MPHA
IMPACT
newsletter......
MICHIGAN PUBLIC HEALTH ASSOCIATION
Fall 2011

President's Message

During the APHA Presidents-Elect meeting in June, I heard familiar themes from my colleagues around the country. Public health professionals and departments everywhere are being asked to do more with less and at a time of increasing pressure to reduce or eliminate government programs and services. However, we are still expected to ensure that our communities have safe food to eat, clean water to drink, and clean air to breatheall the while protecting our communities from outbreaks of infectious diseases and preparing for the disasters that may come our way.

The Michigan Public Health Association has been working to figure out how to do more for our members with decreasing resources. We were thrilled to be part of the APHA Affiliate Capacity Building grant as a member of the Great Lakes Coalition. The additional funding made available through this grant has allowed us to make improvements and additions to our organization. This includes an updated website (www.mipha.org), featuring an improved "Members Only" section with new features, such as allowing members to renew online using PayPal. Also, we have activated our Student Section, which is being led by Ranelle Brew. We have also increased our support of professional development activities, including two advocacy sessions which were offered in 2009 and ongoing support of Michigan's Premier Public Health Conference.

We continue to work with our public health partners to support and promote public health activities around the state. This includes the Annual Conference and Public Health Week, which are both described in more detail in this newsletter. We continue to strive to provide our members with the information the need to continue as leaders in public health through this newsletter and the Michigan Journal of Public Health. In this edition of the newsletter, we have two articles on national public health accreditation and an upcoming edition of the MJPH will be a special issue on community-based participatory research in public health settings.

I am excited about the next two years and the opportunity to serve you as President of MPHA. Our membership includes public health professionals with a wide range of expertise and experience which can be shared among each other. I hope that you will each take advantage of opportunities to become more involved with MPHA, whether by volunteering for a committee, writing for one of our publications, or serving as a mentor to a student member. I look forward to learning more from all of you and engaging you as we seek to continue to do more with less.

Submitted by
Molly E. Polverento, MS, President, MPHA

Upcoming Events

APHA 139th Annual Meeting and Exposition
October 29 – November 2, 2011
Washington, DC
http://www.apha.org/meetings/AnnualMeeting/

2011 MDCH Fall Regional Immunization Conference
November 1, 2011
Bay City, MI
http://register2011.mihealth.org/

2011 MDCH Fall Regional Immunization Conference
November 2, 2011
Troy, MI
http://register2011.mihealth.org/

2011 MDCH Fall Regional Immunization Conference
November 9, 2011
Kalamazoo, MI
http://register2011.mihealth.org/

Michigan Cancer Consortium
November 9, 2011
Lansing, MI
http://www.michigancancer.org/WhatWeDo/AnnualMeetings.cfm

2011 MDCH Fall Regional Immunization Conference
November 10, 2011
Grand Rapids, MI
http://register2011.mihealth.org/

2012 National STD Prevention Conference
March 12-15, 2012
Minneapolis, MN
http://www.cdc.gov/stdconference

Early Hearing Detection and Intervention Conference
March 23, 2012
Lansing, MI
https://events.mphi.org

Michigan Environmental Health Association Annual Education Conference
March 28-30, 2012
Kalamazoo, MI
http://www.meha.net/

2012 Michigan Epidemiology Conference
March 30, 2012
MSU Union – East Lansing, MI

2012 Michigan Premier Public Health Conference
October 16-17, 2012
Ann Arbor/Ypsilanti Marriott at EagleCrest
https://events.mphi.org

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About MPHA

Advocating Public Health since 1919

The Michigan Affiliate for the American Public Health Association since 1921

What is MPHA?

MPHA is an interdisciplinary society of health professionals and other citizens who are concerned about problems and issues affecting public health in Michigan. People from all walks of life share these concerns and are welcomed as members.

What is the purpose of MPHA?

- To promote public health in Michigan through education and advocacy.
- To conduct, or sponsor with others, research in public health and allied fields
- To disseminate information concerning developments in public health

What MPHA can provide for YOU?

