits. A significant difference is that North Carolina remains a Universal Vaccine State. No one under the age of eighteen (18) is charged for vaccines.

Environmental health was moved from the Department of Health and Human Services to the Department of Environmental and Natural Resources in 1989. The environmental programs and staff are still housed in the local health department buildings.

County Boards of Health

According to 130A-35 of the North Carolina statutes, county boards of health are the "policy-making, rule-making, and ad judicatory body for a county health department." The members are appointed by the county board of commissioners. There are eleven (11) members and are similar to Kentucky in their professional requirements. They are as follows:

*Licensed physician
*Licensed dentist
*Licensed optometrist
*Licensed veterinarian
*Registered nurse
*Professional engineer
*Licensed pharmacist
*County commissioner
*3 general representatives

These members generally serve for three (3) years.

State

The Division of Public Health is a part of the North Carolina Department of Health and Human Services. There have been several re-organization efforts since the 1970's. Today, the department is divided into twenty-four (24) divisions and offices.

The Division of Public Health and the Commission for Health Services are led by State Health Director, Leah Devlin. There are ten (10) committees that serve the division. Some of these are the Advisory Committee on Cancer Coordination and Control and the North Carolina Osteoporosis Task Force. Members of these committees make recommendations to the Commission for Health Services concerning their specific areas. According to the website, "the Commission for Health Services was created with the authority and duty to adopt rules to protect and promote public health and is authorized to adopt rules necessary to implement the public health programs administered by the department."

Attitudes and Philosophy Towards Communication

Joy Reed stated that at the state level, they have made significant strides in the past few years to improve communication. Section chiefs are mandated to work with local health departments on all issues.

The geography of the state, much like Kentucky, is a barrier to face-to-face communication. Travel is an issue because so much of the state is in rural areas. Some health department personnel must travel for four (4) hours to attend meetings. Realizing these problems, extra emphasis is being placed on technology for better communication.

Communication Systems

Joy Reed oversees a listserv of all local health department directors and section chiefs. All information comes through her office and out onto the listserv. The directors get their communication by e-mail. An advantage is that everything comes in the same format. A disadvantage is that some do not regularly check their e-mail.

Joy Reed also shared that she has staff available to help with local issues. When an employee from a health department calls with a question, they offer a one-stop shop for answers. The person, who takes the question, follows through until an answer is received. Her staff may not have the solution, but they assure that the question is addressed by an appropriate member of state staff.

The Public Health Training and Information Network have seven (7) sites across the state that can be attended by 100 – 150 people per location. There are eleven (11) smaller sites that are also accessible. Local health department staff is within thirty (30) minutes of any of these places in the entire state. This has been used for training and for information updates.

During the flu vaccine problems this year, every Thursday at 1:00 p.m. any health department could call in to a conference call for an update of the situation. This provided up-to-date information available. Conference calls were also used in 2004 for an e-coli outbreak that occurred at the state fair. The status of the situation was shared among many local health department personnel at the same time with opportunity for input.

The North Carolina Association of Local Health Directors is an active organization. All policy and funding changes that originate at the state level are sent to a committee from this group. Some changes cannot be modified, but communication starts here. They utilize their meetings for this purpose and also use conference calls. Most directors participate; however there have

been problems from a lack of participation at times. The section chiefs start with a committee from this organization with any announcements.

Accountability
Good communication is emphasized throughout the Division of Public Health. It seems to be acclimated into their culture. Admittedly, there are lapses in the system, but communication is a high priority. The importance is in every department and every area.

Conclusion
This study has provided some interesting insights into the North Carolina Division of Public Health. There are ideas that are worth pursuing from our neighboring state. The attitude of Joy Reed and her staff is a great contribution to their communication efforts in North Carolina.

Wisconsin: Partnership plan to improve the health of the public.

