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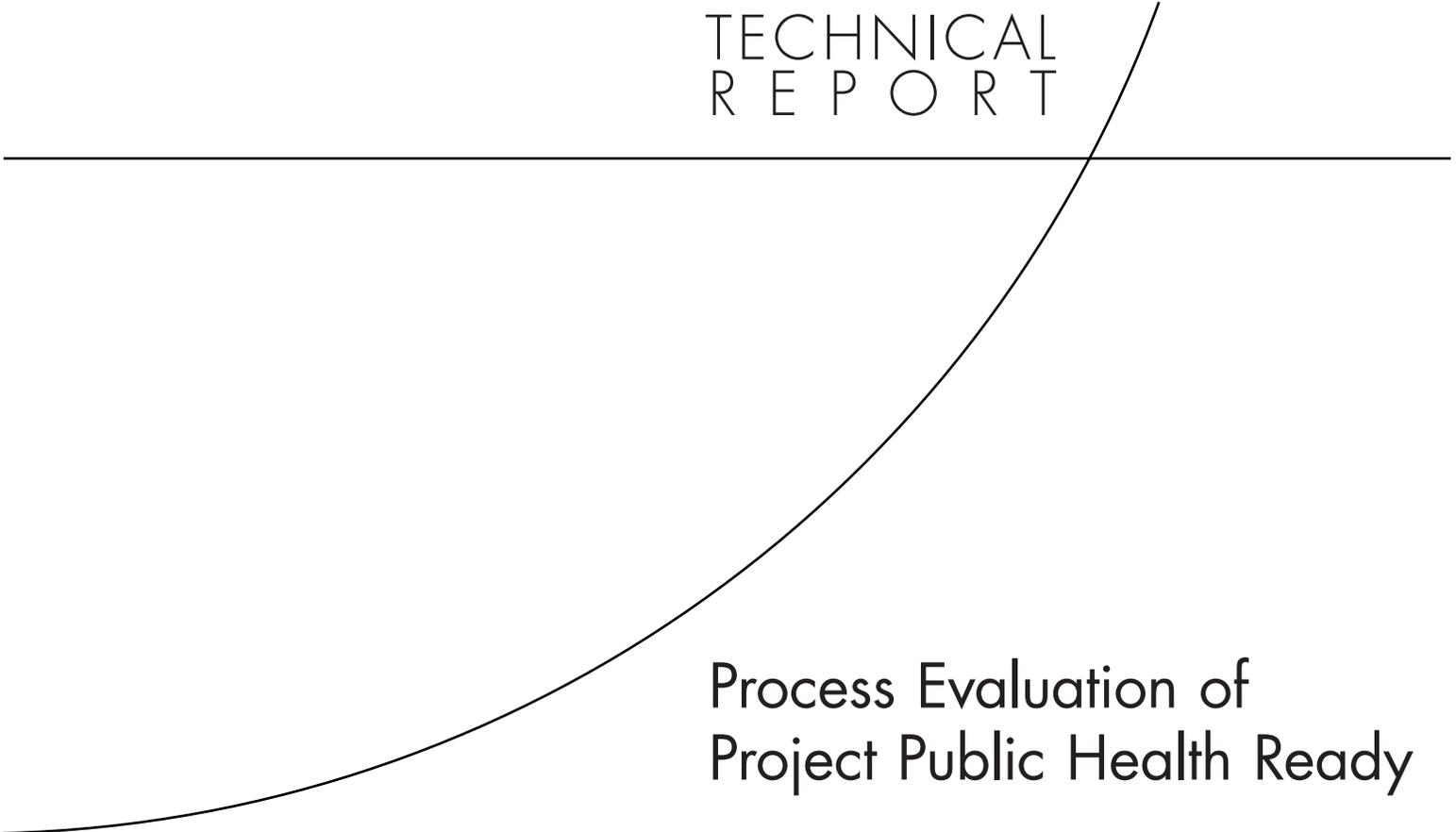
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# Process Evaluation of Project Public Health Ready

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Sponsored by the National Association of County and City Health Officials



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International Health Security

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## SUMMARY

### BACKGROUND

The National Association of County and City Health Officials (NACCHO) in March 2004 contracted with the RAND Center for Domestic and International Health Security to evaluate the pilot year of its Project Public Health Ready program. This report describes the results of this evaluation. The report begins with a brief description of the public health preparedness context, NACCHO, and Project Public Health Ready (PPHR). We then describe our evaluation methodology and summarize our findings. Finally, we describe the resulting conclusions and recommendations.