- A forum for public health issues
- Input on priority issues selected each year by the membership
- Professional conferences
- Review of legislation and its impact
- Career development opportunities
- Leadership development
- Recognition and awards
- Affiliation with the American Public Health Association
- Peer-reviewed MJPH
- Camaraderie, collegiality, and fellowship

What YOU can provide MPHA?

- Help to develop goals and objectives for addressing public health issues through committees, divisions, task forces, or the Board of Directors
- Develop MPHA policies as a member of the Public Policy and/or Legislation Committees
- Participate in leadership within your professional group -- MPHA Divisions
- Serve on MPHA committees such as Awards, Membership, Program, Newsletter, etc.
- Plan, attend, interact, and assist with MPHA conference and seminars

If you are interested in joining MPHA, please visit http://www.mipha.org/join-renew.php

National Public Health Accreditation: A Catalyst for Quality Improvement

On September 14, 2011, the Public Health Accreditation Board (PHAB) launched the first national accreditation program for public health departments. Public health practitioners in the State of Michigan are well aware of accreditation activities since Michigan launched the nation's first state-wide accreditation program in 1998. As health departments in Michigan grapple with the idea of adding national accreditation to a plate that is already overflowing with mandated tasks performed by fewer and fewer employees, it is important to understand the basics of this new program. This article strives to briefly explain the differences between the two programs and discuss some of the potential benefits of national accreditation for health departments in Michigan.

One of the main differences between the programs is that the national accreditation program is voluntary, where as the state-wide accreditation is mandated. As a voluntary program, national accreditation requires health departments to complete certain pre-requisites before an application is submitted; a community health assessment, a community health improvement plan, and a department strategic plan. These items must be submitted at the time of application and must have been updated within the previous five years. PHAB also requires the completion of an on-line orientation to national accreditation by the health department director and staff person responsible for overseeing the application and accreditation process. It is recommended that this orientation be completed prior to beginning the application process.

The goal of each accreditation program is to improve the quality of public health departments. Despite this common goal, the two programs differ in the make-up and organization of the standards upon which health departments are evaluated. The Michigan accreditation program evaluates 12 health department services (e.g. Food Service, Immunization, etc.) that are organized into three categories (Administrative Capacity, Local Public Health Operations, and Categorical Grant-Funded Services). The Michigan accreditation standards are based on minimum program requirements (MPRs) specific to these public health services. MPRs set the standards for program compliance and LHDs are accredited based on their ability to meet these standards.

Similar to the state's system, national accreditation has a list of standards that set a required level of achievement that a health department is expected to meet. The national program has organized these standards into 12 domains that pertain to a broad group of public health services. Instead of being linked to specific programs as in the state model, the first 10 domains are very closely linked to the 10 Essential Public Health Services (Figure 1) and cross all public health programs. Domain 11 addresses management and administration and Domain 12 addresses the governing entity to which the health department is accountable (i.e. county government). National accreditation devotes an entire domain to performance management and quality improvement (domain 9) whereas Michigan accreditation includes an optional quality improvement supplement in the Powers and Duties section of cycle 4.

The national accreditation program also differs from the state's with regard to accreditation cycles and cost. Health departments who

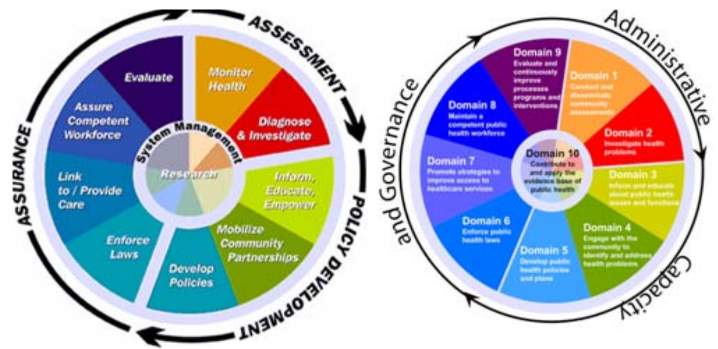

Figure 1: Relationship Between National Accreditation Standards and 10 Essential Public Health Services

successfully meet the standards of national accreditation will be accredited for 5 years, compared to 3 years for those meeting state accreditation standards. Although PHAB is a non-profit organization, they require funds for accreditation activities such as documentation review and site-visits. To support these activities, PHAB charges an application fee that is based on the size of the jurisdictional population served by the health department. The total fee for health departments serving less than 50,000 people is $12,720. The total fee for serving a population of 5-15 million people (such as the Michigan Department of Community Health) is $79,500. The fee can be paid over a five year period that corresponds with the accreditation cycle.