Background
The Wisconsin Department of Public Health is one (1) of nine (9) divisions of the Department of Health and Family Services. The DPH is lead by a State Health Officer (like KY's Commissioner of Public Health). Within DPH are five (5) Bureaus:

1. Health Information and Policy, which contains the communications department for DPH and LHDs, as well as all nursing functions;
2. Communicable Disease and Preparedness;
3. Community Health Promotion;
4. Local Health Support and Emergency Services; and,
5. Environmental and Occupational Health.

These five (5) bureaus within DPH are supported by the Office of Operations, which includes all fiscal support and budgeting. It is important to note that within the Bureau of Health Information and Policy there is a full-time Communications Coordinator.

The Wisconsin Department of Public Health operates five (5) Regional Public Health Offices, geographically located throughout the state. The purpose of each Regional Office is to link DPH to the LHDs.

The state of Wisconsin contains 72 counties, which are served by 74 local health departments; thus, some counties contain city and county health departments. Each local health department is governed by a nine (9) member Local Board of Health, which must contain at least one (1) registered nurse and one (1) physician.

LHDs participate in the administration of 32 various public health programs, ranging from public health preparedness to adult, child health, food safety, etc.

The Story

In 1998 the Wisconsin Department of Public Health began the formulation of a State Health Plan for the decade 2000-2010 as required of the Wisconsin Department of Health and Family Services by s.250.07 Wisconsin Statutes. This work utilized the tenants of the Turning Point Initiative. The Wisconsin Turning Point Initiative was a statewide policy and planning process to transform Wisconsin's public health system for the 21st Century. (Turning Point is a collaborative effort between government, the public, private, nonprofit, and voluntary sectors in partnership with Wisconsin residents. Through Turning Point, the public health system will be modernized and revitalized to address current and emerging 21st century health and environmental problems, concerns and issues.)

During the years 1998 - 2003 more than 1,000 public health leaders (DPH, LHDs, Local Boards of Health) and partners from throughout Wisconsin were involved in preparing the state health plan known as *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public* and its companion implementation plan known as *Healthiest Wisconsin 2010: An Implementation Plan to Improve the Health of the Public.* The State Health Plan includes:

- A definition of public health for Wisconsin to include what it is, what it does, what they want it to be, and how it should be structured;
- Identification of Wisconsin's top public health priorities and the resources and strategies necessary to protect and promote health for all, eliminate health disparities, and transform Wisconsin's public health system.

Turning Point also supported efforts and projects that included:

- Policy changes to support a sustainable transformation for the future;
- The implementation plan used as a companion document to the state health plan; and
- A report that addressed how Wisconsin's public health system should engage and sustain partnerships with special population groups and our communities of color in the transformation of the public health system.

It was determined that a Communications Plan was needed in order to appropriately implement Healthiest Wisconsin 2010 (HW2010). The individuals commissioned to lead this process made up a team called the "Communications and Accountability Workgroup". The Communications Plan was developed around the following statements:

> -A communications plan is the basis for making informed decisions and reinforcing the shared vision of the Plan.
> -A communications plan incorporates principles of science, collaboration, participation, strategic planning, quality assurance, and evaluation that guide public health partners as they set their objectives.
> -A communications plan helps measure the impact and effectiveness of the public health system workforce (agencies, organizations, and people) to work from a common understanding of a contemporary definition, principles, and practices of public health.

- A communications plan encourages greater consistency in the delivery and evaluation of community based health promotion because actions by the partners are guided by the transformational framework, logic models, and work plans (templates) contained in the implementation plan.

The recommendations offered by the Communication and Accountability Team assure proactive engagement by staff in the implementation of the State Health Plan as it relates to their individual job responsibilities and their roles as public health leaders.

These discussions resulted in identification of three specific goals:

GOAL #1, EDUCATION: Develop a working knowledge among DPH staff of the core public health functions, essential public health services, overarching goals, health priorities, and infrastructure priorities included in HW2010.

GOAL #2, INTEGRATION: Develop and integrate HW2010 goals relevant to DPH staff program responsibilities including resources to assist in the integration of HW 2010 goals into planning, implementation and evaluation of program activities.

