The Local Health Department

Chapter 6
PROGRAM MANAGEMENT

The local health director is always in the middle: on one side are the assorted government agencies issuing health objectives and political promises; on the other are the people to whom these services must be delivered. Typically, the scope of national proposals and objectives is larger than a single department can manage, while the community's needs exceed its budgetary resources. The director's job, then, is to translate the promises to a form relevant to the community and the department's capacity. Also, to use the budget for those programs that promise the greatest *measurable* benefit to the community.

The key here is "*measurable*." The elected officials who provide the resources to the department have to make choices among many worthwhile programs every year. Many of the programs city councils or boards of supervisors are asked to fund sound laudable. Immunization of children against measles (to prevent measles encephalitis or death) can be measured by a drop in new infections, and subsequent disease and death. On the other hand, a program to teach children about the consequences of tobacco use, while laudable may not have any useful measurement other than a survey that most communities cannot afford, although the state BRFSS for children is now able to give pretty good measurements.. there are few valid measurements of how many children experiment with tobacco use, or don't start its use, other than response to surveys such as BRFSS. Reduction in tooth decay following use of fluorides in public water supplies is measurable. Use of condoms among teenagers after sex education classes cannot be validated by objective measurements. Successful public health programs are usually associated with clear objectives and valid replicable measurements of results.

Similarly, nationally, it is one thing for a president to declare war on cancer and quite another for physicians and scientists to devise specific procedures and strategies to deal with the many different forms of malignancies that attack man, and to track the results of those efforts. Sweeping pronouncements are politically attractive. Voters enjoy hearing them and politicians enjoy making them, but that does not necessarily make them workable. It remains for the local health director to apply common sense in developing procedures and strategies that might work locally and then track their results.

Politics and health

The health director is not a pure scientist and somehow above politics. To function, he/she must be aware of political realities, of competing interests, programs and agendas in pursuit of the same approvals, votes and appropriations. The health director's best ally in that competition, however, is science. When a health director can demonstrate positive results with precision, it is easier to win approval for programs.

As the person responsible for the care of individuals, a local health director is in the best position to measure the effects of programs on people: to do the data gathering and thus to know what is really going on in the community. Paradoxically, some measurable successes of public health make it more, not less, difficult to convince voters and governmental agencies to continue their support. Fluoridation and other programs aimed at protecting the teeth of children have been so successful in the United States that the bulk of dental care has shifted to the middle aged and older. Children, in general, no longer have great numbers of cavities, except for those overindulging in carbohydrates and getting caries. People under 50 have not seen iron lungs used to treat poliomyelitis patients, mental retardation from mumps or measles encephalitis, post-measles deafness and blindness or deaths from measles, diphtheria, and mumps. Most people do not realize that diseases which were common in the

recent past are not "conquered" but merely held in check by routine public health measures, and that in the absence of these measures they can still be serious and life threatening.

Political challenges are by no means restricted to those of office holders; popular movements, with their penchant for confrontational tactics, can damage the credibility of any agency by simply capturing the attention of the media. A shouted slogan is a more dramatic "sound bite" than a reasoned response, as well as more memorable. Because many genuine public concerns are founded on poor science their value is often misunderstood. It is the health director's responsibility to provide a scientific base for public issues that will lead to a solution, if they are genuine, or to their dismissal if not. If politically astute, the director will work quietly to gather hard data and only then use the media to enlighten the public about issues engineered by others to fulfill some particular agenda. For example, there has been public outcry about the 'terrible side-effects of giving DTP vaccines' by small groups of vocal parents whose children had neurological problems temporally associated with use of the vaccine. It is only after the outcry, after lawsuits charging malpractice, and after congress has enacted laws to compensate parents that enough hard scientific data has been accumulated to show that most, if not all, of these events did not have a genesis in administration of DTP vaccines. A current hot potato in 2007 is the requirement that girls, not boys, by required to accept HPV vaccination. Data from a national study suggests that about one in four U.S. females between the ages of 14 and 59 years may have the sexually transmitted infection HPV (JAMA. 2007;297:876-878)

