The Local Public Health System Governance Performance Assessment Instrument (Governance Instrument)

A Project Managed and Implemented by

The New Jersey Public Policy Research Institute

Rutgers Center for State Health Policy

The Center for Government Services

The New Jersey Local Boards of Health Association

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Background

The local public health infrastructure in the United States has faced many challenges over the years, from ensuring food safety to establishing public sanitation standards and combating disease when the need arises. The evolution of this infrastructure incorporates the ethos upon which other American governing institutions are based, which values locally based administration coupled with leadership by the citizen administrator. Like many other American governing institutions, the local public health infrastructure has performed well by both providing public service and strengthening our democratic traditions. Taken as a whole, though, the capacity of the local health infrastructure varies from state to state and jurisdiction.

For many observers, the strength of the system, with its local units of administration that are said to be more responsive to local conditions, contributes to a proliferation of entities with varying levels of ability. From another perspective, local choice has meant the absence or atrophying of an administrative unit that can set health standards and cope with emergencies. The possibility of new diseases and global terrorism has lead to widespread discussion by public health professionals, including the Centers for Disease Control (CDC), concerning appropriate policies to build capacity without destroying the best of the existing infrastructure.

The National Public Health Performance Standards Program

Recognizing the importance of improving the local health infrastructure, the CDC has collaborated with public health agencies including groups representing many key stakeholders to form an effort called the **National Public Health Performance Standards Program** (NPHPSP).[1] Specifically, the NPHPSP is a partnership designed to develop clear, measurable performance standards for state and local public health agencies to help ensure the delivery of **Essential Public Health Services (see appendix**

1). The goals of the program are to:

- Create instruments for public health practitioners to use in continuous quality-improvement processes.
- Strengthen state and local public health systems by providing mechanisms for demonstrating accountability to constituencies.
- Enhance decision making by strengthening the science base for effective public health practice.

National Public Health Performance Assessment Instruments

To meet these goals, the NPHPSP has developed a series of instruments that public health policy makers and governing bodies, including local boards of health, can use to measure the delivery of essential services within the state and local public health systems.[2] The NPHPSP includes three assessment instruments:

- **The Local Public Health System Performance Assessment Instrument (Local Instrument)** focuses on the local public health system (LPHS), which consists of all entities contributing to the delivery of public health services within a community
- **The State Public Health System Performance Assessment Instrument (State Instrument)** focuses on the state public health system, which includes state public health agencies and other partners that contribute to public health services at the state level
- **The Local Public Health System Governance Performance Assessment Instrument (Governance Instrument)** focuses on the governing body ultimately accountable for public health at the local level. The primary goal of the Governance Instrument is to promote continuous quality improvement of local boards of health or other governing institutions

Each of the instruments is based on an Essential Services model of good local health practice.[3] For each service, specific goals or standards are described, along with the actions needed to accomplish the goal, and questions that help the policy makers or the governing body evaluate the state or local public health system.

The Local Public Health System Governance Performance Assessment Instrument (Governance Instrument): The New Jersey Experience

In January of 2004, the Department for Health and Senior Services (DHSS) commissioned three units within Rutgers University to manage the process of administering the Local Public Health System Governance Performance Assessment Instrument (Governance Instrument) to local boards of health in New Jersey (LBHs). The units were the New Jersey Public Policy Research Institute (NJPPRI), the Center for Government Services (CGS), and the Center for State Health Policy (CSHP). The units, as a group, have significant experience working with local government, communities, and, in the case of CSHP, deep knowledge of the local health infrastructure. The DHSS also asked the New Jersey Local Boards of Health Association (NJLBHA) to become the last member of the Project Study Team.

New Jersey's Local Public Health Context

New Jersey's governmental local public health structure has more than 500 local boards of health and 115 local health departments (16 county, 7 regional, 50 municipal, and 41 multi-municipal) responsible for directly providing or contracting for public health services. New Jersey State Statutes Annotated (N.J.S.A. 26:1A-15) states that the New Jersey Department of Health and Senior Services shall prescribe "recognized public health activities" and "minimum standards of performance," and that local boards of health through their local health departments shall establish and maintain a program meeting those activities and standards of performance. Standards of Performance became effective prior to September 1, 1969, as chapter 51, "Recognized Public Health Activities

and Minimum Standards of Performance for Local Boards of Health in New Jersey." Over the years these Standards have taken many forms, most notably that which was adopted in 2003 as "Public Health Practice Standards of Performance," chapter 52 of the New Jersey Administrative Code (see http://www.state.nj.us/health/lh/chapter-52.pdf).[4]

The purpose of Public Health Practice Standards is to (1) establish standards of performance for public health services that meet the legislative intent as set forth in state law; (2) ensure the provision of a modern and manageable array of public health services to all citizens of New Jersey; (3) designate activities that are required by all local boards of health and will build local public health capacity and encourage the development of an integrated systems approach for local public health; (4) encourage cooperation among local health departments, its governmental and community partners, to protect and improve the health of New Jersey residents; (5) align local public health performance with the Ten Essential Public Health Services, the National Public Health Performance Standards Program (NPHPSP), and National Model Community Standards; (6) build regional local public health systems that are reliable and cost-effective; (7) ensure the assessment of local health department organizational capacity, local board of health, health department, and local public health system performance, and community health; (8) develop and implement outcomes-driven improvement plans based on sound public health science and policy, supported by an integrated systems-based public health infrastructure; and (9) implement and evaluate those plans to ensure that they result in improved public health with an overall goal of increased quality and years of life for New Jersey residents.

Current Performance Assessment Program

Public Health Practice Standards provide for the evaluation of performance, based on outcomes and through a continuous quality-improvement process, to build local health agency and public health system infrastructure and capacity. They also provide for the development of a method to provide accountability to ensure the performance of local health agencies.

To accomplish this, New Jersey has adopted, developed, and/or refined both new and nationally recognized performance assessment methodologies and instruments. Currently, the program consists of the self-assessment and reporting of performance by the state's 115 local health departments and more than 500 boards of health.

Overseen by the department's Division of Local Public Health Practice and Regional Systems Development, each local health department is required to complete two performance and capacity assessments. The annual Local Health Evaluation Report provides a self-evaluation of the department's capacity, infrastructure, and performance in meeting *Public Health Practice Standards* and includes an immediate electronic analysis report and score in several core activity areas, and in overall performance. Secondly, every three years each local health department is required to complete the New Jersey Enhanced Assessment Protocol for Excellence in Public Health (NJ-APEXPH), which builds on the national APEX instrument by aligning it with the current public health practice environment, local public health systems, the Essential Public Health Services, NPHPSP Model Community Standards, Essential Elements of Bioterrorism Preparedness, Healthy NJ 2010, and *Public Health Practice Standards*. New Jersey has also adopted the use of the NPHPSP Local Public Health Governance Performance Assessment instrument.

Additionally, the NPHPSP Local Public Health System Performance Assessment instrument along with the other assessments, make up Mobilizing for Action through Planning and Partnerships (MAPP), a community health improvement process adopted under *Public Health Practice Standards*, and being applied by all local health departments and community partners, statewide. Serving as a foundation for acting on performance and capacity weaknesses determined by these assessments, New Jersey is finalizing the development and implementation of a New Jersey Public Health Continuous Quality Improvement process for use at the agency and systems levels which will be implemented in 2006.