Specific evaluation objectives, which were developed in consultation with NACCHO project leaders, were to:

- Identify issues related to project management and implementation that can be used both immediately and in the future to improve program quality.
- Identify appropriate ongoing evaluation strategies for subsequent years of PPHR.
- Describe whether, how, and the extent to which local public health agencies used the PPHR program and took advantage of the resources built into the process.
- Describe a sample of participants' preparedness to respond to a bioterrorism event following participation in the project (and, if feasible, compare current with prior preparedness).
- Describe participants' perceptions of the value of the program, especially regarding enhancement of knowledge and skills related to emergency preparedness.
- Provide NACCHO and its partners with data that can be used to inform future program direction.

### METHODS

In the initial year of the PPHR program, 13 sites were recruited and 2 did not complete the requirements. We interviewed individuals from all 11 sites that completed the PPHR requirements.

Interviews for three of the sites were conducted during in-person visits. During our site visits, we also conducted a tabletop exercise on preparedness and interviewed at least one individual from the state health department and the academic public health preparedness center associated with each location. These sites

were selected based on recommendations from NACCHO Project Public Health Ready staff and their location in diverse geographic areas and within states with a variety of public health organizational structures, and they may not be representative of other PPHR sites. Interviews for the remaining eight sites were conducted via telephone.

The semi-structured interviews lasted approximately 45 minutes and allowed for participants' additional comments throughout. In all interviews, participants were assured of the anonymity and confidentiality of their individual responses. They were also informed that participation was voluntary and would have no impact on future PPHR recognition or participation. RAND's Institutional Review Board approved this project and our methodology.

## **CONCLUSIONS AND RECOMMENDATIONS**

Overall, Project Public Health Ready was a positive force in the efforts of participating local public health agencies (LPHAs) to prepare for bioterrorism and public health emergencies. Participation in the project provided these LPHAs with (1) a framework to use in organizing their preparedness activities; (2) ideas, materials, and support from their colleagues in the national program, academic public health preparedness centers, and elsewhere; and (3) recognition for their department's efforts. Additional positive results included improved relationships with critical local partners and an improved sense of purpose and understanding of public health functions among department staff. It was not possible to clearly differentiate PPHR activities from other preparedness efforts mandated by CDC, state health departments, and others, but participating departments generally felt that their participation in PPHR helped them to better meet all of their expectations. In particular, PPHR deadlines and requirements led LPHAs to become prepared earlier than if they had not participated in the program. Although a systematic outcome assessment was beyond the scope of our work, we were impressed with the bioterrorism-related activities and planning discussed by the LPHAs that we site visited, and especially with their performance in the tabletop exercise.

Most of the limitations of the project were associated with its status as a pilot program and the early state of development of standards, materials, and knowledge about public health preparedness. LPHAs began the project without a clear idea of the requirements, which were developed during the pilot year. PPHR requirements were, to some extent, inconsistent with state and CDC expectations, themselves very much in flux. Guidance and materials that participants thought would be provided were either not available at all, or the partner academic centers and state health departments were not able to locate and supply them. Support from academic centers and state departments generally was variable, depending in part on these partners' own state of development. Interviewees praised NACCHO staff for their efforts, especially given the challenging start-up situation.

Although there were often substantial non-reimbursed costs associated with participating in PPHR, each of the participating departments said that they were glad to have chosen to be part of the program and would participate again.

Based on the interview and exercise findings that are detailed in the report, the evaluation team offers the following findings and conclusions, followed by associated recommendations, to NACCHO and its partners as they shape future rounds of PPHR.

**Table S.1  
Summary of Key Themes and Corresponding Recommendations**

<b>Findings</b>	<b>Recommendations</b>
<i>Overall PPHR Assessment</i>	
<ul style="list-style-type: none"> <li>• PPHR provides a useful, relevant, efficient, and needed model for organizing public health preparedness planning and training activities as well as assessing and improving workforce competencies. With the incorporation of the recommendations included in this report, it has the potential to become an important tool for LPHAs—and indeed regions and states—nationwide.</li> <li>• PPHR and its components are seen by many as models or paradigms for dealing with a variety of day-to-day public health issues—from HIV-contact-tracing investigations to setting up clinics for flu vaccination campaigns.</li> <li>• The recognition attached to successful PPHR completion is very important to LPHAs. It is a reward for their hard work as well as a leverage point for greater recognition in their communities and states.</li> <li>• In some cases, LPHAs’ PPHR efforts were conducted in close collaboration with surrounding communities that were not formal participants in the project.</li> </ul>	<ol style="list-style-type: none"> <li>1. Continue the PPHR project, seeking to implement it on a larger scale and potentially organizing it at the state or regional level.</li> </ol>