Changing health and political realities

The standards that percolate down from the national level may be somewhat distant from local reality. *Promoting Health--Preventing Disease: Objectives for the Nation (1990 Objectives)*, published by the U.S. Department of Health and Human Services in 1980, proposed goals to be achieved by 1990. The next such set of objectives, published in the summer of 1990, set goals for the year 2000. This was succeeded by the next 10 plan – Healthy People 2000, and then by the current Healthy People 2010 plan. 10 years may be too long a period for such health planning and objective setting, even at the national level. Changes in medical care, whether in disease occurrence or new technologies, can change the perspective on resource allocation rapidly. AIDS, for example, was not even mentioned in the 1980 objectives--it was then unknown. The political situation may also change. In Texas in 1980, for instance, no one could foresee the oil recession of the mid-decade that would hobble the state's programs generally. In the last 5 years we have had to deal with SARS and a potential Flu Pandemic. It remains for the local health director not only to sort out and apply the objectives that work for his jurisdiction, but also to gather data to refine future sets of objectives. Though 10 years may be too long a unit of time for health planning, any planning is better than none at all, and as the shared information improves, so will the goals themselves. Part of the cost of planning is that of carrying out surveys to measure health status, and people’s behaviors and perceptions. The Public Health community must be more effective in helping legislators understand the value of such surveys, or health planning will continue to be out of step with the real world. Often data is out of date by the time it is published, due to poor methods used to aggregate data once gathered.

Adding to the complexity of dealing with various goals and the demands of various action groups (activists by cause) is the sheer number of responsibilities that have been imposed upon health departments. Besides gathering data and setting local objectives, the typical local health department is charged with overseeing clinical services to mothers, children and the indigent for primary care, genetic diseases and terminal illnesses. It is expected to develop and implement programs of general health for the public and to guard against the spread of infectious diseases. Local health departments are also regulatory agencies, licensing food handlers and septic tank sites, monitoring air and water quality, and dealing with occupational hazards. They often operate programs for particular conditions, such as hypertension. While this list is far from complete, it gives some notion of the scope of health department programs to be conducted with finite resources.

Programs and Data.

If politics is the art of the possible, the local health director must be a consummate artist. As I have suggested, information is the medium of this art form. With good data, health directors know which national standards are applicable to their communities, what programs save their communities money and people disability, what issues need attention, and what their departments must do to stay ahead of demands.

Data come from many sources;-physicians, hospitals, staff inspectors, school health nurses and other governmental agencies. The data need to be processed into a single, comprehensive body to be useful. Fortunately, computerized databases make it possible to receive and process a vast amount of information while potentially eliminating duplication of effort. Once a piece of data is captured electronically, it should never necessary to capture it again for storage in a centrally located database. This database should be accessible, through networks or through the Internet. (The Bioterrorism concerns are starting to drive database development in public health.) Staff at program sites should be able to enter new information about individuals and retrieve information about known patients already on file. The person registering a patient for an immunization program should be able to update a patient's clinical history electronically. Timely information helps prevent patients from being given an incorrect vaccine. As an additional benefit, the system can print out vaccination certificates during each clinic visit. Simultaneously, the system records such details as the vaccine manufacturer, date of production, lot number, and the name of the person administering the vaccine. Current data f0orm the American Academy of Family Physicians shows that less than 20% of physicians are using an electronic clinical database in their practices.

Families in most communities may have members living in the same household who visit more than one doctor, clinic or agency, and more than one family member may be visiting each agency, or participating in all the programs of one agency. As different agencies may also deliver services to a single household, the degree of overlap in both directions can be surprising. Not infrequently, the household members themselves get confused about who is looking after whom, and staff members can become entangled in the different eligibility requirements of the various programs, even within the same agency. Fortunately, nearly all agencies require similar financial data before determining the programs for which clients are eligible, and this, at least, may be shared between them all.