Governance, Implementation, and Participating Partners

To ensure the successful implementation of *Public Health Practice Standards*, the performance assessment program activities described above, and overall public health practice and performance improvement, the NJDHSS has established governance processes at both the statewide and local public health system levels.

A *Public Health Practice Standards* Implementation Advisory Group (PSIAG) has been formed to provide input, guidance, and advice on statewide policy for standards implementation, best practices, and performance evaluation improvement. The PSIAG, which meets quarterly, is composed of partner organizations representing the NJDHSS, New Jersey Public Health Council, New Jersey League of Municipalities, New Jersey Health Officers Association, New Jersey Association of County Health Officers, New Jersey Local Boards of Health Association, New Jersey Society for Public Health Education, New Jersey Association of Public Health Nurse Administrators, New Jersey Public Health Association, New Jersey Environmental Health Association, and three public health academic institutions, including the University of Medicine and Dentistry of New Jersey School of Public Health, Rutgers—The State University, and Richard Stockton State College. Members of the PSIAG also serve as representatives on a variety of subcommittees that address specific issues and needs, including those associated with the performance assessment program.

At the regional public health systems level are a Governmental Public Health Partnership (GPHP) and Community Public Health Partnership (CPHP). County or multi-county GPHPs have been formed covering sixteen of New Jersey's twenty-one counties and consist of the health officers, as the chief executive officers, of each local health department and other local government leadership. Each GPHP has the responsibility for guiding the development of a local public health system, ensuring the implementation of the performance assessment program, and using assessment results to plan and implement capacity, performance, and community health improvement. In those counties served by only one county health department, the health officer and its local board of health provide

overall governance for the advancement of these activities. Similarly, each Community Public Health Partnership, which is composed of local governmental public health, public health care, other community public health providers, and stakeholders, guides, participates in, and advises on policy for the best use of performance assessment activities and their results as an integral component of MAPP and regional community health improvement planning.

Project Methodology

One hundred fifty local, county, and regional boards of health participated in the governance assessment tool process as administered by Rutgers University and the New Jersey Local Boards of Health Association (Project Study Team). Some assessment instruments were completed during regional meetings; others were completed during local board of health meetings. After the governance assessment instruments were collected, they were submitted to an on-line centralized database overseen by the Centers for Disease Control (CDC). Once all 150 instruments were submitted, the CDC generated a statewide aggregate database of survey responses for analysis by the Rutgers Center for State Health Policy.

The survey instrument totals twenty-five pages of questions designed to assess the administrative capacity of local boards of health (LBHs). CDC timed the completion of earlier instruments to an average of six hours. The Project Study Team designed the administration of the process to maximize collection of the instruments while providing as much technical assistance as needed to the LBHs. The Project Study Team held twelve centrally located regional meetings in the north, central, and southern parts of the state. Approximately fifty meetings were held with LBHs either at an LBH meeting or through individualized technical assistance to LBH representatives. The collection design encompassed the following:

- Twelve publicized regional meetings held at a community college or other public facility;
- Co-managed and facilitated (Rutgers and the NJLBHA) meetings where the

collection team would answer questions and guide the boards through the day-long process;

- Individual outreach to individual boards of health to help them complete the instrument.

Challenges to the Methodology

The study team faced the following challenges to implementing the methodology:

- The complexity of the New Jersey local health infrastructure, including the fact that LBH are volunteers with limited time to devote to meetings that are not regularly scheduled;
- Lack of centralized data systems at local and state level of governance;
- Perceived complexity of the instrument and time needed to complete the document.

Complexity

Similar to other states, the LBHs in New Jersey first evolved during the colonial era and, importantly, outside a governmental framework. In the case of New Jersey, LBHs were formally recognized by statute in 1947. Every geo-subdivision of government was obligated, statutorily, to have a local board of health. As time went on there were certain exceptions. Under the Faulkner Act, a municipality does not have to have a separate board of health, but there has to be some appointed body in the municipality that serves as the board of health.[5] Another exemption is that towns could form a regional health commission. Still another exemption allowed some counties to create a county board of health department serving their municipalities. Monmouth, Ocean, Atlantic, and Cumberland have a county-appointed board that oversees the county health department.

In counties where there is no county health department and no county board, the LBH serves as primary oversight of local health issues. The present number of health

departments in New Jersey is 115, each served by a state-licensed health officer and appropriate staff. Of these departments, seven are regional health commissions made up of adjoining towns. The sheer number of governmental entities and citizen stakeholders and the myriad ways they exercise authority and responsibility complicated the study. In many instances, LBH members were not aware of their statutory responsibility; and in a significant number of cases the boards had not met for some time (in many instances, the board had not met for years).

Perhaps the most pressing issue relating to project complexity is the fact that sitting on a local board of health is a voluntary position. Getting the members to come out for a meeting to fill out a six-hour survey proved daunting. In some meetings—especially in the more populous counties—we were able to generate a good turnout. At other meetings, despite advance notification, the turnout proved disappointing.

Lack of a Complete List

The lack of a clear center of authority among so many different entities challenged the project team's effectiveness in identifying a complete list of LBH—no matter their fit within the New Jersey health infrastructure. We relied on our partner, the New Jersey Local Boards of Health Association, and the health officers to identify and encourage boards of health to participate in the collection process. As a result of canvassing over 400 boards of health and health officers, the Project Study Team may well have the most complete list of individual board of health members ever assembled in New Jersey. Beyond slowing the collection process, the lack of a maintained, statewide list of LBH limits the ability to build the capacity of LBHs.

Perceived Complexity of the Instrument

There was strong sentiment that the instrument was long, dense, and of little relevance to the LBH's circumstance. Despite this significant hurdle, the collection team

found receptivity and sometimes gratitude when LBHs filled out the survey. Though difficult in places, the questions raised the level of awareness and pointed out gaps in LBH members' understanding of their duties and roles. This was positive.

Despite the positive side of the equation, the fact remains that any subsequent round of national data collection should use (1) a shortened instrument and (2) question items that are clear and unobtrusive measures of the underlying issue.

