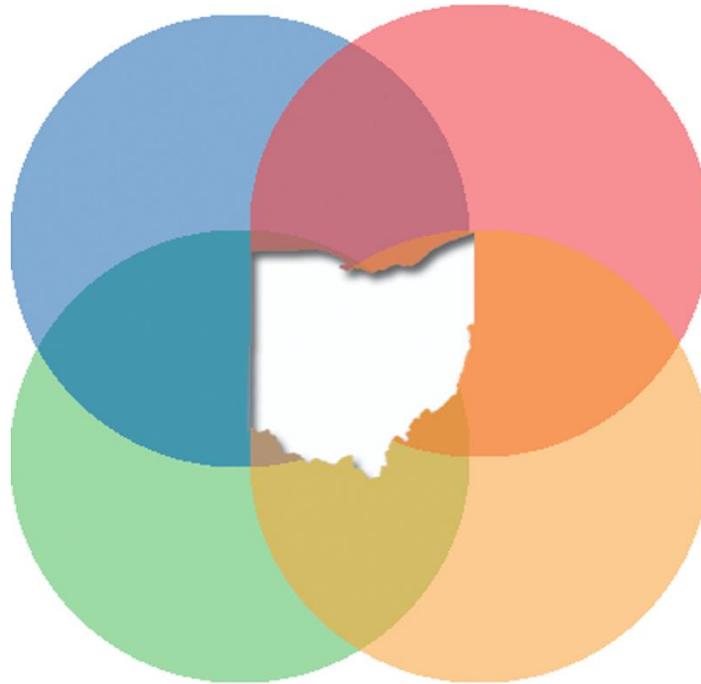




# Public Health Futures

Considerations for a New Framework for Local Public Health in Ohio





# Project Objectives

1. Describe the current status of Ohio's local public health departments (LHDs), including structure, governance, funding, and current collaboration.
2. Identify rules, policies, and standards that may impact the future of local public health (including statutory mandates, national public health accreditation standards, and policy changes affecting health care, such as the Affordable Care Act).
3. Identify stakeholder interests and concerns and develop set of criteria for assessing new models of collaboration or consolidation.



# Objectives, continued

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# Methods

## Current status of Ohio LHDs

- Review of descriptive information about Ohio LHDs, regulatory scan, and AOHC member collaboration survey

## Stakeholder considerations and lessons learned

- Key-informant interviews, literature review

## Consensus and recommendations

- All-member and district meetings, Steering Committee discussions, approval of recommendations



# The Road to Consensus

- Cross jurisdictional sharing and/or regionalization were initially primary focus
- Became clear during consensus-building process that enhancing quality and assuring value were equally—if not more—important
- Shared services = means to an end
- First need to describe a vision for *what* local public health should be doing, and then to develop a framework for *how* to fulfill that vision





