

Pinellas County Local Public Health System Performance Assessment Report Supplement

August 2011



Robert Marlowe, Chairman
Elizabeth Rugg, Executive Director
Kathy LaRoche, Business Development & Planning Director
Teresa Kelly, Special Projects Coordinator

WHO WE ARE

The health councils were created in 1983 by Florida Statute to identify, address and resolve health care issues of local concern. Each health council is a private, non-profit organization governed by a Board of Directors. The Board members are appointed by County Commissioners to represent the concerns of health care consumers, providers and purchasers.

The Suncoast Health Council, Inc. (SHC) serves Pasco and Pinellas counties. The Council has extensive experience working with for-profit and non-profit agencies, public health organizations, consumers and professionals. Collaboration and cooperation are critical to the success of our mission.

We have three strategic goals: (1) support the accessibility of health care and social support systems through *comprehensive health planning*; (2) obtain and provide *education* about essential community health challenges and solutions; and (3) participate as collaborative partners to address current and emerging health issues to develop and sustain efficient and cost effective *service delivery* systems.

SUNCOAST HEALTH COUNCIL, INC.

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TO LEARN MORE ABOUT THE HEALTH COUNCIL

Visit our website - www.healthcouncils.org

Or Contact Us:

Suncoast Health Council, Inc.
9600 Koger Blvd., Suite 221
St. Petersburg, FL 33702
727-217-7070
727-570-3033 (Fax)

Background

The Suncoast Health Council contracted with the Pinellas County Health Department to facilitate the Pinellas County Local Public Health System Performance Assessment process. The process utilizes an instrument that assesses functioning of the entire public health system across the ten essential public health services.

Process

Two half-day sessions were conducted to promote participation by a broad range of system partners, as well as to promote repeat attendance by partners engaged in the assessment of multiple service areas. Three work groups were convened at each half-day session, with each work group assessing one or two essential services. Each group was assigned one (1) facilitator and one (1) note taker to conduct and record the assessment process.

Health Council staff collaborated with the Health Department to develop a list of potential invitees and determine how to divide the 10 essential services. To the extent possible, essential services were grouped with a similar number of total questions per group and a mix of topic “experts” and non-experts was assigned to each group.

Invitations were e-mailed under the signature of the Director of the Health Department. Follow-up phone calls were made and alternates were identified when possible. Background information on the 10 essential services and the model standards were provided with the invitation. Sixty-eight participants were invited on the first day and 67 participants were invited on the second day. The percent of Health Department staff invited by essential function is shown below by assessment date:

July 28, 2011

- 1: Monitor Health Status and ID Problems: 21%
- 2: Diagnose and Investigate Problems and Hazards: 28%
- 8 and 10: Competent Workforce/Research New Solutions: 40%

August 11, 2011

- 3 and 4: Educate People/Mobile Partnerships: 32%
- 5 and 6: Policy Development/Enforcement: 44%
- 7 and 9: Link People and Evaluate Services: 36%

Despite concerted efforts to maintain balance of system partners in each work group, actual attendance on each day was less than RSVPs indicated. This left a few work groups with health department representation higher than our original goal. A total of 47 unduplicated individuals participated in the assessment over both days (see appendix for list).

The first session was held on July 27, 2011 to address essential services 1, 2, 8 and 10. The second session was held on August 11, 2011 to address the remaining essential services.

Each day began with an overview of the 10 essential services and review of the process and intent of the National Public Health System Performance Assessment. Participants broke into three work groups in different rooms to complete the assigned assessments.

An electronic voting system was used to record responses, but a technical problem on the first day required two of the three groups to use a manual voting system.

Results

The results were reported to the Centers for Disease Control and Prevention (CDC) and a report on the ratings was provided and is available as a separate document.

Main discussion points by Model Standard are shown below:

- 1.1 There is no single community health assessment conducted; instead, multiple assessments are produced based on funder requirements. Individual assessments contain many of the recommended elements; however, the community has not met to select or produce a single community-wide assessment. Data from private providers is not always available, and the availability of data is not widely known in the general population or even between partners in the Public Health System.
- 1.2 Florida CHARTS is easily accessed through the Department of Health's website. Many individual providers post their profiles on their individual websites. Geocoded data is available on a more limited basis, and GIS capabilities are limited primarily to Health Department and County government.
- 1.3 Population health registries established by statute include standards and processes.