GOAL #3, COMMUNICATION: Actively engage DPH staff and external partners in communication and dialogue about the HW2010 plan and have regular opportunities for discussion, review, reflection and assessment of HW2010 goals.

<u>Observations</u>
Obviously, this process was one of a grass-roots nature involving many stakeholders, which produces ownership and commitment to the final product. Margaret Schmelzer, RN, MS, State Health Plan and Public Health Policy Officer, indicated that Wisconsin has made much progress, but still has a tremendous amount of work to do. Developing the State Health Plan was a monumental task, but implementing it is the real chore. They have completed the first status report entitled HW2010 Annual Status Report, 2004. The purpose of the annual updates is to improve communication between and amongst DPH, LHDs, Local Boards of Health and the many community partners.

It is vital to note that whole idea of improving the health status of the citizens of Wisconsin is centered on communication.

Part of this review involved extracting information from various Wisconsin documents. These are available for further review.

Iowa: Trying Harder

<u>Background</u>
Iowa was selected as a state to research because of the personal familiarity and professional connections one of our team members had with that state, as well as the structural and local similarities its public health program share with Kentucky's. We first interviewed Kevin Teale, Communications Director, of the Iowa Department for Public Health's (IDPH) Office of

Communications and Public Information. In a telephone interview in August 2004, Mr. Teale shared background information on how Iowa's public health system is organized and how communications for the system are handled through his office. Chris Atchison, Associate Dean of the University of Iowa College of Public Health (CPH) and former Director of the IDPH, provided more information and observations. Mr. Atchison is a colleague of Dr. F. Douglas Scutchfield's; he was interviewed via email in February 2004. These answers were vetted by his colleague, Graham Dameron of the Iowa Association of Local Public Health Agencies (I-ALPHA.)

The website for the IDPH, http://www.idph.state.ia.us/ is a comprehensive source of information on public health in the state. Information from this site is incorporated in the body of this case study and noted in the reference section. Other websites consulted for this project, though not extensively used, were the sites for the Iowa Public Health Association (http://www.iowapha.org/), I-ALPHA (http://www.i-alpha.org/), and the CPH (http://www.public-health.uiowa.edu/).

Structure

Like Kentucky, health departments in Iowa are organized under county or city auspices. What is different from Kentucky is that public health services may be provided outside of a health department by other contractors. Graham Dameron and Chris Atchison sum up Iowa's local structure in these words:

Each of the 99 counties in Iowa has a Board of Health, and at least two cities have a Board of Health. County or city public health departments or public health nursing services operate under the auspices of their Board of Health. One county (Woodbury) has a District Health Department, which is combination of a city and county health department. Many counties and cities choose to provide public health services on a contractual basis, i.e. services are provided by contract between a Board of Health and (a) non-profit community agency (ies) such as a hospital, Visiting Nurse Association and\or a home health agency.

As Dameron and Atchison indicate in their answers, the menu of services offered by health departments or other contractors in Iowa is almost identical to what local health departments do in Kentucky. The only difference seems to be WIC, which is handled in Iowa by "regional community action programs" (analogous to Community Action in Kentucky counties, perhaps?) in most counties, and only by health departments in more populous counties.

Dameron and Atchison describe the ninety-nine county and two city Boards of Health (BOH) as follows:

Local Boards of Health operate as a local governmental entity empowered by the Chapter 137 of the Code of Iowa. Boards are required to meet quarterly, but the more active Boards meet monthly. County Boards of Health, with the exception of a District Board of Health, are comprised of five members who are appointed by the Board of Supervisors (Commissioners). One of the Board members must be a physician or D.O., but the other four members can be anyone in the county with any occupational title. Members of the City Council normally appointed themselves as members of the City Board of Health.

Local Boards of Supervisors (county officials) have little authority over BOHs in Iowa counties; they appoint BOH members, approve county funding, and approve BOH regulations. Their role

under the Iowa Administrative Code is to carry out the ten essential public health services and three core functions of assessment, policy development, and assurance.