The application fee and staff involvement in accreditation activities are obviously substantial investments for a local health department to undertake, so what are the benefits of national accreditation? The accreditation process will not only highlight areas of strength at a local health department, but will also allow health departments to identify and address areas for quality and performance improvement. The nationally adopted accreditation standards are recognized as validating the services provided by health departments and becoming accredited can raise the image of public health among the public, governing entities and community stakeholders. Through the completion of accreditation prerequisites, a health department can improve communication and collaboration within the local public health system. Understanding the health needs of the community through the completion of a community health assessment and collaborating with public health system partners on a health improvement plan can open doors to funding opportunities and the development of new partnerships and programs to meet the identified needs.

The vision of PHAB is a high performing governmental public health system achieved through continuous improvement of health department services and performance. It is their hope that voluntary national accreditation will act as the catalyst for this improvement. With an accreditation process already established in the state of Michigan, the rate at which this catalyst is consumed by local health departments will shed light on whether the value of the products produced by national accreditation is worth the energy and cost required to achieve it.

More information on national accreditation can be found at www.phaboard.org.

Michigan Survey of Local Health Departments Regarding National Voluntary Accreditation

In April 2011, Michigan completed the last round of the Multi-State Learning Collaborative (MLC), a five year initiative funded by the Robert Wood Johnson Foundation. One of the core goals of the MLC was to prepare health departments for national voluntary accreditation, which will begin this year under the leadership of the Public Health Accreditation Board (PHAB). In order to identify opportunities to build on the success of the MLC in preparing for national voluntary accreditation, Michigan's MLC-3 partners gathered information regarding the perceptions of and interest in national accreditation efforts through a survey of Health Officers, conducted in the spring of 2011. The survey was designed to assess knowledge, attitudes, perceived barriers and needs regarding the Public Health Accreditation Board's (PHAB) national voluntary accreditation program. The survey was sent to Health Officers at all 45 LHDs in Michigan, with a response rate of 84% (n = 36).

Respondents indicated that they were familiar to very familiar with both the PHAB standards (44% familiar or very familiar) and the PHAB process (59% familiar or very familiar). However, results indicated LHDs would like additional information about several areas related to the program, including: fees related to participation (90% indicated they would like more information), acceptable documentation on meeting standards (75%), incentives related to participation (75%), definition of pre-requisites (72%), and how participation will benefit LHDs (56%). Written comments indicated that LHDs would like information about coordination between the National and State of Michigan accreditation programs, how fees will be paid, and estimates for staff and time resources required to prepare for National Voluntary Accreditation.

Participants identified several potential benefits from participating in PHAB National Voluntary Accreditation, including increased competitiveness for grants (72% indicated this is a "major benefit" or "benefit"), and improved quality of individual LHD services (65% indicating "major benefit" or "benefit"). Additionally, themes generated from open-ended comments related to perceived benefits included increased visibility of health departments and increased awareness of the value of public health.

Alternately, respondents identified "significant barriers" to participating in National Voluntary Accreditation, including: staff capacity (49% indicated "significant barrier"), cost of Accreditation fees (49%), overall cost of preparing for Accreditation (46%), and cost of completing pre-requisites (43%). Respondents emphasized barriers related to resources in their open-ended responses, including funding, time, and staff resources. Respondents did not tend to perceive lack of expertise (62% indicating "minimal barrier"), inability to meet PHAB Accreditation standards and measures (56%), or lack of local governing entity support (50%) as barriers to participation in National Voluntary Accreditation.