- 2.1 Integration with state surveillance systems is mandated for reportable conditions.
- 2.2 The health department has either primary or significant responsibility for many of the elements. Response to natural and intentional disasters is coordinated with County government that has the lead responsibility in this area.
- 3.1 There are a variety of health education campaigns conducted throughout the public health system. Funding may drive campaigns offered. It is unknown if all providers use best practices or if activities are evaluated. Evaluations that are occurring are not being shared in the broader system. There appears to be little tie-in with local advocates.
- 3.2 Larger organizations have developed communication plans, but this is not as likely in smaller organizations that lack the required resources. Linking of plans appears to be limited. Individual partners have varying degrees of relationships with the media and relationships do not always result in publication or airing.
- 3.3 Emergency response systems are well developed in the County, but on-going staff training might be an area for improvement. There may be additional opportunities for adaptation of emergency communications for some populations based on language preferences and technological limitations.
- 4.1 Constituent and stakeholder identification is more common than it used to be, but this is being driven by funder requirements. The community at large does not play as large a role as it should, but timing of activities could be part of the issue. There are extensive volunteer recruitment initiatives around a limited number of community health issues. Directory updates are dependent upon providers to keep current.
- 4.2 The establishment of partnerships is growing, but has not really evolved to collaborative decision-making. Generally partnerships are formed because they are required for a specific grant, and are led by one agency or another to meet the requirements of a funder. Multiple partnerships and reductions in staffing are creating difficulties in keeping partnerships effective. Most partnerships do not assess themselves.
- 5.1 Funding for health departments are largely dependent upon state budget and some activities are legislatively mandated. Community identified needs may not be adequately funded and can be more dependent upon other grants to fund them.
- 5.2 There are several advocacy groups that are active in specific areas of health policy, but there does not appear to be a specific review timeline or process that is undertaken on a system wide scale. In many areas the State legislature steers the direction of health policy despite attempts to

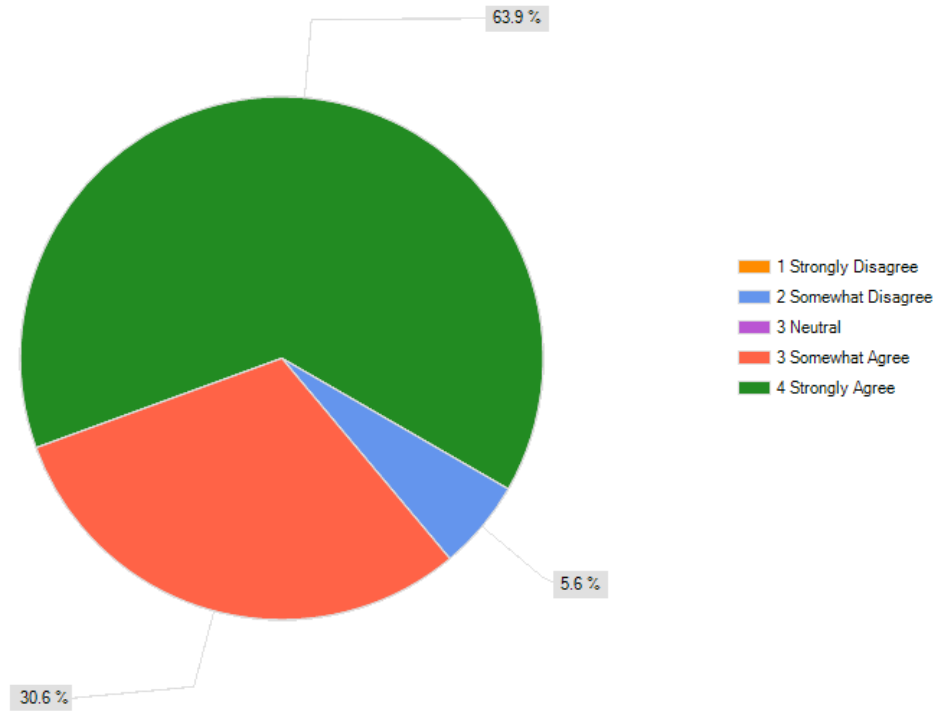
- engage community members and other partners in discussions about policy matters.
- 5.3 MAPP process was undertaken several years ago but should be updated.
- 5.4 LPHS partners are involved in emergency preparedness planning at local and regional levels. Training for service providers on Continuing Operations planning is offered in the community. Mock events are scheduled on a regular basis and address a wide variety of scenarios.
- 6.1 Impacts of existing laws on the community occur in specific instances, but not system wide and not regularly.
- 6.2 The LPHS does not identify local public health issues that are not adequately addressed through existing laws, regulations, and ordinances as thoroughly as it might. Some issues get higher levels of attention because funding exists to address specific issues (such as tobacco and obesity).
- 6.3 Intergovernmental agreements are common.
- 7.1 There was confusion as to whether this question referred to all populations as opposed to any population. Assessments for populations with barriers to care tend to be done in informal surveys, focus groups and occasionally surveys and may be targeted to a specific population. The HIV/AIDS community is one area where this is a common occurrence, but this is a requirement for funding under the Ryan White Care Act.
- 7.2 Some populations are not linked to services including undocumented individuals and resources for the uninsured are being stretched. System links exist to connect prison inmates to services before release but funding reductions could result in interruption of care. Transportation is a barrier to care in neighborhoods where no doctors/clinics are located. Medicaid enrollment linkages are widely available for residents that qualify. Coordination of services still needs work; too many “silos” exist; and the absence of electronic records is an issue with some community providers as are systems that do not link with each other. Payer sources are forcing some providers to work together but do not extend to the private sector. Patients frequently have to answer the same questions at different providers or fill out multiple intake forms to access services.
- 8.1 Workforce assessments are conducted in some areas of the system, such as hospitals and educational institutions, but not as a system wide effort. The State assesses health manpower shortages. Awareness that we are facing shortages in physicians and other health professionals is widely held, but no plans appear to exist to effectively deal with the issues. Some individual providers conduct/track skill development among their employees but again this is not on a system-wide level or shared information.
- 8.2 No comments.