Health department employees in Iowa health departments may join three professional organizations. One is the Iowa Public Health Association, an American Public Health Association affiliate, with sections in all public health disciplines. The second is the Iowa Association of Local Public Health Agencies (I-ALPHA), which claims membership of fifty agencies representing sixty-nine percent of Iowa's population. The third is the Iowa Environmental Health Association, or IEHA, a two hundred-member organization and affiliate of The National Environmental Health Association (NEHA) and the Iowa State Association of Counties (ISAC).

At the state level, IDPH was founded in 1924. IDPH articulates its purpose clearly in several statements on its website and in its five year *Strategic Plan*. Its vision is "Healthy Iowans living in a healthy environment", and its mission is "promoting and protecting the health of Iowans". It has a long list of core functions, including: child and adult protection, emergency management and domestic security and public health preparedness, health and support services, regulation and compliance, research, analysis, and information management, resource management. Finally, there are "guiding principles" for the Department. These are highlighted in bold font in the statement below:

We must be **leaders** in promoting and protecting the health of Iowans.

With a collective sense of **social justice**, our activities will reflect understanding and acceptance of **diversity** among Iowans. We encourage involvement in our activities by all Iowa **communities**.

We must strive to be agents for **change**, initiating activities, responding to emerging issues, and assuring the highest **quality** of services we can provide.

We will base our decision on accurate **data**, **collaborating** with organizations within and outside of government. We want to arrive at decisions, whenever possible, through **consensus**.

Finally—but perhaps most important—we must focus on our **customers**, the people of Iowa, individually and collectively, effecting **outcomes** that are clear improvements in their lives.

IDPH, like DPH, is part of a Cabinet in the executive branch of Iowa's state government, the Department of Health Services. It is headed by Director Mary Mincer Hansen, who holds a doctorate in nursing. Besides the Director's Office, there are five major divisions within IDPH: Acute Disease Prevention and Emergency Response; Behavioral Health and Professional Licensure; Environmental Health; Health Promotion and Chronic Disease Prevention; and Tobacco Use Prevention and Control. .

On a smaller scale, two distinctions stand out in IDPH's organization. These are not major functional ones at the division level, but they have no direct counterparts in DPH's structure. The first is the Office of Communications and Public Information, which is in the Director's Office. DPH has no corollary; that department depends on the Cabinet for Health and Family Service's Office of Communications for this function. Second, in the Division of Health Promotion and Chronic Disease Prevention can be found the Bureau of Local Public Health Services, which is

described on IDPH's website as "as liaison between the Iowa Department of Public Health (IDPH), local boards of health, and local public health providers for education, leadership and technical assistance on public health issues." No one department in DPH handles these functions; they are spread among the divisions. We will return to the role these two entities play in state-local communications later in this case study.

On the public health policy-making level, Iowa has its Iowa State Board of Health. Established under chapter 136 of the Code of Iowa, the State Board of Health has the powers and duties to adopt, promulgate, amend and repeal rules and regulations, and advises or makes recommendations to the governor, General Assembly, and the Director of IDPH on public health, hygiene, and sanitation. It has no authority over the local boards of health. The Board consists of five members learned in health disciplines and four members from the general public. The members are appointed by the governor of Iowa and serve three year staggered terms.

Besides the State Board of Health, another avenue for citizen and organizational input in public health policy is the Director's Public Health Advisory Committee (DPHAC). DPHAC provides leadership and guidance to IDPH's Director on public health issues in Iowa. DPHAC includes representation from local health departments who are nominated by boards of health and from a number public health community partners and organizations such as IEHA, the AFL-CIO, the Iowa Nurses Association, and the Iowa Hospital Association.