Information sharing

While public health information may not be made public, there is rarely any reason to withhold it from the various agencies with legitimate interests in the families they serve jointly. A community can and should decide which data, although confidential, should be available on a need-to-know basis to human service agencies funded and functioning within a single jurisdiction. Modern management techniques, using computerized databases, can provide information and restrict access to it, can ensure that essential services are provided with limited staffs and with far less paperwork. In this way, basic demographic data can be exchanged among health, welfare, mental health, education, rehabilitation and possibly charitable agencies. All agency staff needs to know such things as the names of family members, location of households and program identifiers such as departmental registration numbers. Whichever agency first contacts the eligible person should collect this data, and once that person is entered into the database by the first human service agency approached, there is no need to re-interview the person at the succeeding agencies. By developing a team of human service eligibility supervisors who can work together to determine data needs, communities can further maximize the efficiencies computers make possible. Under their guidance, individual agencies can identify the types of data each needs and can work together to install a common human services database, with the agency requiring the greatest amount of data keeping the permanent record. When clients move from one agency to another for primary services, protocols for stripping out the information not needed about them by the new agency are applied and the data are shared electronically. The eligibility system

supervisors make eligibility decisions automatically available to any other agency to which a client is referred within the system, or to which the client goes independently.

Automated procedures not only perform a system eligibility function, but act as a referral mechanism to other agencies. A woman bringing in small children to be immunized, for instance, would be tagged electronically as eligible for WIC (a program providing supplemental food to pregnant women and young children), food stamps, and additional social services. Procedures for developing such interdepartmental data systems are discussed in another lecture.

Because medical data should be kept indefinitely it is good practice, in today's litigious environment, to store it on a hard disk or CD and make daily backup copies kept at 2-3 different sites simultaneously. Computers can make backups relatively easily, generating hard copy files required for audits while placing electronic copies of the records into permanent (archived) files on media such as magnetic tape or, increasingly today, compact disks. Data system improvements are among the most important advances in public health in the past twenty years. They allow us to track patients, analyze diseases, and evaluate the effectiveness and efficiency of our programs quickly and accurately. It is too bad so few departments use them.

Health Education

If information is the medium of the health director's art, education is its message. Ordinary people who are well informed are quite capable of making intelligent decisions about their priorities while people who are ill informed tend to make poor ones. It is in everyone's best interest to be well informed, particularly in democratically governed communities.

It is seductively easy to rationalize the department's staff spending all their time in direct patient service rather than any in community education. Given the number of responsibilities a typical health department has, there is always a sense of urgency about getting on with the job or jobs at hand. Still, without community support a health department becomes moribund, and a department very busy doing things that are not well understood outside its offices can quickly lose community support. Particularly when the things it does are perceived as intrusive, painful and/or expensive, the health department may find itself cast in the role of adversary in times of confrontation by special interest groups.

On the other hand, when people generally understand what the department is doing and the principles underlying its programs, their support tends to be very strong indeed. Maintaining staff morale, funding continuing education, and obtaining additional staff all becomes much easier with such support, and the general health of the community improves. We should always devote a proportion of staff time to an effort to make people aware of programs and what they mean. Such activity pays off very time.

Communities that understand their health departments do not see them as an adversary or "just another bureaucracy". When there is an outbreak of disease, the health department is looked to for help rather than castigated for allowing it to happen. When infant death rates fail to drop, the community might ask what help it could give. During disagreements, especially when the federal or state government has made a policy announcement about health, the department's staff are often the nearest civil servants within reach. When trust and understanding have been built and maintained, channels of communication remain open.

It is hard to measure the impact of efforts to educate the public and governmental officials, yet health departments, which make such efforts, prosper. In bad times, they seem to have the fewest cuts in personnel and programs of all community departments, and in good times their proposals tend to receive support. Because they address chronic needs, health departments rarely have first claim on community funds. More acute problems, like crumbling

sewer systems, potholed roads or overcrowded schools are often first in line. But when tendency for neglected chronic problems to fulminate into acute ones is properly understood, health departments are not placed at the end of the line, either. It takes constant care to keep the public informed, but such public relations are as much a function of a successful agency as the clinical or environmental programs it operates. If the health department's services benefit the public, then it will be expected to continue providing them.