- 8.3 We have several educational institutions in the community that provide for training needs. Conferences are less common than they used to be for some providers due to cost of attendance. Core competencies in public health essential services are not widely addressed; rather, more specific job-related training takes priority. Cultural competency has been a focus locally.
- 8.4 Activities in this area depend to some degree on the size of the organization and may not occur at all levels. There are some attempts at collaborative leadership but there are many people still not at the table and the efforts are not entirely "independent" but led by specific interests. Few system partners have funding to allocate toward leadership development and coaching/mentoring is not common.
- 9.1 Community input/satisfaction measure is an area for improvement in the LPHS.
- 9.2 Personal health services evaluation varies throughout the system. Standard quality measures are beginning to be used. Results are not generally shared with the wider system, but are utilized for internal purposes. Electronic health records are still not available in some safety-net providers and private physician offices. A Regional Health Information Organization exists but stalled for a period of time. It is getting back on track.
- 9.3 Exchange of information is not common and is not widely measured. The local health department utilizes evidenced-based approaches and evaluation of its programs but that may not be the case throughout the system.
- 10.1 Resources for pilot testing of ideas are dependent upon funders being willing to support those activities (some are). A few system members have active research agendas, but agendas are also driven to some extent by funders of the research, not determined as much by community identified needs. Probably more opportunities for Community Based Participatory Research with University of South Florida.
- 10.2 Area is rich in institutions of higher learning. Medical school, several levels of nursing, MPH program all available in area.
- 10.3 There is depth in research but not as much breadth as there might be. Several larger system partners participate actively in research but smaller providers are not as active in this area. May be opportunities for more involvement.