Attitudes and Philosophy towards Communications

Our research on IDPH's website did not yield a philosophical statement or guidelines on communications. The department's mission and vision statements and guiding principles do not allude to communications. However, the response from Atchison and Dameron to our query on communications does demonstrate that state-local communications, at least where public health issues have local impact, are valued, intentional, and reciprocal, if not always perfect. They state: "IDPH's intent, although not always successful, is to communicate as soon as possible with the local public health officials regarding any public health issue where it may have local impact. Local public health officials try to do the same. Local public health officials consult with appropriate State staff on a frequent basis." They characterize the state-local relationship as "symbiotic" and acknowledge that neither party can provide health services to Iowans without the other.

Atchison and Dameron say that there is accountability when state-local communications fail. They pragmatically point out these monetary and political consequences: "lack of communication will eventually lead to failing the requirements imposed by any State\Federal grant and the local public health can lose their funding source. The State is held accountable for it communication by its funding agencies (primarily CDC), the governor and the Legislature." On the positive side, they assert--though they do not substantiate this claim with measurable data--that communications has quantifiable results on Iowa's public health status. They write:

> There has been a measurable impact on health status of Iowans, but communication is only one important contributor to that success. Good communication is very vital to the successful planning, development, implementation and evaluation of programs, which directly impact the population's health status.

Communication Mechanisms: Office of Communications and Public Information: Consultants; and Meetings

Several mechanisms promote state-local communications in Iowa's public health system. One is the Office of Communications and Public Information, a four-person office that reports directly to IDPH's Director. Their mission is: "with our partners, to inform and educate the public and public health practitioners." Their work concentrates on media relations for health departments; several helpful Abode files on tips for dealing with the media and crisis communications are on their web page on IDPH's website. They also are a source of general information for Iowans on public health. The Office produces the *Annual Report* that IDPH does as a statutory mandate. Finally, they are a linkage for public health employees through the Iowa Health FOCUS Newsletter, which is similar to the old DPH *Local Health Link*.

Where the Office is most helpful in state-local communications is their function as a "one stop" for press releases and information on public health topics. Like their counterparts in CFHS' Office of Communications, this office takes the onus off local health departments to do this sort of professional media work. Where IDPH makes this more valuable, however, is positing this information, and other pertinent documents quickly on IDPH's website, which is updated daily. In early March 2005, for instance, one can find timely, pertinent information on flu vaccine and Iowa's ongoing pertussis outbreak, and a March 1st statement on the impact on President Bush's budget on IDPH. Numerous documents of interest to the public, such State Board of Health meeting minutes, the *Annual Reports*, Power Point presentations by Director Mary Mincer Hansen, the *Healthy Iowans 2010* report, and so on, can easily be accessed, both the past archived editions and the most recent ones.

A second way state-local communication is fostered is through the Bureau of Local Public Health Services. Part of the Division of Community Health Services, the Bureau was established in 2002. It serves as liaison between IDPH, local boards of health, and local public health providers for education, leadership and technical assistance on public health issues. Other priority services, as enumerated on IDPH website, are:

- Build and promote public health infrastructure by education, consultation, support and technical assistance for local boards of health.
- Build and promote public health infrastructure by education, consultation, support and technical assistance for public health systems.
- Provide leadership and partnerships internally and externally.
- Support a population-based approach to health issues within the Iowa Department of Public Health.
- Facilitate the application of continuous quality improvement methods.
- Promote professional development of technology and workforce development.
- Administer state funding to local boards of health and boards of supervisors for local public health services inclusive of public health nursing, home care aide, board of health infrastructure and tobacco settlement funds.

The Bureau's state-local links in the field in the state are its staff of community health consultants, who are assigned to several counties in each of the six regions that the state is divided into by the Bureau. Atchison and Dameron state that "regional public health consultants …are responsible for communicating with counties in their respective regions." From what the IDPH website says, the consultants are to provide technical expertise, consultation, and support

to local health departments and boards of health. They staff the Advisory Councils and hold quarterly regional meetings with the agencies in the counties for which they are responsible.