Public relations efforts take many forms at many levels. As a local health director, I sat on infection control and utilization review committees of local hospitals and met at least annually with the boards of directors of those hospitals. Being known personally to the medical community and making my views known to them was a necessary step in building my department's credibility and increasing the community's receptivity to my ideas. For example, because my staff and I met with the cancer society and hospital medical staffs we could link evaluation and treatment of women together when we found positive pap smears in our clinics. We worked closely with the local children's hospital and were able to refer poor children to their specialty services by facilitating reimbursement from the state as well as enhancing pediatric residency training with hospital medical staff and residents working in our child health programs.

When good data is available it is possible to be more active in community education as opposed to working quietly to gather data when little is available. For instance one can help the community understand and accept immunization programs better by meeting with community groups such as PTA, junior league, and churches. Staff can write informational releases for newspapers, radio and TV, and work to get them in print or on the air. When dealing with more emotionally charged issues such as family planning, it is possible to work closely with such diverse groups as ministers from various faiths as well as advocates like Planned Parenthood. Additionally, the department's staff--nursing, environmental and support, can make a personal effort to educate friends, neighbors, their church congregations, and social groups. Because the newspaper owner and the senior staff of the local television and radio stations understood and supported the family planning program, they ran frequent notices and public service announcements in both English and Spanish.

Most of the funding battles for maternal and child health and immunization programs are won by ad hoc boards, appointed by the city and county officials. These are often composed of people from the school superintendent's office, educators, ministers, physicians, dentists, hospital auxiliaries, and persons from charitable agencies. Such boards should meet with the department staff regularly, tour the facilities, review all plans, help develop and critique policy, review annual program achievements and present the results to the relevant city and county boards. Invariably, they push for additional resources.

Finally, health department web sites need to be proactively engaged in helping people live healthy lifestyles with links to information.

Dealing with sensitive topics

Sexually transmitted diseases (STDs) are certainly an area of public health concern, yet one that poses difficulties. Many health departments handle STD information poorly because directors are often afraid of offending elected officials. Yet it is the diseases, rather than their transmission, that ought to be the focus. It is possible, proper and necessary to discuss these diseases epidemiologically without steamy details. The long term effects of Syphilis, Gonorrhea, Chlamydia and pelvic inflammatory disease upon the population most at risk--young men and women--as well as the community's share of the consequences are tied to the health department's role in preventing them, by providing information people need to know. STDs are probably spread more by ignorance than any other type of disease, and that ignorance can be fought in schools, churches, recreation centers and the media without offense so long as care is taken to confine the discussion to the disease and its transmission rather than focusing on issues such as homosexual rights.

Recently, many city and state public health departments have improved their credibility by dealing with the HIV epidemic as a disease, using prior models for controlling tuberculosis and syphilis, rather than focusing attention on political actions, or trying to change individual morals. Coming to understand the disease and the needs of the patients has given us a new opportunity to plan the use of scarce resources, to integrate programs and to tell the public health story. Health departments emphasize education of both the general public and the medical profession about the limited ways in which the disease could be transmitted as well as use of condoms to prevent transmission of the virus in seminal fluids. They have continued motivating the public to be calm when faced with a new disease, as well as helping the media to provide useful medical information to the public.

Formulating health standards

The local health director is charged with developing and implementing local health goals and objectives for the various programs under his control. These should not conflict with state and national ones. However, not all national or even all state goals may be applicable to the situation the director or program manager faces. Goals for black lung disease, for instance, are useful only in jurisdictions containing coal mines. Particular demographics often dictate focusing attention on selected segments of the population rather than others. Some goals are more appropriately addressed by other agencies, such as environment or housing.

Model Standards

The current national health guidelines were initiated as P. L. 95-83, the Health Services Extension Act of 1977, which called for standards to "identify populations in need of preventive or protective health services," to "establish model standards with respect to preventive health services in communities," and to "maintain community-oriented preventive health programs." A work group composed of representatives from the Centers for Disease Control, the Association of State and Territorial Health Officials, the National Association of County Health Officials, the U.S. Conference of City Health Officers and the American Public Health Association had seen the need for such standards, worked for the passage of the law and subsequently produced *Model Standards for Community Preventive Health Services* (Model Standards) in August, 1979 (Second Edition, 1985). Providing wide scope for maximum local flexibility in application, Model Standards covered 28 program areas, a number the developers admit is by no means exhaustive of public health concerns. The preventive services directly mandated by the Act include:

> Air quality; chronic disease control; communicable disease control; dental health; emergency medical services; family planning; food protection; genetic disease control; health education; home health services; housing services; injury control; institutional services; maternal and child health; noise control; nutritional services; occupational health; primary care; public health laboratory; radiological health; safe drinking water; sanitation; school health; solid waste management; surveillance/epidemiology; vector and animal control; and wastewater management.