Data Analysis

Limitations of Data Analysis

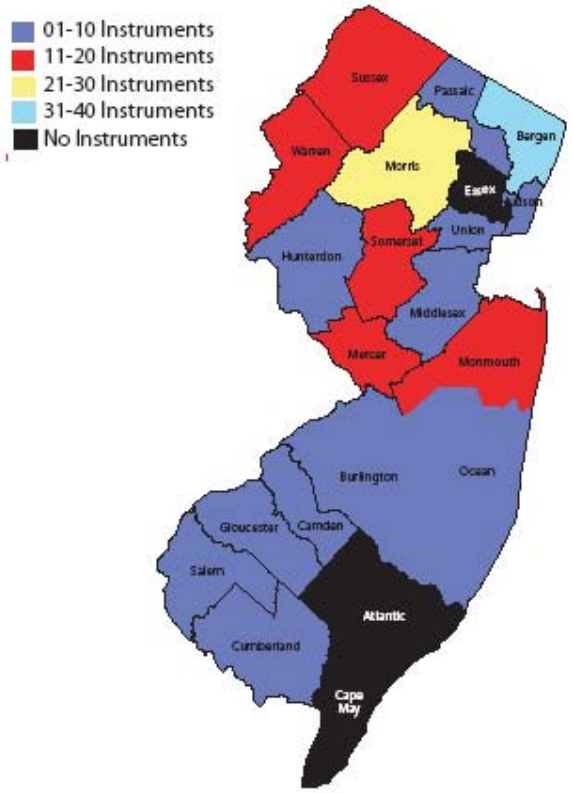
As mentioned before, complexities of obtaining completed instruments limited the collection of a representative sample. Statistically, the sample of governance assessment instruments drawn from New Jersey's local boards of health was not randomly selected but rather a convenience sample. As a result, it is possible that the analysis results presented are skewed. In addition, limitations to the data could include misinterpretation of survey questions and influence of the survey administrator, municipal health officer, or other stakeholders involved in answering survey questions. These limitations are important to note while examining the governance assessment tool results.

Participating LBH Demographics

The average population size of communities served by participating LBHs was 19,521, although documents were received from LBHs with populations as small as 41 individuals and as large as over 500,000. Each local board of health encompassed between five and seven members and was associated with a single health officer. Of the 112 health departments statewide, 56 health officers oversee health departments that participated in the governance assessment tool.

Participating LBHs were spread over eighteen counties statewide. As can be seen in figure 1, Bergen County, with 36 participating local health departments, submitted the largest number of governance assessment instruments.

Figure 1: County Density of Governance Tool Documents Completed



The second largest set of responses was received from Morris County, where 21 local boards completed the governance assessment tool. Between 11 and 20 assessment instruments were received from Sussex, Warren, Somerset, Mercer, and Monmouth counties. Between 1 and 10 assessment instruments were received from Passaic, Hudson, Union, Hunterdon, Middlesex, Ocean, Burlington, Camden, Gloucester, Salem, and Cumberland counties. LBHs from Essex County did not return governance assessment instruments. Atlantic and Cape May counties will be working with the NJLBHA in the future to complete a governance assessment tool. The density of statewide governance assessment instruments in each county is shown in figure 1.

The governance assessment instruments received from LBHs included responses from autonomous and municipal boards of health as well as advisory boards of health. In addition, a few county boards of health participated, as did several regional health commissions. As can be seen in table 2, autonomous boards of health have the largest representation, with 82 governance instruments submitted, followed by municipal boards of health, with 26 boards completing the governance assessment tool. Twenty-one advisory boards completed the governance tool. Three county boards of health (Monmouth, Ocean, and Cumberland) submitted the governance assessment tool, as did 3 regional health commissions (Princeton, Middlebrook, and Monmouth). Sixteen LBHs submitted governance instruments identifying themselves as autonomous as well as belonging to a regional health commission. Table 1 defines each type of board:

Table 1. New Jersey Local Boards of Health Structure and the Number of Governance Assessment Instruments Received by Board Type

Type of board	Board definition	Document submissions
Autonomous	An independent policy-making body that has authority to adopt or repeal municipal health ordinances.	82
Municipal	Municipal governing body serves as board of health.	26
Advisory	Monitors public health issues within its jurisdiction, but only in an advisory capacity on behalf of municipal mayor and governing body.	21
Regional health commission	Compilation of several boards of health that pool resources to provide local services on a regional basis, from a centralized health commission. Municipalities can maintain their local board of health or cede their health powers to the commission.	3

County board of health	Compilation of several boards of health that pool resources to create a county board of health that provides services on a regular basis from a centralized board of health. Municipalities can not maintain their local board of health and must cede their health powers to the county.	3
Regional health commission/ autonomous	Maintains local autonomous board of health but also belongs to a regional health commission.	16

It is important to note that although only a handful of county and regional local health departments submitted governance assessment instruments, these boards can represent several municipalities. For instance, one document was submitted for the Ocean County Board of Health, but this board of health serves 27 municipalities. Other exceptions include regional health commissions; anywhere from 5 to 22 municipalities may be serviced by any individual commission. In many cases, the municipalities share power with the county board of health or have been contracted with their health commission and thus receive most, if not all, of their health services from that source. Overall, 237 of New Jersey's municipalities and 150 LHDs were represented by their respective local boards of health's completion of the governance assessment tool.

Assessment and Study Results

The governance assessment tool was based on ten essential public health services and was used to assess the capacity of New Jersey's local boards of health. Each of the ten essential public health services had several "service indicators," as summarized in table 2:

Table 2. Ten Essential Services and Corresponding Indicators
Essential Service 1: Oversight to Ensure Community Health Status Monitoring: • Appropriate resources, guidance, and oversight, promotion of broad-based participation and coordination, development, implementation, and review of policies designed to facilitate monitoring, and a process of continuous evaluation and improvement of public health monitoring.
Essential Service 2: Oversight to Ensure Public Health Surveillance and Response: • Acts to assist the community in securing the needed resources; ensures the development, implementation, and review of policies necessary for the diagnosis and investigation of health threats in the community; ensures collaboration among all relevant groups; conducts periodic reviews of these activities, and reports on them; ensures the development, implementation, and review of appropriate polices and procedures for public health emergencies.

Essential Service 3: Oversight of Public Health Information, Education, and Empowerment Activities:

- Identifies and facilitates access to resources; ensures the development, implementation, and review of written policies; determines whether populations within the community are receiving culturally and linguistically appropriate public health information and education and evaluates these activities in light of community needs, including ensuring community input.

Essential Service 4: Oversight to Ensure Constituency Building and Partnership Activity:

- Ensures constituency building, partnership activities, and resource development; ensures the development, implementation, and review of policies; conducts annual evaluations of these activities and provides feedback to constituents; implements strategies to enhance participation among current and potential constituents.

Essential Service 5: Oversight of Public Health Policy Making and Planning:

- Maintains and annually ensures the availability of a handbook for its members; has a statutory charter, mission statement, or other strategic planning statement; ensures the availability of adequate resources; ensures the development, implementation, and review of polices supporting the community health improvement process; convenes all relevant individuals, agencies, or organizations to implement a community health improvement; routinely evaluates, sets goals for, and monitors improvement in community health status and ensures that each member of the governing body understands, exercises, and advocates for appropriate legal authority.

Essential Service 6: Oversight of Public Health Legal and Regulatory Affairs:

- Ensures that appropriate legal authority exists for the adoption, dissemination, evaluation, improvement, and enforcement of laws; ensures that its bylaws, rules, and procedures comply with local, state, and federal statutes and regulations; ensures its access to legal counsel; identifies and advocates for resources that could be used for public health inspection and enforcement activities and ensures an inclusive annual evaluation of laws and rules.

Essential Service 7: Oversight to Ensure Public Health Outreach and Enabling Services:

- Identifies individuals, agencies, or organizations involved with or responsible for the coordination of services, ensures or advocates for necessary authority, ensures culturally and linguistically appropriate materials to service special population groups; identifies and advocates resources necessary to provide services for the entire community, with special attention to socially disadvantaged people and high-risk population groups; ensures the development, implementation, and review of policies; conducts periodic evaluations, including input and feedback regarding potential or actual outreach.