In fact, meetings are a major means of communication in Iowa's public health system. Atchison and Dameron report that the three public health associations have monthly or bimonthly meetings, and two of the organizations have state staff participation in their meetings. The Iowa Public Health Association has an annual meeting for all organizations; its Public Health Conference is similar to KPHA's annual convention. This conference, per Atchison and Dameron, affords "ample time for communication". Another statewide conference is Barn Raising V, the Governor's Conference on Public Health, which corresponds to DPH's Helen B. Fraiser Maternal and Child Health Conference.

Director Mary Mincer Hansen convenes and travels to meetings with local health department representatives across the state. According to Atchison and Dameron, she and her staff have held regional meetings and invited local public health agencies to attend over the past two years. She "frequently" visits individual counties for special occasions and attends the locally sponsored regional meetings. Apparently, Dr. Hansen "used to" meet with local health department directors after State Board of Health meetings; it is unclear from what Atchison and Dameron wrote whether she continues this practice or not.

As DPH has done through its Distance Learning Center, IDPH has entered the telecommunications age for meetings and trainings through its Iowan Communications Network (ICN). Not much detail on ICN applications is available on IDPH's website. Atchison and Dameron do mention the time and cost savings already realized by this medium, however.

Conclusions

Iowa may have its occasional failings in state-local communications—Atchison and Dameron acknowledge these—but it does have established mechanisms in place to keep the lines of communications open. Especially noteworthy are the Office of Communications and Public Information, the community health consultants out in the state, and the regular schedule of local and state meetings.

Survey Results:

After data compilation of the four identified state communication models, we surveyed local health department directors and representatives from the Department for Public Health.

Thirty three out of 56 (63%) health department directors completed the communication survey. Of the 33 responding, 28 directors felt overall communication was ineffective and inefficient. When questioned to identify the preferred communication methods, LHD directors prefer email when communicating with other directors, face to face communication with their Boards of Health, and email/telephone/face to face when dealing with the State Department for Public Health. Nineteen positive responses were received as examples of effective and efficient communication divisions within the Department for Public Health. Eighteen examples of barriers within the division of DPH were identified. The question was raised to identify ways to improve the current communication model for public health infrastructure and the team received 18 enlightened responses.

Eleven out of 31 (35%) Division Directors completed the communication survey. Seven out of eleven directors believed overall communication was ineffective and inefficient. As with the local health department directors, questions were raised as to the preferred communication methods. Division directors prefer face-to-face when dealing with LHD and DPH with email and telephone communication the second preferred method. Division directors were asked to identify LHD's who demonstrate effective and efficient communication. Nine comments were received. The Division Directors were also asked to identify LHD which demonstrate barriers to effective and efficient communication. Six responses were received. Lastly, the Division Directors listed ten examples of ways to improve the current communication model.

Suggestions for improvement from the LHD directors and division directors will be included with our final recommendations as well as ways to correct identified barriers

RECOMMENDATIONS

The four case studies discuss proven mechanisms and attitudes towards state-local communications in public health that work in other states. Kentucky should look to these states as role models and consider adopting what has worked best for them. What we have identified through our research and would recommend as "best practices" from these states include the following: (1) make effective, responsive and timely state-local communication a core value for Kentucky's public health system; (2) establish liaison positions at the local level on a regionalized basis or assigning these duties to a staff member in each division of the Department for Public Health; (3) improve electronic communications through better state website design and enhanced use of existing technology such as the Health Alert Network, TRAIN, and the Distance Learning Center.

We would note that none of our recommendations necessarily requires the expenditure of new funds. In this era of tight state and local budgets, this should be welcome news to state and local stakeholders. The attitudinal change we advocate costs nothing but the individual and institutional resolve to implement it and accountability through existing chains of command to insure it is followed. The liaison positions we recommend could be assigned to existing staff at the state or local levels. Thanks to the importance of emergency preparedness and the increase funding that goes along with it, electronic communications are already a priority in public health; we already have a good start there. Lack of sufficient funding should not be a major obstacle if there is the desire and determination in our public health system to make communications matter to us all.