PHAB will require three pre-requisites to apply for national voluntary accreditation: a community health assessment, health improvement plan, and agency strategic plan. When asked about progress toward completing these pre-requisites, most respondents indicated that their LHD had at least started work on most of these pre-requisites or plan to complete them. Respondents most frequently indicated that staff capacity (between 46% and 64% of respondents) and lack of financial resources (17%-46%) were barriers to completing the pre-requisites. Alternatively, lack of expertise (5%-14%), lack of political support (0% -14%), or perceived return on investment (8% - 9%) were not frequently noted as barriers.

Despite these barriers, just over two-thirds of respondents indicated that their LHD planned to participate in National Voluntary Accreditation. In fact, 35% of respondents indicated that they believed their LHD would be ready to apply for National Voluntary Accreditation within one to two years.

Additionally, respondents were asked about their LHD's capacity to obtain National Voluntary Accreditation. Just over half of respondents (n=22) indicated they were "confident in [their] agency's capacity to obtain National Voluntary Accreditation" in 2014-2015. Just under a quarter indicated they were confident in their agency's capacity to do so in 2012-2013.

In order to assess the resources and technical assistance needs of Michigan's LHDs, respondents were asked to rank order a list of items. Responses to this question, ranked from highest to lowest, were:

1. Additional funding
2. Additional staff
3. Assistance with National Accreditation fees
4. Technical assistance on pre-requisites
5. Assistance with developing an agency-wide quality improvement plan
6. General information on National Accreditation

Respondents were also asked about possible modifications to Michigan's Accreditation Program that might help prepare LHDs for participation in National Voluntary Accreditation. Most respondents agreed or strongly agreed that Michigan's Accreditation program should be changed to a 5-year review cycle (mirroring the timeframe for the national program) (79%), that PHAB standards should be incorporated

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Epidemiology Section

On April 1st, 2011, the Epidemiology Section of the Michigan Public Health Association held its 10th Annual Michigan Epidemiology Conference at the University of Michigan, School of Public Health Crossroads Building. The event was a resounding success with both record-breaking registration and attendance.

This year's keynote speaker, Dr. Eric Noji, is formerly of the CDC and currently the CEO of Noji Global Health & Security, an organization he established in 2007 specializing in humanitarian resource mobilization and management. Dr. Noji has an exceptional background in disaster response and relief through several government and nongovernmental organizations including WHO, USAID, Medecins sans Frontieres, the World Bank, UNICEF and UNHCR. Dr. Noji presented a timely and very gripping discussion of his experiences with response and relief related to the March 11th, 2011 earthquake, tsunami and nuclear disaster in Japan. He reviewed the many facets of the disaster itself, the various public health risks associated with these types of disasters and methods of response, communication and mitigation.

The morning continued with the plenary sessions and began with a talk by Dr. Julie Funk, an Associate Professor of pre-harvest food safety in the Department of Large Animal Clinical Sciences at Michigan State University's College of Veterinary Medicine and Director of their Online Master of Science in Food Safety Program. Dr. Funk gave a fascinating presentation on the epidemiology of food safety as related to animal food systems with a focus on the pork industry. She contrasted differing methods of pork husbandry and the resulting level of pathogens in the final market product as well as briefly touching on antibiotic use and overuse in feed animals and its potential dangers.

The morning ended as it began with our final morning speaker focusing on disaster response, but this time describing events that occurred a little closer to home. Paul Makoski, the Director of the Environmental Health Division of the Calhoun County Public Health Department lectured on the emergency response to the July 2011, Marshall, Michigan, Enbridge Oil pipeline rupture and release, the largest environmental disaster ever in the Midwest. In addition to presenting a riveting description of the events surrounding the spill with stunning visuals, Mr. Makoski focused on the spill's health consequences and the immediate and continuing role of public health in the mitigation.

As always epidemiology students and professionals alike responded in high numbers to the call for abstracts. Over 50 posters were presented at the conference. Congratulations to Beth Anderson of the Chronic Disease Epidemiology Division at the Michigan Department of Community Health and Caitrin Kelly a recent UMSPH MPH Graduate for being judged as having the two best posters and receiving a year membership to MPHA courtesy of the Epidemiology Section. Twelve abstracts were selected for oral presentation with very diverse topics within infectious and chronic disease epidemiology and the epidemiology of health behaviors.