# Part 1

## The Current Status of Ohio's Local Health Departments

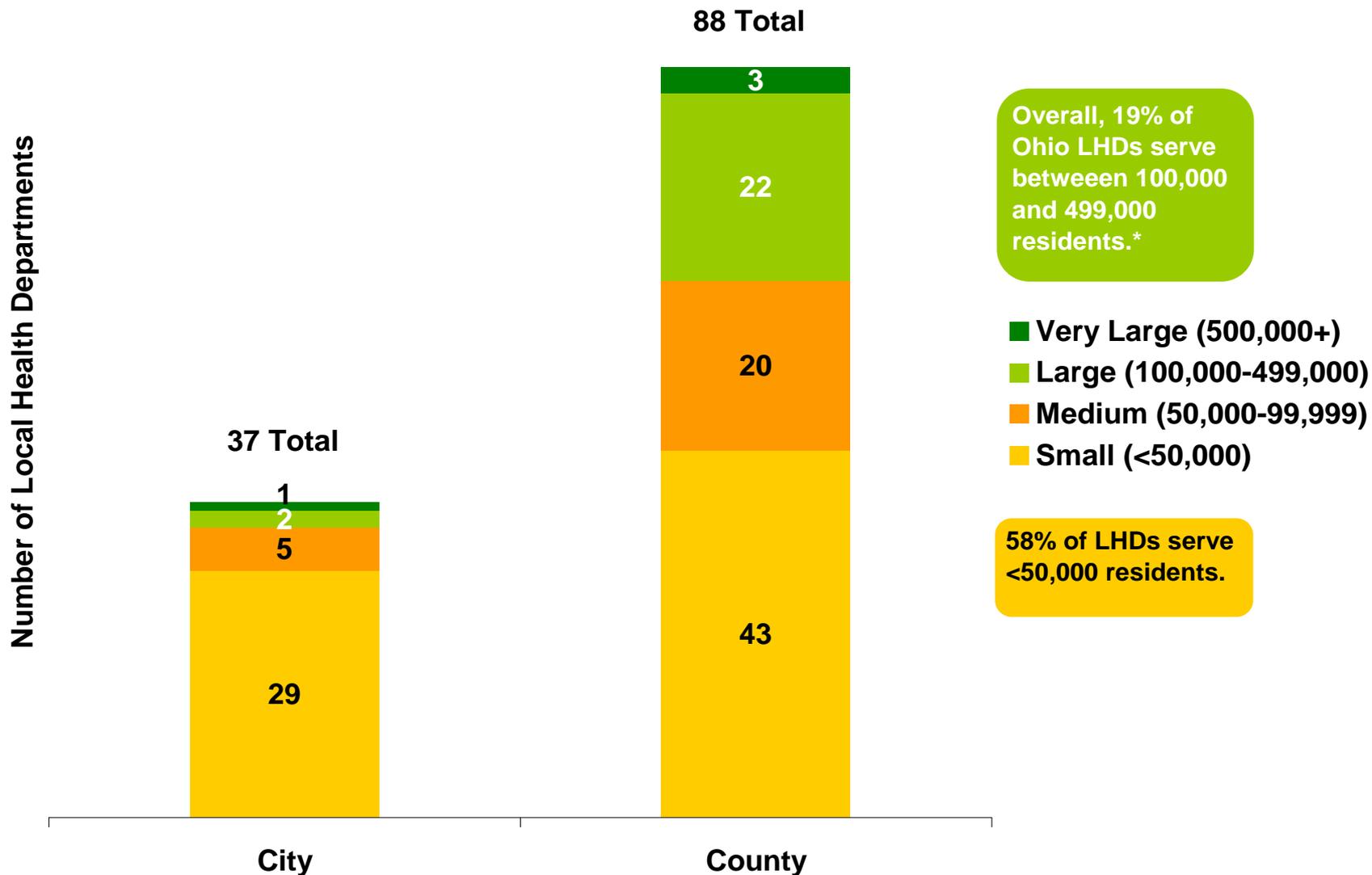


# Structure & Governance

- Local, decentralized structure
- Significant variability across LHDs in terms of population size, per-capita expenditures, and capacity
- 71% of LHDs are general/combined (“county”), 29% are “city”
- 74% of counties have one LHD