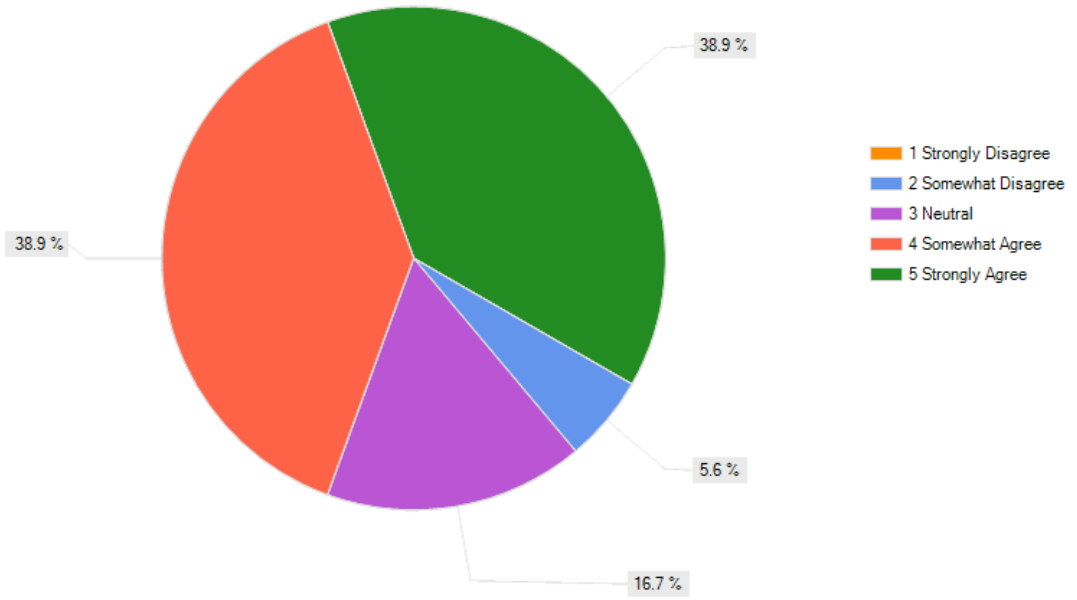
Impact of the process

Participants were asked to complete an evaluation on the impact of the process. Results were as follows:

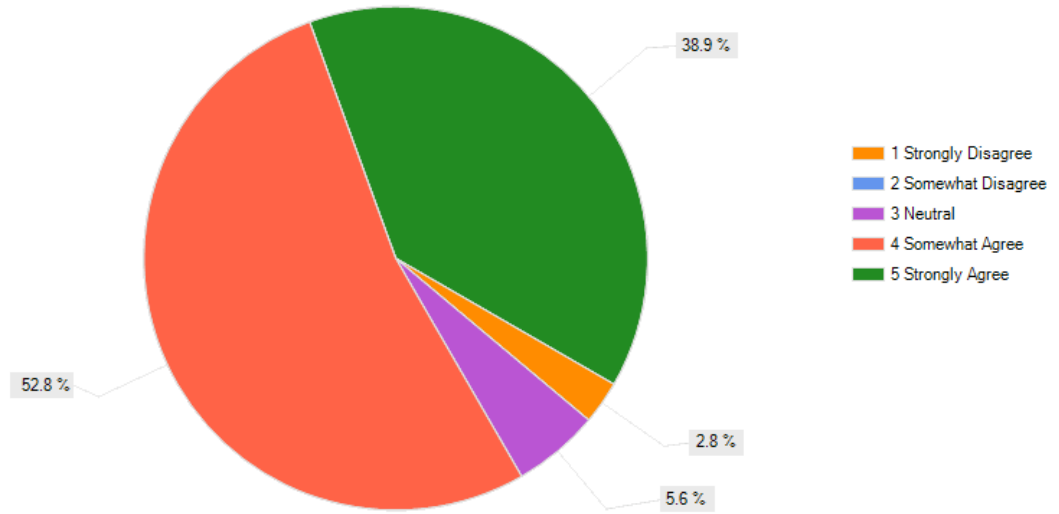
I understand the purpose of the Public Health System Assessment.