Essential Service 8: Oversight of Public Health Workforce Issues:

- Oversees licensing and credentialing of public health personnel; develops, implements, and reviews policies designed to ensure improvements in workforce management, and leadership quality; identifies national, state, and local resources; develops, implements, and reviews policies for the orientation of new members; periodically evaluates current workforce competence, including compliance with licensure and credentialing requirements.

Essential Service 9: Oversight of Public Health Service Evaluation:

- Develops, implements, and reviews policies; evaluates in line with community health priorities; considers relevant aspects of service delivery—that necessary resources are available to conduct periodic evaluations, development, implementation, and review of written policies endorsing the importance of nationally recognized performance standards; that all public health constituents and partners within the LPHS are encouraged to provide input into evaluation processes; and that the results of evaluations are used to improve system performance.

Essential Service 10: Oversight to Assure Public Health Innovation and Research:

- Ensures the development, implementation, and/or review of policies reflecting its commitment to public health research and innovation activities; assists the community in establishing linkages between academic institutions and local public health entities; ensures that research results are incorporated into new policies and programs.

The questions in each section of the governance assessment tool addressed these service indicators.[6] LBHs were asked to answer each question while keeping in mind the services they provided for their community.

Each question had four possible responses, depending on what percentage of the essential public health service the LBH felt it provided for its community.

Table 3. Definition of Governance Assessment Tool Answers	
Answer	**Definition**
Yes	Greater than 75 percent of the activity described within the question is met.
High partiality	Greater than 50 percent, but no more than 75 percent of the activity described within the question is met.
Low partiality	Greater than 25 percent, but no more than 50 percent of the activity described within the question is met.
No	No more than 25 percent of the activity or resource described within the question is met.

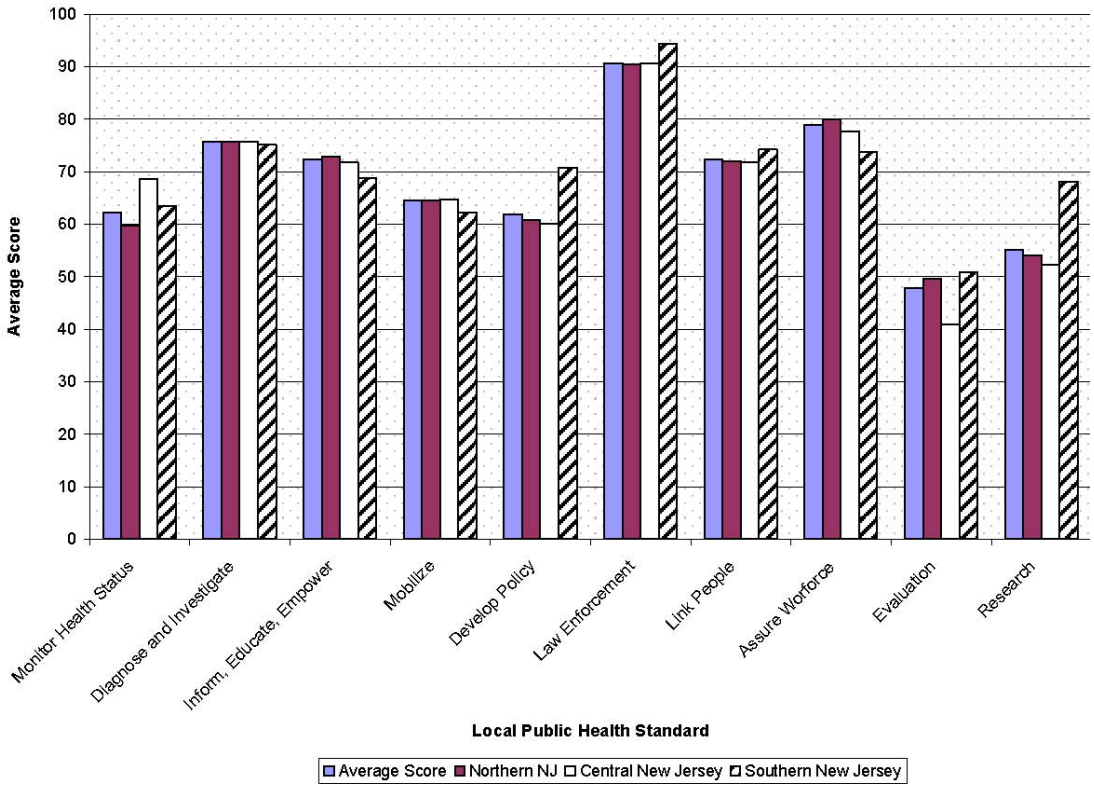
As table 3 shows, each answer is associated with a percentage. Depending on how a local board of health answered each question, it is still unclear exactly the percentage intended by the board of health. For instance, a board of health that answers no to a question could be meeting up to 25 percent of the corresponding public health standard. In addition, there were no options for survey participants to select "not applicable." The average state scores for each essential public health service (on a scale of 1 to 100 percent) are outlined in table 4. The highest average score was 90.7 and was associated

Table 4. Statewide Average Scores for Ten Essential Public Health Standards	
Essential public health standard	**Average state score**
G1 Oversight to Ensure Community Health Status Monitoring	62.32
G2 Oversight to Ensure Public Health Surveillance and Response	75.77
G3 Oversight of PH Information, Education, and Empowerment Activities	72.35
G4 Oversight to Ensure Constituency Building and Partnership Activity	64.53
G5 Oversight of Public Health Policy Making and Planning	61.93
G6 Oversight of Public Health Legal and Regulatory Affairs	90.7
G7 Oversight to Ensure Public Health Outreach and Enabling Services	72.27
G8 Oversight of Public Health Workforce Issues	79.01
G9 Oversight of Public Health Service Evaluation	47.77
G10 Oversight to Ensure Public Health Innovation and Research	55.05
Average total performance score	**68.17**

with essential public health service 6, "Oversight of Public Health Legal and Regulatory Affairs." This statewide score indicates that on average, local boards of health in New

Jersey feel that they meet 90.70 percent of the activity described by this public health service. The lowest average score was associated with public health standard 9, "Oversight of Public Health Service Evaluation." On average, local boards of health feel that they only meet 47.77 percent of the activity described by this public health standard. Essential public health standard 9 was the only statewide score under 50 percent. All other essential standards were met with a score of 55 percent or greater. The overall total performance average for New Jersey was 68.17 percent, indicating that overall, New Jersey local boards of health meet the ten essential public health service goals with an average of more than 50 percent, but no more than 75 percent (this score would be coded as "high partiality" in the governance assessment tool).