# Number of city and county LHDs, 2011



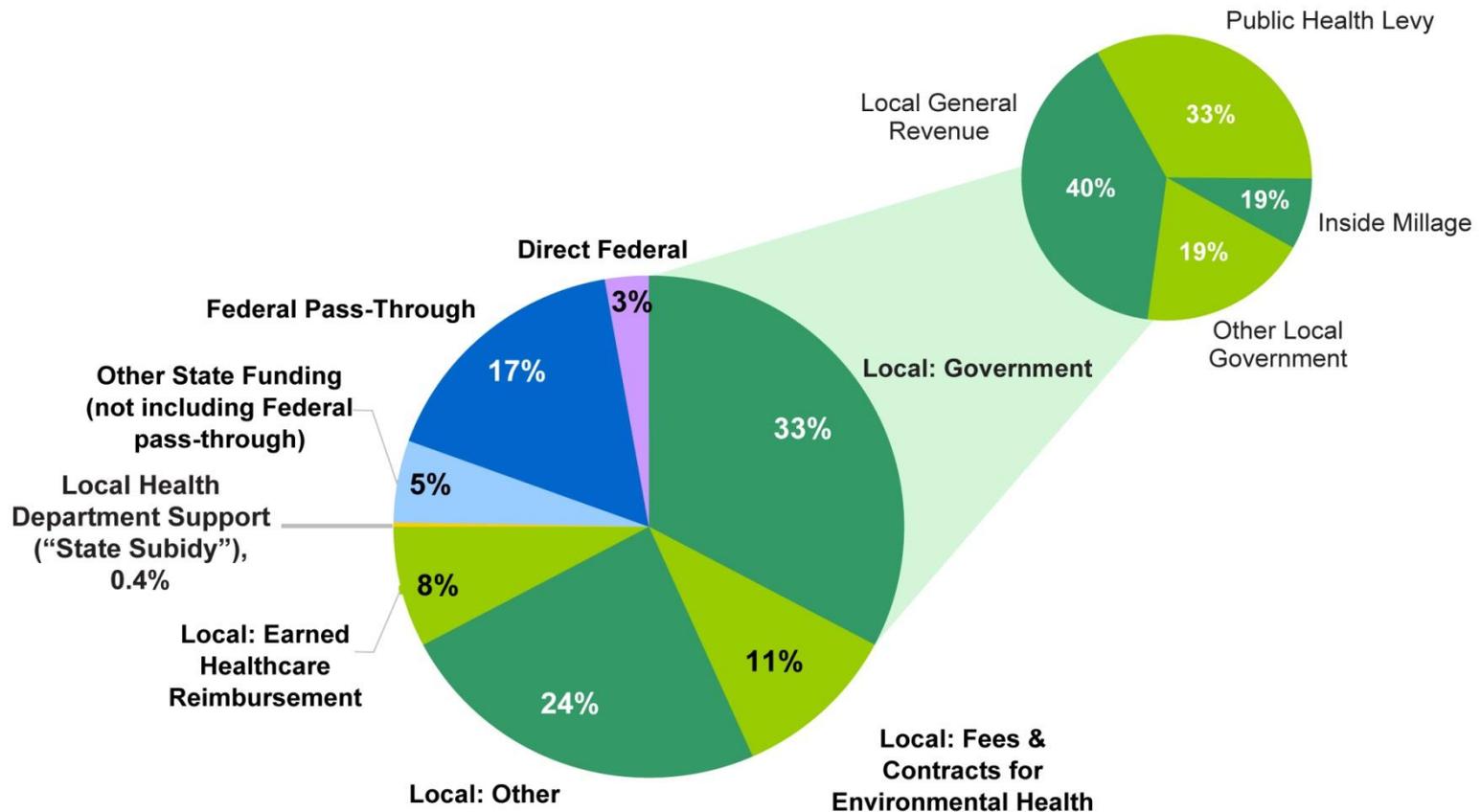


# Funding

- Ohio ranks 33<sup>rd</sup> in median per-capita LHD expenditures and 41<sup>st</sup> state public health expenditures
- Local funding = about 75% of revenue
  - Varies widely by jurisdiction
  - Vulnerable to local political conditions
- State-generated revenue= about 6%
  - Although 22% of revenue flows through the state (including federal pass-through)