CONCLUSIONS

Our Change Master Project, "Can You Hear Me Now" demonstrates the need for better communication between the Department for Public Health and Local Health Departments. The results of our survey precisely highlight our strengths and deficiencies and the varying perceptions of stakeholders. The best practices we found through our case studies give us concrete, practical ideas for improving communications among all parties.

With the rationale and tools for change identified and available, what is next? As we selected a corporate slogan for the name of our Change Master Team and project, we would suggest another advertising jingle to set our course for the future: "Just Do It." With the Department for Public Health involved in a strategic planning process, with new leadership in the Commissioner's Office and the division level, and with a new executive team at the Kentucky Health Department Association, we should take advantage of this providential timing and the eager, intelligent, and willing minds and hearts in our public health leadership. We believe the will is there to mend our broken communications infrastructure and replace it with a better one. We urge everyone: "Just Do It."

LEADERSHIP DEVELOPMENT OPPORTUNITIES

Renee Blair

Participating in the Kentucky Public Health Leadership Institute this past year has been a very rewarding, as well as tremendous, learning experience. Although I was skeptical in the beginning, this opportunity has greatly enhanced my efforts to improve upon my management skills. The quality interaction with others that share the same ideas and concerns about their health departments has been very enlightening. The instructors have been very instrumental in motivating me to refocus toward improving my leadership and communication abilities. The most rewarding experience this past year has been the opportunity to work with seven of the greatest health department directors across the state. Your enthusiasm and positive approach for improving our infrastructure has been an outstanding motivational tool for me. Thank you. I admire and respect each of you for your public health knowledge, perseverance and your tremendous integrity in your role as Public Health Director. I sincerely appreciate allowing me this opportunity. It has been an honor and privilege to be a part of this experience.

Dennis Chaney

I am thankful I decided to invest in my professional growth and development as a public health professional by participating this past year in the Kentucky Public Health Leadership Institute. There are two significant aspects of KPHLI of which I would like to reflect. The most gratifying aspect of KPHLI was the opportunity to watch all of us mature/grow as a group and as individuals. The ability of any group of individuals to cross geographical and agency boundaries, academic training, as well as age, gender and personal/professional interests greatly influence the success of any team. Thanks to the commitment to Cynthia Lamberth, I believe we received the necessary stimuli to "think outside the box", come together for a common cause, all in the name of public health. For myself, I realized we are all striving for the same ultimate goal, to improve the overall health status of the communities we serve. In doing so, we each brought our specific skill set to the proverbial table to make a difference. My hope is that each team within the KPHLI Class of 2005 will have the necessary support to implement their projects. The second aspect of KPHLI of which I would like to reflect is the opportunity to work with seven of the most consciences public health directors in the Commonwealth of Kentucky. You guys are the best. It has been an honor and privilege to get to know each of you beyond the work setting. I have tremendous respect for each of you. Together, as stewards of the tax dollars afforded us, we will make a difference!

Nancy Crewe

My year as a scholar with the Kentucky Public Health Leadership Institute (KPHLI) has afforded me with two significant leadership development opportunities. The first has been the opportunity to learn, interact, socialize, and grow with seven local health department directors. All are capable, committed, and caring individuals who are assets to public health in this state: I respect and appreciate each of them. Together, we pooled our expertise and talents to research and propose solutions for the state-local communications problem in Kentucky's public health system. Our final project reflects a synergy of talent and intellect that, individually, we might not have accomplished, and if our recommendations are implemented, they could have a great and positive impact on public health in Kentucky. What more could I—or my peers--hope to gain from KPHLI?

My second opportunity for learning development was a personal one. The discipline that KPHLI requires has nudged me back into academic pursuits. Getting into the habit of study had been my main motive for entering the program. My education since I left my second (unfinished) master's program more than a decade ago has been broad and eclectic, but unfocused. I wanted to buckle down and study after a long hiatus. While KPHLI lacks the rigor of graduate school, it did give me a taste of master's level preparation in public health. As I mull over and select from options for graduate school in the next couple of years, the habits and thought processes revived by KPHLI should help me succeed when I start structured learning again, for real.