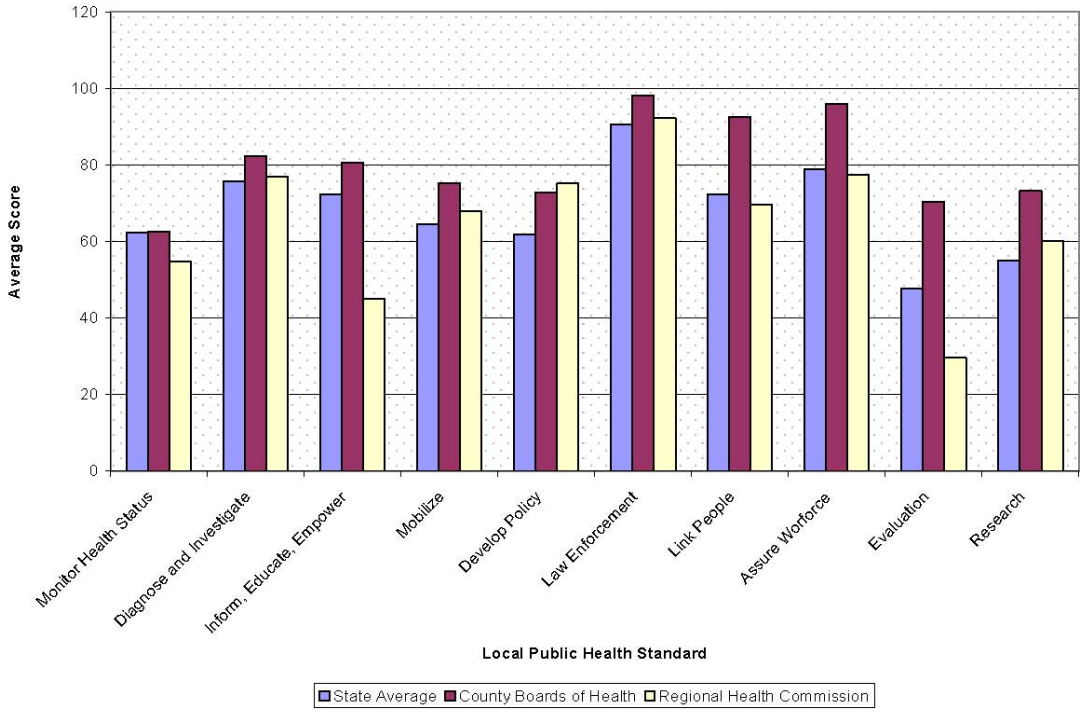
Figure 2: State LPHS Average and Regional LPHS Averages (North, Central, South)



The next analysis involved a regional look at the state. For the purposes of analysis, the counties represented in the survey were split into three regions: northern, central, and southern. Northern New Jersey counties were Sussex, Passaic, Bergen, Morris, Warren, Hudson, Union, and Hunterdon encompassing 102 total governance assessment instruments. Central New Jersey counties were Middlesex, Mercer, Somerset, and Monmouth, encompassing 34 governance instruments. Counties coded as southern

were Ocean, Burlington, Camden, Gloucester, Salem, and Cumberland, with 15 total governance assessment instruments. As can be seen in figure 2, most of the essential standards statewide averages match with the three regions of the state. It is interesting to note, however, that the averages for public health standards "develop policy," "law enforcement," "link people," and "research" are greater in the southern New Jersey region than the state average (and in other regions). Most local boards of health in southern New Jersey are linked with county health departments that provide a myriad of services for their corresponding municipalities. Figure 2 also shows that central New Jersey excels in monitoring health status but falls below the state average with evaluation. Northern New Jersey's ten essential health services mirror the state's average. Overall, the lowest score for all regions was the evaluation service while the highest score was seen within the law enforcement essential service.

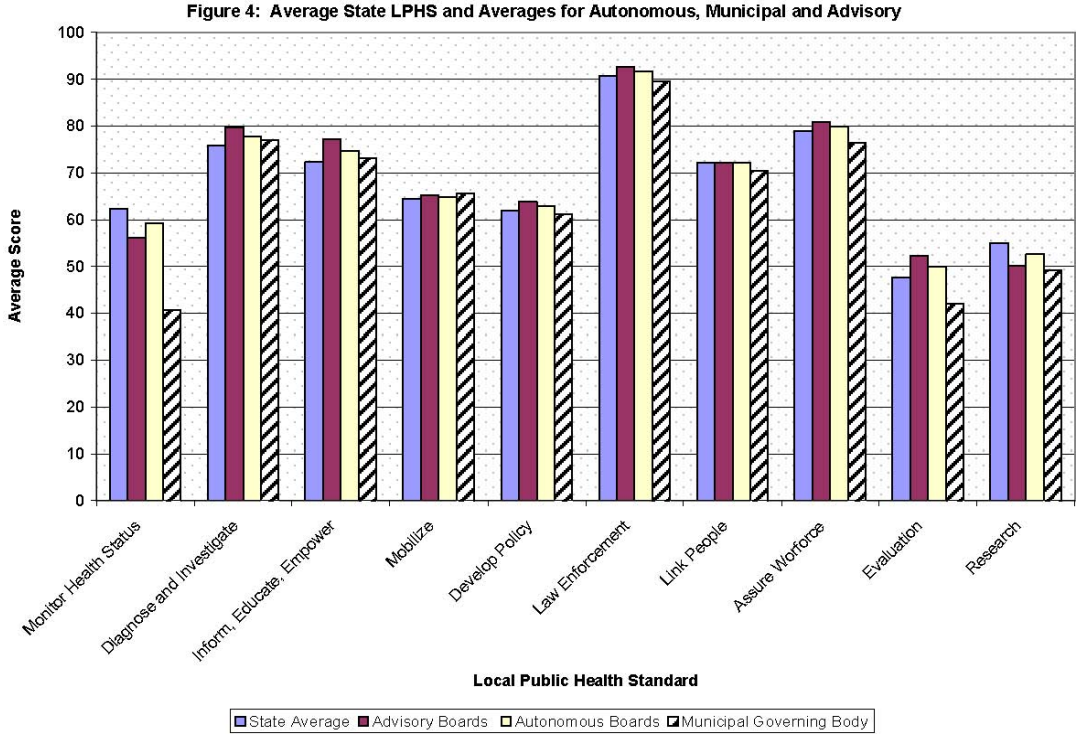
Figure 3: Average State LPHS and Average LPHS for Regional Health Commissions and County Boards of Health



The analysis also revealed that of the five different types of boards of health, those boards that identified themselves as county boards of health had the highest essential service average overall (see figure 3). It is critical to note at this point in the analysis that the sample size was limited for this analysis. Only three county boards and three regional health commissions completed the governance assessment tool. Keeping

this in mind, county boards of health were first compared to the statewide average and then to regional health commissions. As with the state and regional health commission average scores, the county board's "Oversight of Public Health Legal and Regulatory Affairs" standard received the highest score. However, some county scores were higher than state and regional health commission averages, including "Oversight to Ensure Public Health Outreach and Enabling Services," "Oversight of Public Health Workforce Issues," "Oversight of Public Health Service Evaluation," and "Oversight to Ensure Public Health Innovation and Research." Surprisingly, the county board's lowest scoring essential service was monitoring health status, not evaluation (as seen in the state and regional health commission documents). It is also notable that the scoring for regional health commissions dips below the state and county averages for two essential public health standards: "Oversight of Public Health Information, Education, and Empowerment Activities" and "Oversight of Public Health Service Evaluation."