Congratulations to The University of Michigan School of Public Health which was again awarded the John Snow Award which is presented to the university with the most abstracts accepted for presentation at the conference. This is the 2nd year that Epidemiology Section was given this award.

The Epidemiology Section was very pleased with this year's conference and according to the evaluations it seems that the attendees were as well. We are all looking forward to the 2012 conference which, tentatively, will be held on or near the Michigan State University campus. Please visit our website for more information and archived past conference materials at www.mipha.org/epidemiology .

Michigan Survey... Cont

into Michigan's Accreditation Program as important indicators (87%), and that where possible, the 10 Essential Services should be correlated to Michigan minimum program requirements (MPRs) (94%). When asked their level of agreement with statements regarding how Michigan and National Accreditation programs should interact, respondents indicated that they would like to see alignment of the Michigan and National programs in some manner.

Overall, these results suggest that LHDs in Michigan have the knowledge and skills to meet PHAB standards, but lack of staff time and inadequate financial resources are barriers to participating in National Voluntary Accreditation. LHDs would like more information about PHAB program specifics, such as fees and incentives, acceptable documentation, definitions of prerequisites, and evidence related to the benefits of participating in the program. Much of this information is now available in the standards and guidance recently released by PHAB. Finally, respondents expressed interest in exploring opportunities to align Michigan's program with National Voluntary Accreditation. As National Voluntary Accreditation is rolled out and Michigan's Local Public Health Accreditation Program begins its fifth cycle, these results will be used to build on the successes of the MLC-3 and to continue to assure and enhance the quality of local public health in Michigan.

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Community Health Needs Assessment - Opportunity is Upon Us

We all know that Assessment (along with Assurance and Policy Development) is a core function of public health.[1] We also know that state funding to assure local health departments conduct comprehensive community health needs assessments (CHNA) was one of the first funding streams to be eliminated. However, new opportunities are upon us.

Did you know, for example, one component of the Affordable Care Act requires non-profit hospitals to conduct a CHNA every three years or pay a penalty of $50,000?[2] The specific IRS requirements are still being developed but initial guidance indicates the process needs to involve public health, community stakeholders, and result in a health improvement plan. Another new opportunity relates to the National Public Health Accreditation program being launched this fall. In order for a local health department to apply to be accredited they must submit three prerequisite documents – a department strategic plan, a community health assessment, and a community health improvement plan.[3] These recent developments create new opportunities for local health departments to reassess capacity and desire to be at the table or lead the CHNA process.

In August 2010, the Mid-Michigan District Health Department (covering Clinton, Gratiot and Montcalm counties) embraced this new opportunity and reaffirmed with our Board of Health a commitment to spearhead a CHNA process in each of our three counties. The first to be approached was Montcalm County, a rural community with a population of approximately 62,000 residents, four rural hospitals, and a Federally Qualified Health Center (FQHC). To maximize resources and collectively engage in the assessment process (rather than each hospital independently doing its own planning), the health department offered to lead the CHNA process with financial support from the hospitals and FQHC. A quick "yes" was confirmed by all (lesson one – be careful what you ask for). The next step included convening an internal health department planning team with health education, data/epidemiology staff, and the Health Officer. The internal planning team reviewed various assessment models, including Mobilizing for Action through Planning and Partnerships (MAPP), Healthy Carolinians, and the Association for Community Health Improvement (ACHI) Assessment Toolkit. The Healthy Carolinian Model was selected based on its public health focus, simplicity and existing worksheets and templates (lesson two – select or modify an existing model, don't try and reinvent the wheel). Step three included the establishment of a Steering Committee to provide much of the oversight and operational management, including data collection and analysis. In addition to the health department, hospitals and FQHC, a representative from the local Community College and staff to the Human Services Collaborative was added to the Steering Committee. Step four established a Community Assessment (Advisory) Team. This was completed by sending a letter of invitation to community stakeholders, followed by a personal phone call to enlist membership – key talking points included "why a CHNA now?" and "why your organization is important to the process and should be involved". The response from the community to join the advisory team was very positive – we were in business. Step five and beyond is when the real work will begin – collecting and analyzing data, and seeking community consensus on health priorities.