Mark Hensley
KPHLI has been an unforgettable experience that I will look back upon many years to come. It has afforded me many opportunities to network with peers and discover new and different management techniques to ensure effective public health leadership. It has offered a forum to share ideas and concerns as it pertains to public health throughout the Commonwealth. Knowledge was gained both formally and informally in a variety of ways including classroom discussion and one on one interaction presenting different facets pertaining to public health. Personally, I would like to thank all 2004-2005 KPHLI Scholars for the camaraderie and the new friendships that will be continued for many years to come. I would especially like to thank my team members "CAN YOU HEAR ME NOW ?" for such a rewarding year. It has been an honor and pleasure to work with seven very high caliber Public Health Directors . THANKS. Finally I would like to close with the following thought…"*Management is doing things right; leadership is doing the right things."*~ Peter F. Drucker

Marcia Hodge
My KPHLI experience has been a great one. I have enjoyed the sessions and speakers. The assignments have made me think and have given me new insight. The textbooks, especially The Fifth Discipline, are also very good and I will use them over and over in the future. The best part of KPHLI has been working with my Change Master Project Team. We all come from very different backgrounds, yet we are very much alike. Getting to know them has been such a joy. In their own way, each team member has contributed to the success of our team. Sometimes in my daily work, I feel like the Lone Ranger, but not with this group. The privilege of knowing each one and sharing this project has been the highlight of my time in public health. I will always be grateful for this opportunity.

Paul Hopkins
Being a KPHLI scholar gave me the opportunity to gain the knowledge in becoming a more effective leader with which I could not have obtained otherwise. Working with my team members has been a rewarding personal and professional experience. The Leadership Summits were excellent both in their content and the professionals that presented each learning module. I hope that my leadership traits have been expanded and improved as a result of my participation in the institute.

Rosie Miklavcic
The Kentucky Public Health Leadership has been a very rewarding experience for me. After just spending 4 tough years completing my Masters in Public Health, I wasn't sure I was "up" for

more structured learning. But as in most situations I am faced with I gain a whole lot more that anticipated.
The most rewarding experience has been the opportunity to work with seven other directors. The process of sharing ideas and concerns about each others health departments and the friendships that have been developed or enhanced has been a true source of joy and comfort. I admire and respect them for their knowledge of public health but most of all for their enthusiasm and integrity for their role as director.
Through the speakers and instructors I have improved my leadership skills personally and professionally. I have found myself referring back to several of the articles shared and chapters in the *The Fifth Discipline* for information and support when struggling with a management decision or personnel conflict.
I want thank the Institute staff for all they have done to make this journey a very positive one for me. It is an honor to be considered a KPHLI scholar. To my teammates: I am proud that we tackled a daunting challenge. I believe others "can hear us now"!

Rebecca Tandy
I am deeply honored to have been given the opportunity to experience the Kentucky Public Health Leadership Institute (KPHLI). Initially, I was reluctant to enroll in KPHLI; however, after one of my nursing staff members shared with me the experience of KPHLI and knowledge she gained through it, I knew it was a must for this public health director. KPHLI was not what I had originally imagined it to be. It has been more than that. One of the highlights of this experience has been the opportunity to interact with several of the most highly motivated and caring individuals associated with public health in Kentucky. I am deeply humbled to have been given the opportunity to collaborate with seven outstanding directors on our project "Can You Hear Me Now?" Through KPHLI I have revisited some core values of leadership and accountability. Too often we are caught up in the moment without reflecting on our mission and goals, and how they relate to our clients. The opportunity to discuss these topics in relation to our individual organizations and public health as a whole has been a very enlightening and exhilarating experience. I look forward to the accomplishments of our class and future classes of KPHLI.

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