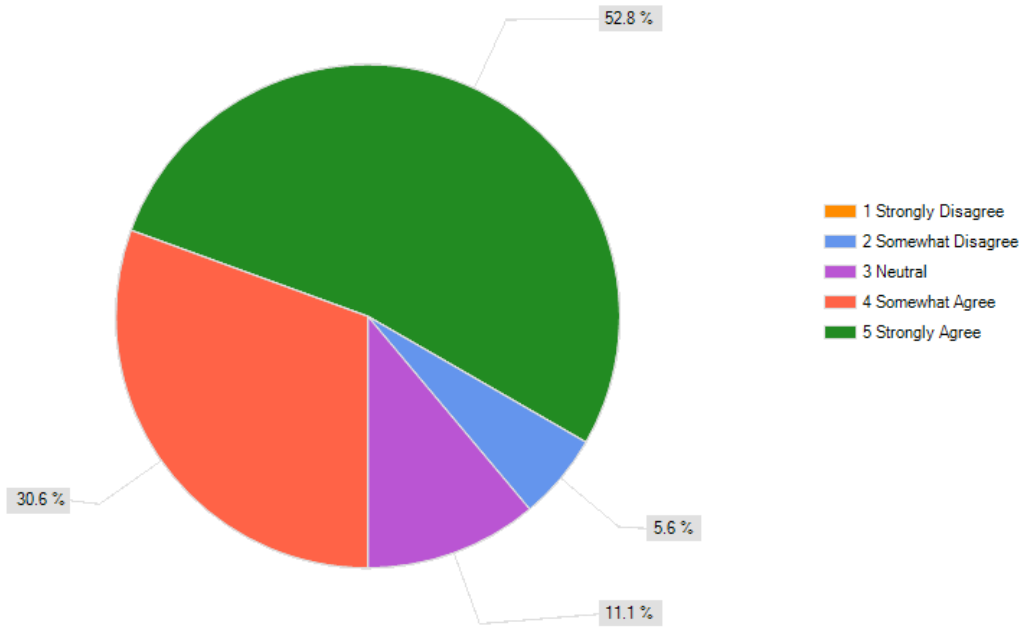
My participation added important information to the public health system assessment.



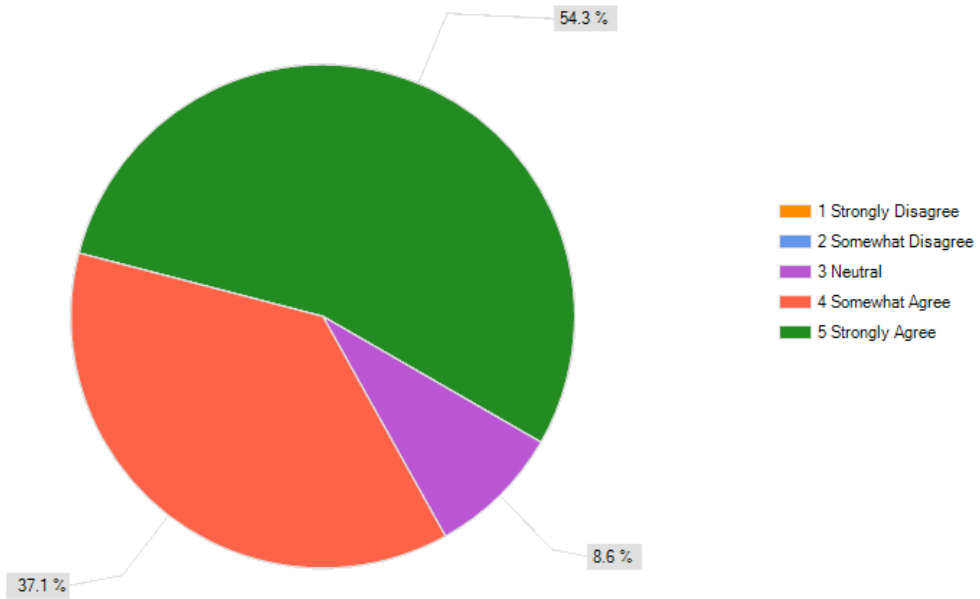
My participation today increased my knowledge of the public health system.