Findings	Recommendations
<i>Implementation</i>	
<ul style="list-style-type: none"> <li>• Sites had little guidance regarding the best way to actually implement the PPHR activities. Most found creative ways to get started that suited their agency characteristics and culture. They described what worked (and what did not work) about the approaches they developed.</li> <li>• PPHR is not a “one size fits all” project. LPHAs worked hard to implement it in ways that were appropriate for their characteristics and culture. No two sites had the same approach, mix of individuals involved, or financial or staffing circumstances at the outset.</li> <li>• Leadership from the LPHA director or other key leaders is essential to successful completion of the requirements.</li> </ul>	<p>2. Provide new sites with case studies of the approaches that the pilot sites undertook to implement PPHR activities, with an emphasis on the appropriateness and adaptability of each approach to LPHAs with different characteristics and cultures. Include the key role of LPHA leaders.</p>
<i>Site Characteristics</i>	
<ul style="list-style-type: none"> <li>• The pilot sites – particularly those that received site visits from the evaluation team –were in many ways among the “cream of the crop.” Despite the differences in the PPHR approaches and products, 11 out of the 13 sites that began the program received PPHR recognition.</li> </ul>	<p>3. NACCHO and its partners must be cautious in adapting the model to future participating sites, which may not enter the project with the same capacities, public health and political savvy, and level of preparedness as the pilot sites. Encouraging a mentoring relationship with past PPHR participants is one potential way to address this.</p>
<i>Time and Effort</i>	
<ul style="list-style-type: none"> <li>• Although most believed that PPHR participation was well worth the time and resources required, they were all concerned with the lack of adequate staff to complete the PPHR requirements at the same time that they had to continue fulfilling their day-to-day public health roles and activities.</li> <li>• Some LPHAs encountered conflicts between PPHR requirements and state or CDC requirements for bioterrorism preparedness.</li> </ul>	<p>4. Work with partner agencies, including CDC, to enhance state’s understanding of and engagement with LPHAs’ PPHR activities.</p> <p>5. Provide templates or guidance for meshing PPHR plans with existing local, state, or regional preparedness plans. Most LPHAs entering PPHR this year will have already developed plans as part of these broader efforts and should not have to reinvent the wheel.</p>
<i>Plan Development and Writing</i>	
<ul style="list-style-type: none"> <li>• While training usually addressed a wide array of LPHAs’ staff, the development and writing of preparedness plans tended to center around the LPHA director and/or other core leadership staff. In some cases, just one person wrote the plan.</li> </ul>	<p>6. Require a participatory plan development and writing approach. Extending timelines and providing tools for plan development—including sample work plans—may be needed to facilitate this.</p>

Findings	Recommendations
<i>Changes in Priorities, Deliverables, and Timing</i>	
<ul style="list-style-type: none"> <li>LPHAs voiced substantial frustration over shifting priorities, deliverables, and timelines, although most understood that this was a by-product of being a pilot site. Nonetheless, it created some residual ill will.</li> </ul>	<ol style="list-style-type: none"> <li>Make requirements and timelines clear up front and provide sites with a realistic assessment of the potential that priorities may change during the project. Provide estimates of the time and resources needed to complete the requirements based on the experience of pilot sites.</li> <li>Implement an evaluation strategy from the outset of the project. If present from the beginning, evaluators could help the project team craft objectives that are measurable and lend themselves to more rigorous qualitative and quantitative analyses. Additionally, evaluators could attend project meetings, conference calls, etc. and be able to assess these activities with objectivity, rather than relying on second-hand reports months after the fact. They could also provide important data for quality assessment.</li> </ol>
<i>Tools and Models</i>	
<ul style="list-style-type: none"> <li>LPHAs voiced frustration over a lack of concrete tools and models provided by PPHR leaders and state and academic partners. Many believed that this was because there were few tools out there—or no means by which to evaluate the usefulness of the tools.</li> </ul>	<ol style="list-style-type: none"> <li>Provide more concrete tools, templates, and model documents to participating sites. Rely as much as possible on products developed by the pilot LPHAs.</li> <li>Provide a clearinghouse for information and evaluation of training opportunities that address PPHR competency requirements so that sites do not have to “weed through” the available offerings.</li> <li>Develop and/or disseminate standardized exercises, which are scaleable to varied health departments. Include standardized after-action reports to more objectively gauge preparedness.</li> </ol>
<i>Site Visits and Other Interactions</i>	
<ul style="list-style-type: none"> <li>There seemed to be very limited interaction among participating LPHAs (aside from formal PPHR-wide meetings and conference calls). No participants mentioned site visits; only a few mentioned informal interactions.</li> </ul>	<ol style="list-style-type: none"> <li>Consider enhancing PPHR activities to include funded site visits by participating LPHAs or others that have completed the program, including observing others’ exercises.</li> </ol>
<i>Training Assessment Tools</i>	
<ul style="list-style-type: none"> <li>The use of training needs assessment tools created some confusion for PPHR sites. Many found the tools they used to be unsatisfactory or inefficient. The University of Illinois at Chicago Learning Management System was used by several sites and garnered the most positive feedback.</li> </ul>	<ol style="list-style-type: none"> <li>Consider using one training assessment tool for all sites or providing criteria for choosing an appropriate tool based on LPHA characteristics.</li> </ol>