The Model Standards defined "focus", "objectives", "indicators" and "population in need" in a tabular format for each of the twenty eight program areas, to help the user analyze a community's needs in a step-by-step fashion. Two types of standards, process and outcome, are presented under the "objectives" and clearly labeled there. A process standard is a proposed activity, such as

> "by 20__ the community will have access to a voluntary program of genetic services," which may or may not be achieved but is a statement too general for any rigorous measurements of progress to be made.

> An outcome standard must be measurable. It specifies performance in terms of quantities, as in "by 20__ the number of unwanted pregnancies will represent less than __ percent of all pregnancies."

The blanks are deliberate: Model Standards is designed to provide models for the widest possible range of conditions. Target dates must be in conformity with the locality's political cycle, and proposed rates must be within a reasonable range of the local current baseline to be achievable.

Ideally, *all* objectives should be of the measurable 'outcome' type, but this is not always possible. When setting goals, the health director may not have sufficiently detailed data to yield specific targets and therefore must compromise, setting outcome objectives when possible and process objectives otherwise. Always, however, data gathered during the course of each program should lead to refined measurements of its effects, and a proportionately greater use of outcome objectives in the future. *This material has been replaced by "Guidelines for Community Preventive Services"* The new material focuses on evidence-based decisions. Additional information is available at the National Public Health Performance Standards web site.

1990 Objectives

While the Model Standards were being proposed, the then U.S. Department of Health, Education and Welfare (now the U.S. Department of Health and Human Services) issued *1990 Objectives*, under the same Public Law as well as under P.L. 93-641, Section 1501, calling for national health planning goals,. Published in 1979 to set broad goals for the decade ending in 1990, this document focuses on the 15 priority areas identified by the 1979 Surgeon General's Report, *Healthy People*. These were:

> High blood pressure control; family planning; pregnancy and infant health; immunization; sexually transmitted diseases; toxic agent control; occupational safety and health; accident prevention and injury control; fluoridation and dental health; surveillance and control of infectious diseases; smoking and health; misuse of alcohol and drugs; physical fitness and exercise; and control of stress and violent behavior.

As might be suspected from their emphasis in the Surgeon General's Report, these areas are more condition-oriented, while those of the Model Standards are more administratively oriented. The overlap between the two is considerable though not immediately apparent. The 1990 Objectives' areas of alcohol, tobacco, hypertension and fitness, for instance, are included under "chronic disease control" in Model Standards, while the second edition of Model Standards (1985) elevates several such conditions to "area" status. Another major difference found when one first looks at the Model Standards is that the discussion starts with goals rather than objectives. The goals are broad statements of desired progress. You have to read into the text of the specific standards before you come to objectives, either outcome or process, that are comparable to the 1990 Objectives.

In a narrative format the 1990 Objectives devotes a separate chapter to each area it considers. Each chapter defines the nature and extent of its problem, details prevention/promotion measures, lists specific objectives for 1990, gives the principal assumptions upon which its objectives are based and concludes with its data sources. The objectives are outcome based and provide specific figures from the most recent year for which data were available, for example:

> c: By 1990, the cirrhosis mortality rate should be reduced to 12 per 100,000 per year. (In 1978, the rate was 13.8 per 100,000 per year.)

d: By 1990, the incidence of infants born with the Fetal Alcohol Syndrome should be reduced by 25 percent. (In 1977. the rate was 1 per 2,000 live births, or approximately 1,650 cases.) --1990 Objectives, p. 70

Thus, not only is the goal presented, but also its relationship to the real-world conditions at the time of its establishment is made clear.

The 1990 Objectives were followed by the first 'Healthy People – 2000'. It provided a general assessment of how well the first set of goals had been fulfilled, as well as an expansion of areas representing new health challenges (including AIDS and neonatal addiction). This has now been superseded by Healthy People 2010 (March of 2000) although the format is almost identical to the 1990 guides shown above.