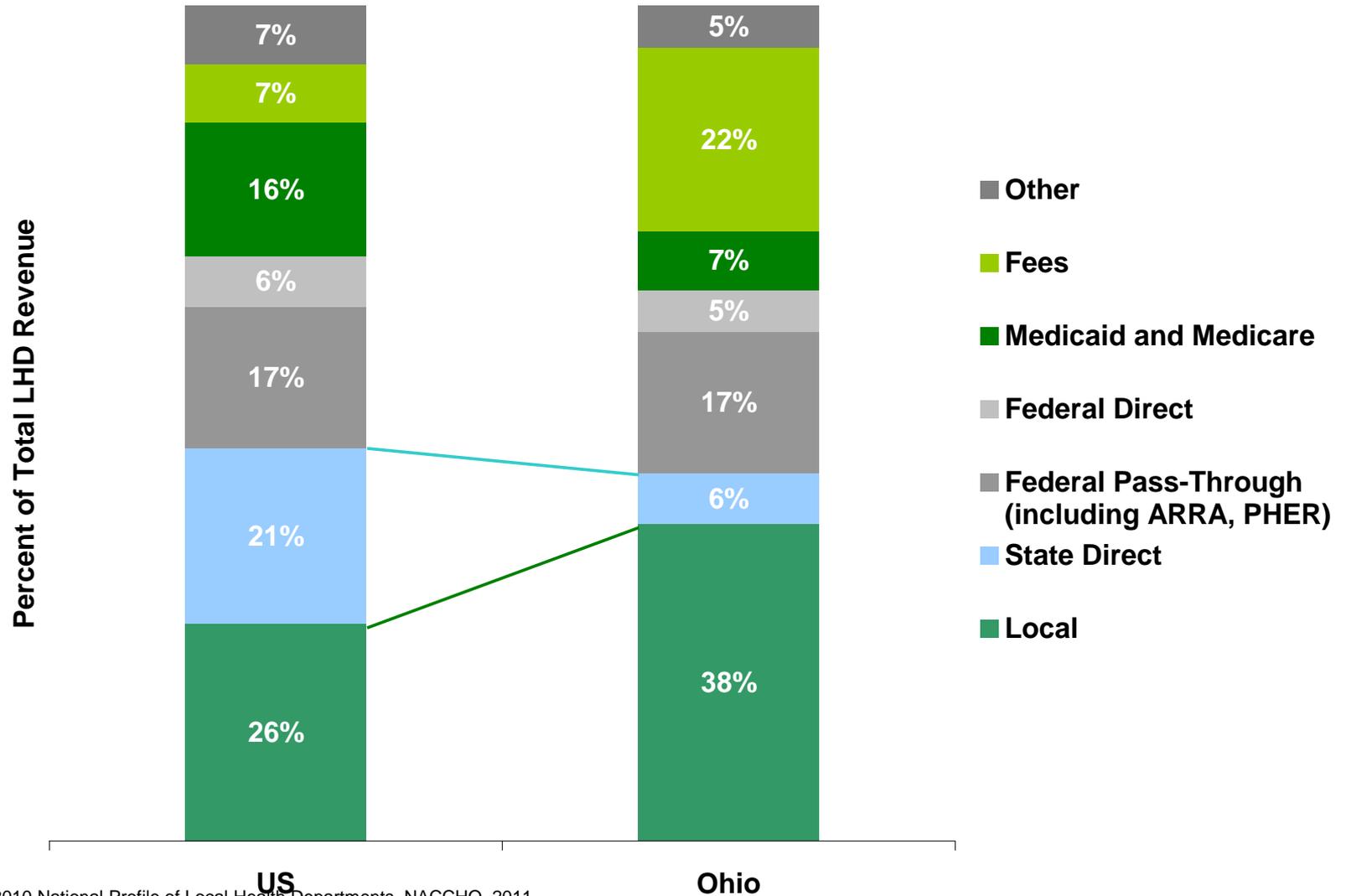


# 2010 LHD Revenue, by category (total \$564,835,411)





# Percent of total annual LHD revenue, US & Ohio



Source: 2010 National Profile of Local Health Departments, NACCHO, 2011



# Current Collaboration

- Since 1919, number of functioning LHDs decreased from 180 to 125
  - City-county unions (mergers)
  - Contract arrangements
- LHDs currently engage in great deal of collaboration and resource sharing (2012 AOHC Survey results)
  - 90% reported contractual arrangements
  - 66% reported shared services or “pooling”
  - 51% reported more sharing over past four years (42% no change, 8% less)



# **Strong Interest in Future Sharing**

**Services with greatest “high interest” in future sharing, among those not currently being shared:**

- **Expertise**
  - Subject matter experts, Leadership development, Policy development, and Accreditation guidance
- **Administrative**
  - Information technology, human services, technology



# Economic Environment

- According to 2009 NACCHO survey, 72% of LHDs reported loss of staff and 85% reported cuts to at least one program
- “Leaner government” at state and local levels
- ODH staff reductions = fewer services provided for LHDs



# Policy Environment

- Accreditation and performance improvement standards
  - New tools for describing and assessing essential functions
- Health care reform
  - ACA: Access to care, Data, Resources
  - Ohio reforms: Office of Health Transformation initiatives
- State Health Improvement Plan



# Challenges

- Complexity and fragmentation of funding
- Opportunities for better alignment between funding streams and the services LHDs are mandated and expected to provide