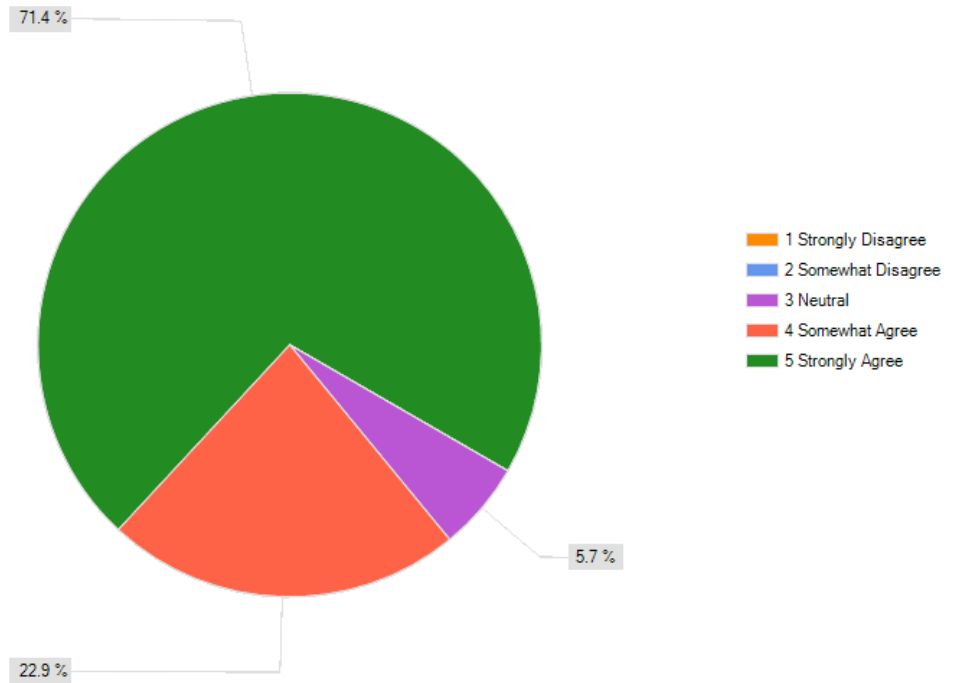
I feel communications between partners in the system was enhanced by the assessment process.



I see opportunities for collaboration with other partners as a result of the assessment.



I see opportunities for public health system improvements as a result of the assessment.



Appendix-Participants

Jane Bambace, Pinellas County Health Department
Sandra Beale, St. Anthony's Faith Community Nursing
Patricia Boswell, Pinellas County Health Department
Lounell Britt, James Sanderlin Center
Marilyn Carr, Pinellas County Health Department
Deborah Close, Bon Secours Health System
Lisa Cohen, Pinellas County Health Department
Connie Cooper, Registered Nurse
Richard Curtin, Pinellas County Health Department
Mari Deitres, Health Start Coalition
Claude Dharamraj, Pinellas County Health Department
Bev Diehr, Pinellas County Health Department
Sharlene Edwards, Pinellas County Health Department
Susan Finlaw-Dusseault, Pinellas County Health Department
Cynthia Fleece, Bayfront Family Health Center
Ailyn Flores, Intercultural Advocacy Center
Gayle Guidash, Pinellas County Health Department
Amber Hagelstein, PEMHS, Inc.
Maggie Hall, Pinellas County Health Department
Cathy Hastings, Pinellas County Health Department
Carrie Hepburn, Tampa Bay Healthcare Collaborative
Angie Honda, Suncoast Health Council
Angela Hovarth, Pinellas County Health Department
Nan Jensen, Pinellas County Cooperative Extension
Lynn Kiehne, Pinellas County
Cathy Lammers, Disability Achievement Center
Martha Lenderman, Juvenile Welfare Board
Wendy Loomas, Pinellas County Health Department
Darrell Pfalzgraf, Pinellas County Health Department
Marisa Pfalzgraf, Pinellas County Health Department
Debra Prewit, Juvenile Welfare Board
Carol Radin, City of St. Petersburg Sunshine Center
Debra Rivard, St. Anthony's Faith Community Nursing
Elizabeth Rugg, Suncoast Health Council
Ronda Russick, St. Petersburg Free Clinic
Patricia Ryder, Pinellas County Health Department
Marcie Sadorf, Bayshore Health and Homemaker Services
Jane Schafer, Hospice of the Florida Suncoast
Jodi Shingledecker, Pinellas County Schools
Ross Silvers, Pinellas Suncoast Transit Authority / DART
Melissa Symanski, Pinellas County Health Department
Collette Tomberlin, Suncoast Health Council
Mark Varga, Operation PAR

Christine Vongsyprasom, Pinellas County Health Department
Shelba Waldron, Juvenile Welfare Board
Dale Watson, Pinellas County Health Department
Cheri Wright-Jones, Allegany Franciscan Ministries