Applying the Objectives.

Texas, Virginia and other states and localities used Healthy People 2000 to derive state & local goals from these national agenda. The approaches used by these two states to develop their objectives were very different. In Texas, a steering council of 30 members, representing government, private health professionals and businesses, assisted by an advisory committee of program specialists from the state agency, used a modified version (one that better reflected the needs of Texas) of the national objectives to formulate their own set. In Virginia, a "Health Congress" was formed of members from state agencies, local health departments, voluntary non-profit agencies, health care providers, educators and the state legislature. After several days of intense effort, this group identified the major health priorities of concern within the state. Afterwards, local departments, with these priorities in mind, compiled their own objectives based on the Model Standards and their own knowledge of local health needs, met and unmet. In a "bottom upwards" process, these local objectives were then consolidated into regional objectives and the regional objectives into objectives for the state.

Although the final Virginia objectives were developed four years later they were similar to those from Texas. They included all the areas covered by 1990 Objectives, plus additional programs important to Virginia. The outcomes from these two very different approaches were essentially the same, yet both plans contained state-specific elements, and the process of formulating them helped all the participants to improve their understanding of their respective states.

All have been updated through the Healthy People 2000 and Healthy People 2010 iterations.

The next three essays will demonstrate the mechanics of making local health programs work in the areas of disease control, disease prevention and clinical services. The specific topics are selected to provide the reader with examples of program goals and objectives selected from the Healthy People documents. The selected goals and objectives are used to describe methods to combine local health department resources with those of other public, private and non-profit health care and human service agencies to provide effective and efficient programs of service to the community. The selected objectives are ones that have been used in different places at different times. over the last twenty years. The techniques used to attain these objectives are aimed to help readers understand the value of the objectives. These techniques can be applied to the myriad other objectives found in 'Healthy People'. The Model Standards had excellent examples of the goal statements. Both the original goals and objectives have been increased in breadth and depth in the 'Healthy People 2000 and 2010.' They will be narrowed with the advent of the'Guideline for Community Preventive Services' in 2001. Unfortunately few of these goals have been, or are likely to met, as they have been driven more by activism than science.

When reading next three essays remember that goals reflect broad areas of national policy that may seem utopian for local health departments. These are emphasized to remind you that the local department must modify these goals to reflect local long-range goals. It will also be necessary to revise the objectives, which in both documents are national objectives, to reflect local conditions. In some communities the local objectives may already surpass national goals, but still not be satisfactory to that community. In others, the national objectives may be too ambitious for a locality. When reviewing the material in the next three chapters you will find it helps to keep the 'Healthy People' documents available.

Recommended Reading:

1. Goldsmith S and Eggers WD. Governing by Network, Chapter 7
2. Fallon LF & Zgodzinzki EJ. Public Health Management, Chapter 8
3. Healthy People 2010
4. Healthy People 2000
5. Public Health in the 21st Century, IOM 2003
6. NACCHO Model Practices Program
7. The Future of Public Health, Washington DC, National Academy Press, 1988
8. The 1990 Health Objectives for the Nation: Midcourse Review. US Dept of Health and Human Services, 1986.
9. Fein R: Medical Care Medical Costs. Cambridge, Harvard University Press, 1986
10. Anderson C.. L.: Community Health. ed 2, St Louis, The C.V. Mosby Co, 1973
11. Peterson P. Q. (Ed): Community Health Services. Washington DC, International City Managers' Association, 1968
12. Promoting Health, Preventing Disease-Objectives for the Nation. US Dept of Health, Education, and Welfare, 1980.
13. Coe R. M, & Pepper M: Community Medicine, Some New Perspectives. New York, The McGraw Hill Book Co, 1978
14. Model Standards-Guide to Community Preventive Health Services. Ed 2, American Public Health Association, 1986
15. Public Health and Preventive Medicine. ed 13, Last J. M. (ed), Norwalk, Appleton-Century-Crofts, 1992
16. Miller CA, Moos M-K: Fifteen Health Departments. Washington DC, American Public Health Association, 1981