Services LHDs  
**Can** provide

Services LHDs  
**Must** Provide

Services LHDs  
**Should** Provide

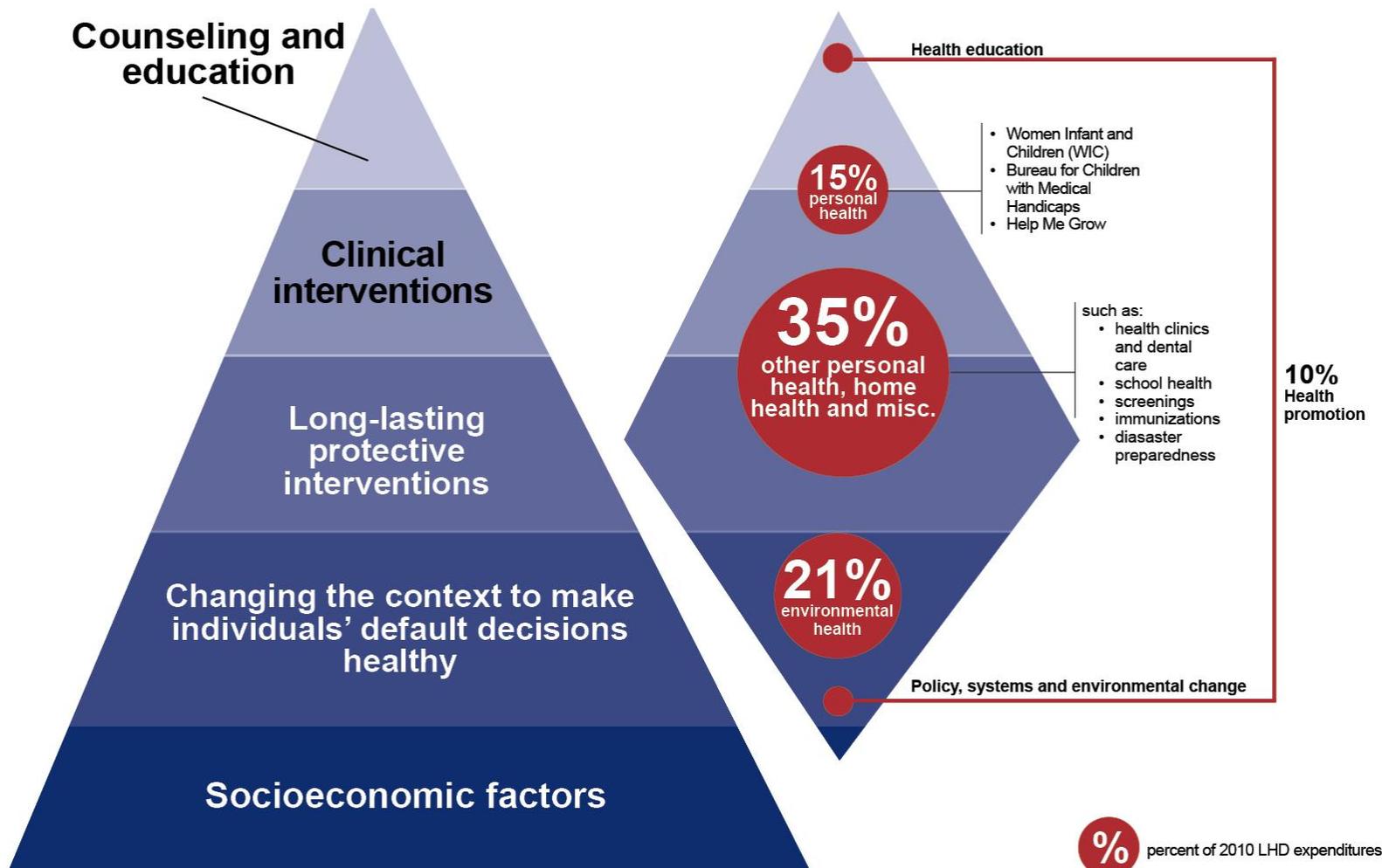
\$

Mandated services  
(ORC, OAC)  
& Relationships  
with state agencies

PHAB standards,  
Health Impact  
Pyramid,  
& Community Needs



# Health Impact Pyramid and Percent of 2010 Ohio LHD expenditures





## Part 2.

- Stakeholder Considerations: Key Informant Interviews (n=25)
- Lessons Learned: Literature review and Ohio shared services examples



# Key Messages from Key Informants

- The time is right to develop a new model
- Already doing a great deal of collaborating, but high motivation to do more and find new ways to share
- Next steps should be empowering – initiated by local public health



# Key Messages

- No single strategy emerged for future model of cross-jurisdictional sharing
- Issue: How many local health agencies there should be?
- Issue: consolidation as way to get there: “not a silver bullet” and “not one size fits all”



# Key Messages

- Need to define future model for local public health
  - Minimum standard of public health protection should be available statewide
  - **High priority:** find a way to organize and fund capacity to support minimum standard
  - Identifying truly local needs
  - Prioritize what public health can do that other systems cannot or will not do
  - Be more connected with broader health care system



# **Lessons Learned:**

## **Success Factors from Literature Review and AOHC Collaboration Survey**

- Mutual trust and a history of collaboration
- Strong commitment from top-level leadership
- Partnerships between communities with similar demographics
- Success at increasing efficiency and/or cost reductions



# Lessons Learned, continued

- Ability to maintain services needed and expected by community but no longer feasible for one LHD to provide
- Achieving clarity of purpose about reasons for engaging in collaboration
- Weighing the costs of collaboration and anticipating business process barriers



# Key Concepts

- Shared Services Continuum
- Clarity of Purpose
- Determinants of LHD Performance
- Minimum Efficient Scale
- Public Health Accreditation Board Standards
- Health Impact Pyramid
- Minimum Package of Public Health Services



# Part 3

## Consensus and Recommendations



# Vision

The Association of Ohio Health Commissioners (AOHC) envisions a future where all Ohioans are assured basic public health protections, regardless of where they live, and where local public health continues to be a vital leader in improving Ohio's health outcomes. We envision a network of local health departments that:

- Are rooted in strong engagement with local communities;
- Are supported by adequate resources and capabilities that align with community need and public health science; and
- Deliver high quality services, demonstrate accountability and outcomes, and maximize efficiency.