The Montcalm CHNA Advisory Committee has met four times and taken an active interest in the process, including recently adopting a vision statement – "Montcalm County is an empowered community where people are engaged in leading healthy, active lives". The committee is currently wrapping up the data collection phase of the assessment process. To supplement secondary data that already exists, the assessment team developed and recently mailed a community survey to gather community input regarding health-related behaviors, access to care, and other health-related issues impacting Montcalm County. Future CHNA steps include: Data Analysis, Creation of a Community Health Profile, Prioritizing Health Issues, Seeking Community Input on Health Priorities, and Development of a Health Improvement Plan. (lesson three – communication, communication – we are enlisting the assistance of hospital public relations and marketing staff to ensure awareness and recognition throughout the broader community). It is anticipated the entire process will take 12-14 months from the formation of the Assessment Team to completion of a Health Improvement Plan.

MMDHD is also partnering with Barry-Eaton District and Ingham County Health Departments to facilitate a Capital Area Needs Assessment to include Clinton, Eaton and Ingham Counties, to be launched this fall. In addition, the ground work has been laid to begin a Gratiot County CHNA, in partnership with Gratiot Medical System and Alma College early in 2012. (lesson four – consider pre-planning and preparation time if the local health department plans to take the lead in the process)

Prepared by
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Health Officer
Mid-Michigan Health District

Source:
[1] Institute of Medicine, Division of Health Care Services; Committee for the Study of the Future of Public Health. The Future of Public Health. The National Academies Press, 1988

[2] Internal Revenue Service. IRS.gov. New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act. Schedule H (990)

[3] Public Health Accreditation Board. Guide to National Public Health Department Accreditation, May 2011. www.phaboard.org

Affiliate Representative to the Governing Council (ARGC)

I am Hope Rollins, your ARGC until 2013 and was also re-elected again to serve as the Region V Chair for the Great Lakes Public Health Coalition, a six state collaborative effort. Region V is the only collaboration within APHA and has thrived for years. I am looking forward to hopefully seeing many of you at the APHA Annual Meeting in Washington, DC later this month. I am here to serve you and hopefully make a closer connection to APHA.

Recognizing that the affiliate president serves as the primary contact person between APHA and the affiliate, the ARGC assists the President in disseminating information received from APHA to the members of the affiliate governing body and vice versa. The ARGC is to represent the affiliate as an informed voice, on the APHA Governing Council, and is responsible for maintaining liaison with the ARGC's of other affiliates.

The ARGC is expected to assist the affiliate President and the affiliate to support and stimulate the APHA/Affiliate relationship by:

1. Ensuring that APHA is informed on a timely basis of all changes in the affiliate leadership.
2. Encouraging and promoting affiliate leadership participation in those APHA activities specifically designed for affiliates, i.e., President's-Elect meeting, Affiliate Leadership meeting.
3. Working with the affiliate President to ensure timely payment of the annual APHA dues assessment.
4. Being informed and prepared with the policy direction of the affiliate in order to effectively represent the affiliate within the APHA Governing Council. Resolutions and position papers and proposed Constitution and Bylaws changes will be reviewed with the affiliate governing body prior to the APHA annual meeting.
5. Assisting APHA, in cooperation with the affiliate President and Legislative Chair, with legislative advocacy and implementation of approved APHA policies and resolutions.
6. Assisting the affiliate President in preparing and submitting affiliate responses to the following routine processes carried out by APHA:
   • nominations; Awards nominations; membership deployment; requests for and review of resolutions and position papers.
7. Encouraging the participation of the affiliate in the development and submission of mini-project proposals to APHA.
8. Attending the Affiliate Leadership meeting, ARGC caucus(es), and the two (2) scheduled meetings of the Governing Council preceding and during the APHA Annual Meeting.
9. Maintaining an ongoing communication with other ARGC's and the Committee on Affiliates Regional ARGC's.
10. The following criteria apply to the ARGC:
    • The ARGC must be a member of APHA and a member of an affiliate in good standing with APHA.
    • The ARGC should serve a three (3) year term.
    • The ARGC should be a voting member of the Affiliate governing body or executive committee/board.

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