Figure 4: Average State LPHS and Averages for Autonomous, Municipal and Advisory



The third analysis looked at municipal, advisory, and autonomous boards of health.[7] For this analysis, the sample size was 98 governance assessment instruments from autonomous local boards of health, 26 municipal governance instruments, and 21 advisory governance instruments. This analysis revealed small differences in essential

service scoring across these three types of boards, as figure 4 shows. It is relevant to note, however, that municipal governing bodies scored lowest with monitoring health services, similar to county boards of health. The lowest scoring essential service for autonomous and advisory boards of health was evaluation, similar to the state average. Law enforcement remained the highest scoring essential public health service for all three board types.

Overall, the scores for these essential services are close to one another, across municipal, advisory and autonomous boards of health. Final analysis included a review of average county performances for the ten essential public health standards. Boards of health from 18 counties submitted governance assessment instruments. Table 5 outlines the number of documents received from each county. These county numbers cannot be compared against one another since the number of documents received by each county varies. Bergen County submitted the largest number of documents (36), followed by Morris County (21) and Sussex County (18).

Table 5. Governance Tool Documents Received, by County

County	Number of documents submitted	County average[8]	County	Number of documents submitted	County average
Bergen	36	67	Monmouth	11	57
Burlington	2	70	Morris	21	70
Camden	2	82	Ocean	1	91
Cumberland	2	66	Passaic	5	69
Gloucester	2	42	Salem	6	81
Hudson	1	90	Somerset	13	74
Hunterdon	1	85	Sussex	18	62
Mercer	6	58	Union	8	67
Middlesex		90	Warren	11	70

In conclusion, the scoring for each public health service was mostly uniform, with a few exceptions, including the southern New Jersey region and county and regional boards of health. These results are not unrelated, as many county boards of health are centered in southern New Jersey. This analysis outlines the capacity of the public health

system in New Jersey and will be a helpful tool for local health departments to expand services where needed.

Conclusion

This project and study sought to assess the capacity of New Jersey's local boards of health (LBH) relative to national and locally established standards of health practices called **Essential Public Health Services (see appendix 1).** The Local Public Health System Governance Performance Assessment Instrument (Governance Instrument), which was administered by Rutgers University and the New Jersey Local Boards of Health Association (Project Study Team), is part of three performance instruments devised by the Centers for Disease Control in partnership with national and local representatives of the public health infrastructure.

Over the course of a year, the Project Study Team collected 150 Governance Instruments by holding 12 regional meetings across the state of New Jersey; other instruments were completed during local board of health meetings. The study team faced challenges to completing the project and study, including the following:

- The complexity of the New Jersey local health infrastructure, including the fact that LBH are volunteers with limited time to devote to meetings that are not regularly scheduled;
- Perceived complexity of the instrument and time needed to complete the document.

After the governance assessment instruments were collected, they were submitted to an on-line centralized database overseen by the Centers for Disease Control (CDC). Once all 150 instruments were submitted, the CDC generated a statewide aggregate database of survey responses for analysis by the Rutgers Center for State Health Policy.

The analysis indicates that, for the most part, the respondents reported that the

boards of health have capacity if that capacity is defined by the ability to carry out the ten essential services described by the CDC. It is important to point out that of the ten essential services, the respondents identified **(1) Oversight of Public Health Service Evaluation, (2) Oversight to Assure Public Health Innovation and Research, and (3) Oversight of Public Health Policy Making and Planning** as the areas for which they have least capacity. The New Jersey data here are limited and cannot be generalized without caution. Boards of health that participated in the study tended to be those with members who engaged in local board of health affairs at high level and were more connected, on average, to the public health infrastructure. The study revealed that many boards of health are unaware of their responsibilities and function. As such, many local boards of health do not meet on a regular basis. Still others have not met for years. Thus, getting 150 instruments, while an important first exercise, indicates that much more work needs be done to bring the local boards of health into the mainstream of New Jersey's public health infrastructure.

The local boards of health can be an integral first response element in a public health crisis and can perform an important advisory function in routine public health matters, but at the moment, the lack of regular activity and training limits their potential role. The primary recommendation of the Project Study Team is that it is essential to put in place a freestanding evaluative process to assess the role and efficacy of local boards of health, using this study as the basis for future examination. Without such a process, local boards of health may well remain an underutilized and unknown force in New Jersey's local health process.

This study should be seen as a precursor to the evaluative process suggested above, but the results reported here should be built on through the future collection of as many instruments as possible, the results processed, analyzed, and used to start a significant conversation (over a two-year period) regarding role, function, and ability of local boards of health. The collected data and future data should also be used by the county health infrastructure for planning purposes, including a more active role by the counties in building the capacity of their local boards of health. Many counties are already planning and assisting their local boards of health. The goal, however, should be

to reduce the uneven nature of contact between local boards of health and the counties across all the counties of New Jersey.

Apart from our major recommendation, the Project Study Team recommends the following (which flow from the data, project notes, and activities) to help improve the form, function, and capacity of local boards of health:

- Improve the process for maintaining a current contact base of local boards of health members.
- Hold a yearly conference that would help build the knowledge base and capacity of local boards of health.
- Use the data from the Local Public Health System Governance Performance Assessment Instrument process to improve county health planning
- Collaborate with the New Jersey Local Boards of Health Association and the local health officers to establish and disseminate a set of locally derived practice standards.
- Disseminate information to incoming board of health members that defines the roles and responsibilities of the office.
- Collaborate with the New Jersey Local Boards of Health Association to construct a Web portal that contains updated information about health regulation and innovative health practices.
- Work with local universities to establish a health extension program that would help build the capacity of local boards of health.

NOTES

1. The major national partner organizations instrumental in the development of the standards included the Association of State and Territorial Health Officials (ASTHO), the National Association of County Health Officials (NACCHO), and the National Association of Local Boards of Health (NALBOH).

2. Since this program began in 1998, numerous drafts of the instruments have been developed and tested at the state and local levels in several states. The process was first field tested in Texas, Florida, Hawaii, Missouri, Ohio, Minnesota, Mississippi, New York, and Massachusetts.

3. The official public health agency—either at the state or local level—has the major responsibility for carrying out these activities, but the CDC recognizes that public health agencies cannot do this alone. Hospitals, public safety, voluntary health organizations, mental health centers, schools, civic groups, faith institutions, and others all contribute to accomplishing the actions necessary to achieve public health.

4. Much of this section was excerpted from an internal memorandum prepared in 2005 by the Local Public Health Practice and Regional Systems Development Division, New Jersey Department of Health and Senior Services. We wish to thank Richard Matzer, director of the division, for allowing us access to the material.