# Recommendations

- Rationale: Key challenges and opportunities addressed by the recommendations
- Steering Committee Recommendations
  - Local public health capacity, services, and quality
  - Jurisdictional structure
  - Financing
  - Implementation strategy



# **Challenges and Opportunities– Role of Public Health**

- Maintain communicable disease prevention and environmental health protections
- Assert PH's role in chronic disease prevention and population health approach
- Re-balance clinical services role within new healthcare landscape
- Lead health outcomes improvement
  - State and Community Health Improvement Plans



# **Challenges and Opportunities– Structure**

- Strike balance between local control and statewide standardization
- Use cross-jurisdictional sharing and consolidation as tools to build LHD capacity and improve performance



# Challenges and Opportunities— Finance

- Build political support for increasing—or at least maintaining—funding for local public health
- Identify initial steps to address problems caused by fragmented funding:
  - Lack of dedicated funding for Foundational Capabilities or cross-jurisdictional sharing or consolidation
  - Inability to make long-term investments due to revenue instability
  - Misalignment between current funding streams and services LHDs are mandated and expected to provide based on current public health science and local community need



# #1

- All Ohioans, regardless of where they live, should have access to the Core Public Health Services described in the Ohio Minimum Package of Local Public Health Services.



# Ohio Minimum Package of Local Public Health Services

## Core public health services

All LHDs should be responsible for providing the following services in their district — directly or by contracting with another LHD

- **Environmental health services**,\* such as water safety, school inspections, nuisance abatement, and food safety (restaurant and grocery store inspections)
- **Communicable disease control**, vaccination capacity, and quarantine authority\*
- **Epidemiology** services for communicable disease outbreaks and trending\* and disease prevalence and morbidity/mortality reporting\*
- **Access to birth and death records**
- **Health promotion and prevention** (health education\* and policy, systems, and environmental change)
  - Chronic disease prevention (including tobacco, physical activity, nutrition)
  - Injury prevention
  - Infant mortality/preterm birth prevention
- **Emergency preparedness**, response, and ensuring safety of an area after a disaster
- **Linking people to health services** to make sure they receive needed medical care\*
- **Community engagement**, community health assessment and improvement planning, and partnerships

\*Service mandated by state of Ohio (ORC, OAC) (Note: Ohio law mandates several specific services related to environmental health and communicable diseases. Not all are listed here. See Appendix D for complete list.)

## Other public health services

(Varies by community need as determined by Community Health Assessments)  
LHDs play a role in assuring that these services are provided in their community — either by local public health or other organization(s), including health care providers and other government agencies

### Clinical preventive and primary care services

- Immunizations
- Medical and dental clinics (primary care)
- Care coordination and navigation
- Reproductive and sexual health services (including STD testing, contact tracing, diagnosis, and treatment)

### Specific maternal and child health programs, such as

- WIC (Women Infants and Children) nutrition program
- Help Me Grow home visiting program (HMG)
- Bureau for Children with Medical Handicaps program (BCMh)

### Non-mandated environmental health services, such as

- Lead screening, radon testing, residential plumbing inspections, etc.

### Other-optional depending on community need and other available providers

- Home health, hospice care, home visiting programs (other than HMG)
- School nurses; Drug and alcohol use prevention; Behavioral health
- Municipal ordinance enforcement

## Foundational Capabilities

All LHDs should have access to the following skills and resources. Access can occur through cross-jurisdictional sharing.

### Quality assurance

- Accreditation
- Quality improvement and program evaluation
- Identification of evidence-based practices

### Information management and analysis

- Data analysis expertise for surveillance, epidemiology, community health assessment, performance management, and research
- Information technology infrastructure
- Interface with health information technology

### Policy development

- Policy analysis and planning
- Expertise for policy, systems, and environmental change strategies

### Resource development

- Grant writing expertise and grant seeking support
- Workforce development (training, certification, recruitment)
- Service reimbursement, contracting, and fee collection infrastructure (interface with third party payers)

### Legal support

- Specialized consultation and analysis on public health law

### Laboratory capacity

- Environmental health lab
- Clinical lab services (as appropriate)

### Support and expertise for LHD community engagement strategies

- Community and governing entity engagement, convening and planning
- Public information, marketing, and communications
- Community health assessment and improvement planning
- Partnerships to address socio-economic factors and health equity

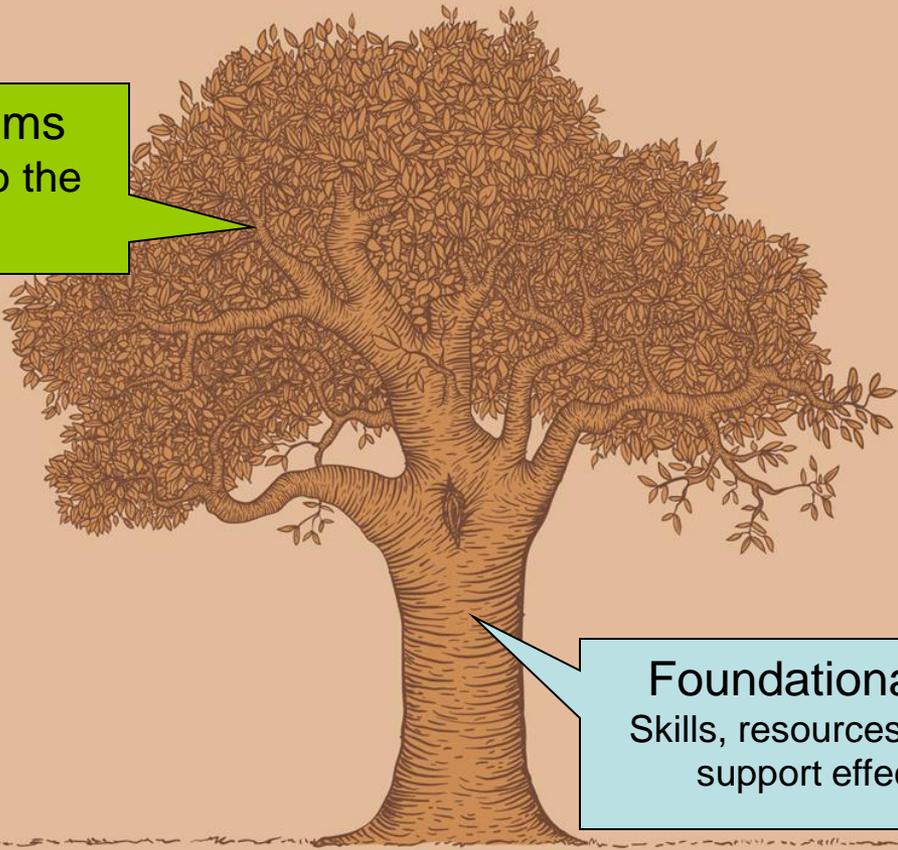


## #2

- All LHDs should have access to the skills and resources that make up the Foundational Capabilities in order to effectively support the core services.



# The Minimum Package of Public Health Services



The Basic Programs  
Services delivered to the  
public

Foundational Capabilities  
Skills, resources, and systems that  
support effective programs