5. New Jersey is divided into 566 incorporated municipalities for purposes of local government. New Jersey has a strong "home rule" history—a reliance on county and municipal government to meet the needs of its citizens, though much authority to set public policy resides at the state level. The Optional Municipal Charter Law, or Faulkner Act, was enacted in 1950 and revised in 1981. The Faulkner Act offers four basic plans (mayor-council, council-manager, small municipality, and mayor-council-administrator) and two procedures by which the voters of a municipality can adopt one of the plans. Twenty-one percent of municipalities in New Jersey, including the six most populous cities (Newark, Jersey City, Camden, Trenton, Paterson, and Elizabeth), govern under the Faulkner Act. It provides many choices for communities with a preference for a strong executive and professional management of municipal affairs. It also offers initiative, referendum, and recall of elected officials to the citizens. All municipalities have a policy-making body (council, committee, commission, or board of trustees) and a mayor as formal executive (in village form the title is president). The relationship between mayor and policy-making body varies with the form of municipal government. Communities may have an elected executive to manage day-to-day affairs or an appointed administrator. Municipalities may elect officials at-large, by wards, or a combination of the two in either partisan or nonpartisan elections. See also http://www.lwvnj.org/guide/municip.html.

6. A full review of these indicators can be found in appendix 1.

7. Boards that identified as part of a regional health commission as well as an autonomous board were included in the average for autonomous boards of health.

8. “County average” refers to the aggregate score for governance assessment instruments received from each corresponding county.

Appendix 1: Essential Public Health Service Indicators

Ten Essential Services and Corresponding Indicators
Essential Service 1: Oversight to Assure Community Health Status Monitoring; • Assures appropriate resources, guidance, and oversight, • Assures promotion of broad-based participation and coordination, • Assures development, implementation, and review of policies designed to facilitate monitoring, • Assures a process of continuous evaluation and improvement of public health monitoring.
Essential Service 2: Oversight to Assure Public Health Surveillance and Response; • Acts to assist the community in securing the needed resources to carry out these activities, • Assures the development, implementation, and review of policies to ensure the diagnosis and investigation of health threats in the community, • Assures collaboration among all relevant groups for the diagnosis and investigation of health threats to the community, • Conducts periodic reviews of these activities and reports its conclusions and recommendations to the community, • Assures the development, implementation, and review of appropriate polices and procedures for public health emergencies.
Essential Service 3: Oversight of Public Health Information, Education, and Empowerment Activities; • Identifies and facilitates access to national, state, and local resources that could be used in support of these activities, • Assures the development, implementation, and review of written policies encouraging these activities, • Determines whether populations within the community are receiving culturally and linguistically appropriate public health information and education so that they can make positive choices about their individual health status, • Evaluates these activities in light of community needs, including assuring that all population subgroups have an opportunity to provide input on community health issues.
Essential Service 4: Oversight to Assure Constituency Building and Partnership Activity; • Assures constituency building, partnership activities, and resource development partners to identify and solve health problems, • Assures the development, implementation, and review of policies articulation commitment to these activities, • Conducts annual evaluations of these activities and provides relevant feedback to its constituents and the community at large, • Implements strategies to enhance participation among current and potential constituents.

Essential Service 5: Oversight of Public Health Policy Making and Planning;

- Maintains and annually assures the availability of a handbook for its members, has a statutory charter, mission statement, or other strategic planning statement,
- Assures the availability of adequate resources (financial, personnel, and technical) and organizational support necessary to implement the Essential Service of Public Health,
- Assures the development, implementation, and review of polices that support the community health improvement process and works to strategically align community resources for health improvement,
- Convenes all relevant individuals, agencies, or organizations to implement and carry out a community health improvement process that includes the setting of public health objectives and leads to the strategic alignment of resources to improve community health,
- Routinely evaluates, sets goals for, and monitors improvement in community health status,
- Assures that each member of the governing body understands, exercises, and advocates for appropriate legal authority to accomplish these assurance functions.

Essential Service 6: Oversight of Public Health Legal and Regulatory Affairs;

- Assures that appropriate legal authority exists for the adoption, dissemination, evaluation, improvement, and enforcement of laws, rules, and regulations designed to protect the health of the community,
- Assures that its bylaws, rules, and procedures comply with local, state, and federal statutes and regulations,
- Assures its access to legal counsel,
- Identifies and advocates for national, state, and local resources that could be used for public health inspection and enforcement activities,
- Assures an annual evaluation of laws, rules, and regulations that includes the participation of individuals and groups that benefit from particular legal requirements as well as those who are regulated and may oppose particular legal requirements.

Essential Service 7: Oversight to Assure Public Health Outreach and Enabling Services;

- Identifies individuals, agencies, or organizations involved in or responsible for the coordination of services,
- Assures or advocates for necessary authority to allow these people and organizations to provide necessary services,
- Assures culturally and linguistically appropriate materials and staff to provide adequate linkage to services for special population groups,
- Identifies and advocates for national, state, and local resources- both public and private- necessary to facilitate access to needed services for the entire community, with special attention to socially disadvantaged people and high-risk population groups,
- Assures the development, implementation, and review of policies supporting the employment of these resources in the development, coordination, and evaluation of outreach and enabling services,
- Conducts periodic evaluations, including input and feedback regarding potential or actual outreach and enabling services from a wide spectrum of community participants, including representatives of socially disadvantaged and high-risk populations.

Essential Service 8: Oversight of Public Health Workforce Issues;

- Conducts licensing and credentialing of public health personnel, including both paid and volunteer workers,
- Assures development, implementation, and review of policies designed to assure improvements in workforce management, and leadership quality,
- Assures identification of national, state and local resources available for workforce instruction, leadership development, and continuing education,
- Assures the development, implementation, and review of policies for the orientation of new members of each board or governing body,
- Conducts periodic evaluation of current workforce competence- including compliance with licensure and credentialing requirements – and workforce training and education programs.

Essential Service 9: Oversight of Public Health Service Evaluation;

- Assures the development, implementation, and review of policies supporting periodic evaluations of population-based and personal health services, including processes and outcomes of health improvement activities,
- Conducts evaluations in line with community health priorities, and considers relevant aspects of service delivery including scope, timeliness, frequency, cost-effectiveness, and overall quality of essential public health services provided,
- Assures that necessary resources are available to conduct periodic evaluations, including evaluations of the board of health or other governing body itself,
- Assures the development, implementation, and review of written policies endorsing the importance of nationally recognized performance standards applicable to local public health systems and facilitating their application,
- Assures that all public health constituents and partners within the LPHS (including governmental, not-for-profit, and private entities responsible for the provision of the essential public health services) are encouraged to provide input into evaluation processes,
- Assures that the results of evaluations are used to improve system performance.

Essential Service 10: Oversight to Assure Public Health Innovation and Research;

- Assures the development, implementation, and/or review of policies reflecting its commitment to public health research and innovation activities,
- Assists the community in the establishment of linkages between academic (or other health-research) institutions and local public health entities to carry out community-based research activities,
- Assures that research results are incorporated into new policies and programs to reflect the highest current standard of public health practice consistent with community resources.

Appendix 2: State Average Scores for Each Governance Tool Assessment Question

Governance Tool Assessment Survey Question	State Average
EPHS 1: Monitor Health Status	62.32
G1 Oversight to Assure Community Health Status Monitoring	62.32
1_1 Periodically identify individuals, agencies, or organizations active in community health status monitoring?	77.7
1_2 Periodically determine resources necessary for community health status monitoring?	72.56
1_3 Routinely provide oversight of health status monitoring activities?	69.09
1_4 Promote participation among those active in collecting, analyzing, and disseminating data?	62.56
1_5 Assure development, implementation, and/or review of policies that identify data needed?	56.83
1_6 Assure development, implementation, and/or review of policies that designate appropriate uses for data?	56.6
1_7 Annually review reports on the community's health (community health profile)?	61.59
1_8 Use data from community health assessment(s) to monitor progress towards health-related objectives?	58.28
1_9 Continuous improvement of the methods by which the community health status is monitored?	66.14
1_10 Adopt objectives for continuous evaluation and improvement of monitoring efforts?	41.85
EPHS 2: Diagnose and Investigate Health Problems	75.77
G2 Oversight to Assure Public Health Surveillance and Response	75.77
2_1 Assure access to appropriate resources required for diagnosis and investigation of health threats?	93.17
2_2 Lobby or advocate for a change in resource allocation for diagnosis and investigation of health threats?	87.86
2_3 Assure development, implementation, and/or review of policies /procedures for diagnosis and investigation?	64.17
2_4 Review of authority and regulatory mechanisms that support the diagnosis and investigation?	67.99
2_5 Assure collaboration among individuals, agencies, or organizations regarding diagnosis and investigation?	80.35

2_6 Reviews of laboratory services, epidemiologic programs, and surveillance and response capacity?	49.05
2_7 Assure development, implementation, and/or review of policies and procedures for emergencies?	87.8
EPHS 3: Inform, Educate, and Empower People	72.35
G3 Oversight of PH Information, Education, and Empowerment Activities	72.35
3_1 Assure access to resources required for community health information, education, or empowerment?	87.63
3_2 Assure written policies in support of public health information, education, and empowerment programs?	72.95
3_3 Assure culturally and linguistically appropriate public health information and education?	62.91
3_4 Assure a periodic evaluation of public health information, education, and empowerment activities?	65.91
EPHS 4: Mobilize Partnerships	64.53
G4 Oversight to Assure Constituency Building and Partnership Activity	64.53
4_1 Identify those providing public health leadership in constituency building and partnership activities?	79.03
4_2 Assure access to resources that could be used for constituency building or partnership activities?	79.25
4_3 Assure coordination of resources to enhance partnerships and collaborations?	75.72
4_4 Assure written policies in support of public health constituency building or partnership activities?	48.57
4_5 Annually assure an evaluation of public health constituency and partnership activities is performed?	45.45
4_6 Periodically implement strategies to enhance participation among current and potential constituents?	59.16
EPHS 5: Develop Policies and Plans	61.93
G5 Oversight of Public Health Policy Making and Planning	61.93
5_1 Maintain and annually assure the availability of a handbook in paper or electronic format?	67.48
5_2 Have a statutory charter, mission statement, or other similar strategic planning statement?	56.56

5_3 Assure adequate resources and organizational support necessary to implement the EPHS?	78.81
5_4 Support a community health improvement process?	61.37
5_5 Assure all relevant individuals, agencies, and organizations have opportunity to participate in the CHIP?	55.63
5_6 Evaluate the community health improvement process?	44.8
5_7 Assure that each of its members understands, exercises, and advocates for appropriate legal authority?	68.87
EPHS 6: Enforce Laws and Regulations	90.7
G6 Oversight of Public Health Legal and Regulatory Affairs	90.7
6_1 Annually assure its authority to enact laws, rules, and regulations?	91.93
6_2 Assure the sources of authority for each person and organization involved in the following?	95.12
6_3 Assure that its bylaws, rules and procedures comply with local, state, and federal statutes and regulations?	95.61
6_4 Assure its access to legal counsel?	96.91
6_5 Assure the identification of resources for inspection and enforcement activities?	94.7
6_6 Routinely advocate for laws and regulations that protect health and ensure safety?	89.91
6_7 Annually evaluate the laws, rules, and regulations it has enacted in the past year?	67.54
6_8 Enter into or ratify any contracts for provision of the Essential Services of Public Health?	93.91
EPHS 7: Link People to Needed Personal Health Services	72.27
G7 Oversight to Assure Public Health Outreach and Enabling Services	72.27
7_1 Identify those responsible for the coordination of needed outreach and enabling services?	84.11
7_2 Assure or advocate for necessary authority to allow those identified to deliver needed services?	83.66
7_3 Assure culturally and linguistically appropriate materials and staff for special population groups?	66.67
7_4 Identify and advocate for resources necessary to facilitate access to needed services for the community?	77.89
7_5 Assure policies supporting the employment of these resources in outreach and enabling services?	66.67
7_6 Have the authority to obtain information necessary to monitor outreach and enabling services?	78.81

7_7 Periodically conduct an evaluation of community outreach and enabling services?	48.11
EPHS 8: Assure a Competent Workforce	79.01
G8 Oversight of Public Health Workforce Issues	79.01
8_1 Assure the proper credentialing of the public health workforce?	94.48
8_2 Assure the maintenance of credentials and licenses held by public health workforce personnel?	93.38
8_3 Routinely assure development, implementation, and/or review of policies supporting workforce competency?	79.88
8_4 Routinely assure development, implementation, and/or review of policies supporting leadership development?	85.76
8_5 Assure policies that describe/define knowledge, skills, and abilities needed by the public health workforce?	80.35
8_6 Assure policies that describe/define knowledge, skills, and abilities needed by personal healthcare workforce?	54.97
8_7 Routinely assure policies supporting continuing education for public health workers?	84.33
8_8 Identify resources that could be used for workforce training, leadership development, or continuing education?	86.95
8_9 Routinely assure policies supporting orientation of new members of the BOH or other governing body?	57.06
8_10 Assure annual performance evaluations of the workforce employed to provide public health services?	67.77
8_11 Review reports of workforce training, leadership development, and continuing education efforts?	73.95
8_12 Evaluate the extent to which public health personnel are properly licensed and credentialed?	89.18
EPHS 9: Evaluate Effectiveness, Accessibility, and Quality	47.77
G9 Oversight of Public Health Service Evaluation	47.77
9_1 Routinely assure policies supporting the evaluation of population-based health service delivery?	53.2
9_2 Routinely assure policies supporting the evaluation of personal healthcare service delivery?	42.83
9_3 Assure an evaluation plan for personal and population-based services?	41.72
9_4 Assure that the evaluation plan has been implemented?	41.06
9_5 Annually identify resources that could be used to support evaluation?	46.58

9_6 Assure policies endorsing the importance of nationally recognized performance standards for LPHSs?	60.32
9_7 Identify individuals, agencies, or organizations that will participate in the evaluation process?	50.86
9_8 Review the findings of the evaluation?	46.14
9_9 Recommend changes based on the evaluation results?	47.24
EPHS 10: Research for New Insights and Innovative Solutions	55.05
G10 Oversight to Assure Public Health Innovation and Research	55.05
10_1 Assure the development, implementation, and/or review of policies designed to foster and reward innovation?	43.75
10_2 Periodically identify those engaged in community-based research for new insights or innovative solutions?	55.85
10_3 Assure collaboration between academic institutions and local public health entities?	55.19
10_4 Assure that agency staff have reviewed information sources relating to innovative public health practice?	65.41
Average Total Performance Score	68.17