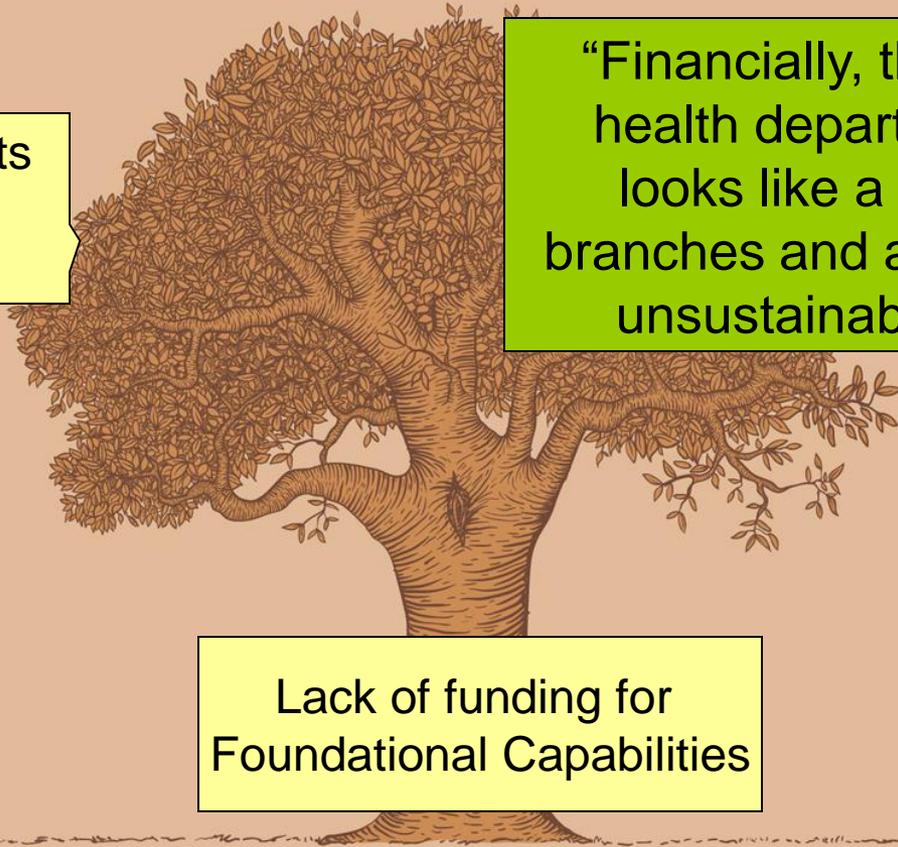


# The Minimum Package of Public Health Services

Categorical grants  
for specific  
programs

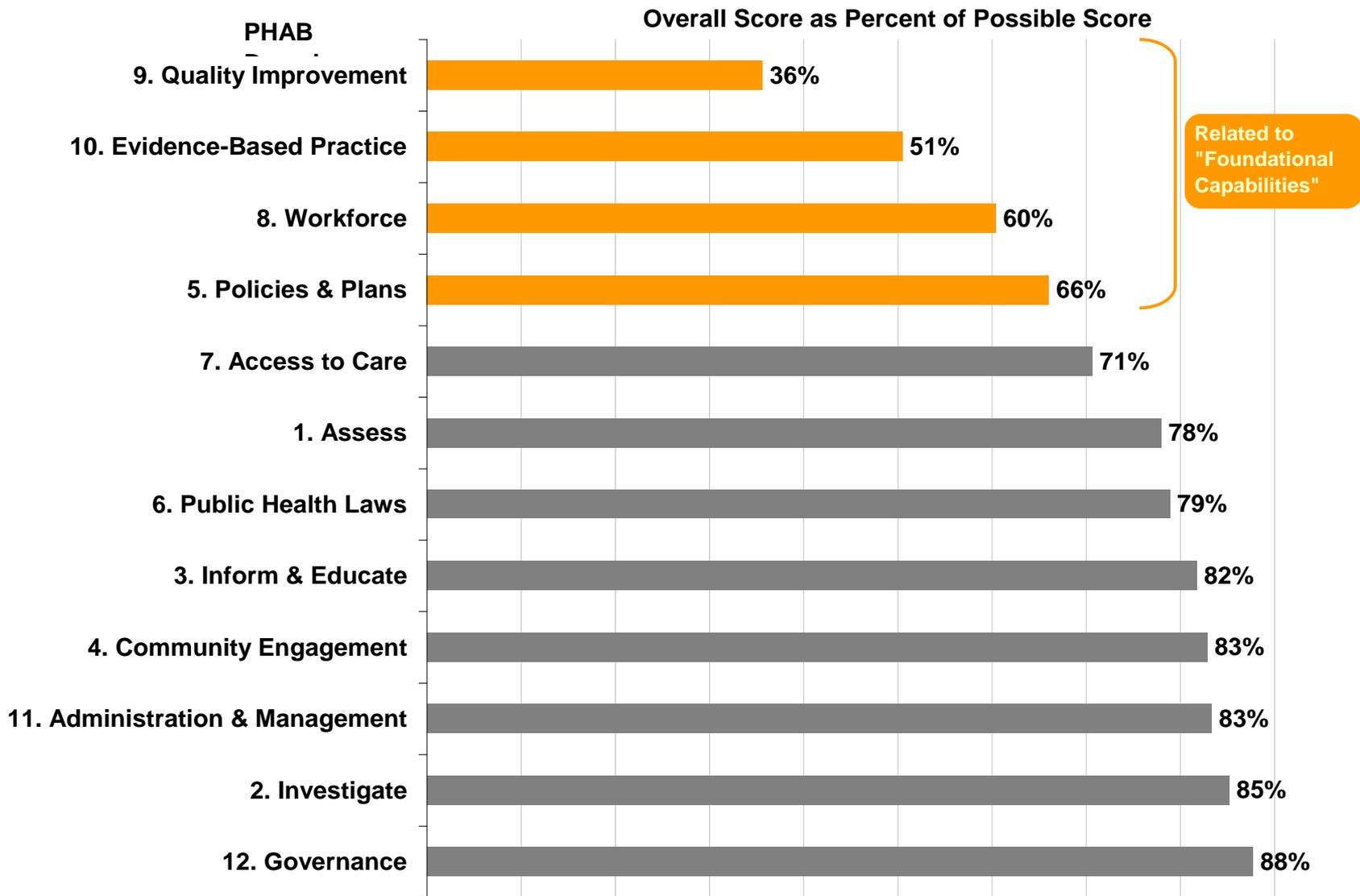
“Financially, the contemporary health department commonly looks like a tree with heavy branches and a spindly trunk— an unsustainable state.” (IOM)

Lack of funding for  
Foundational Capabilities



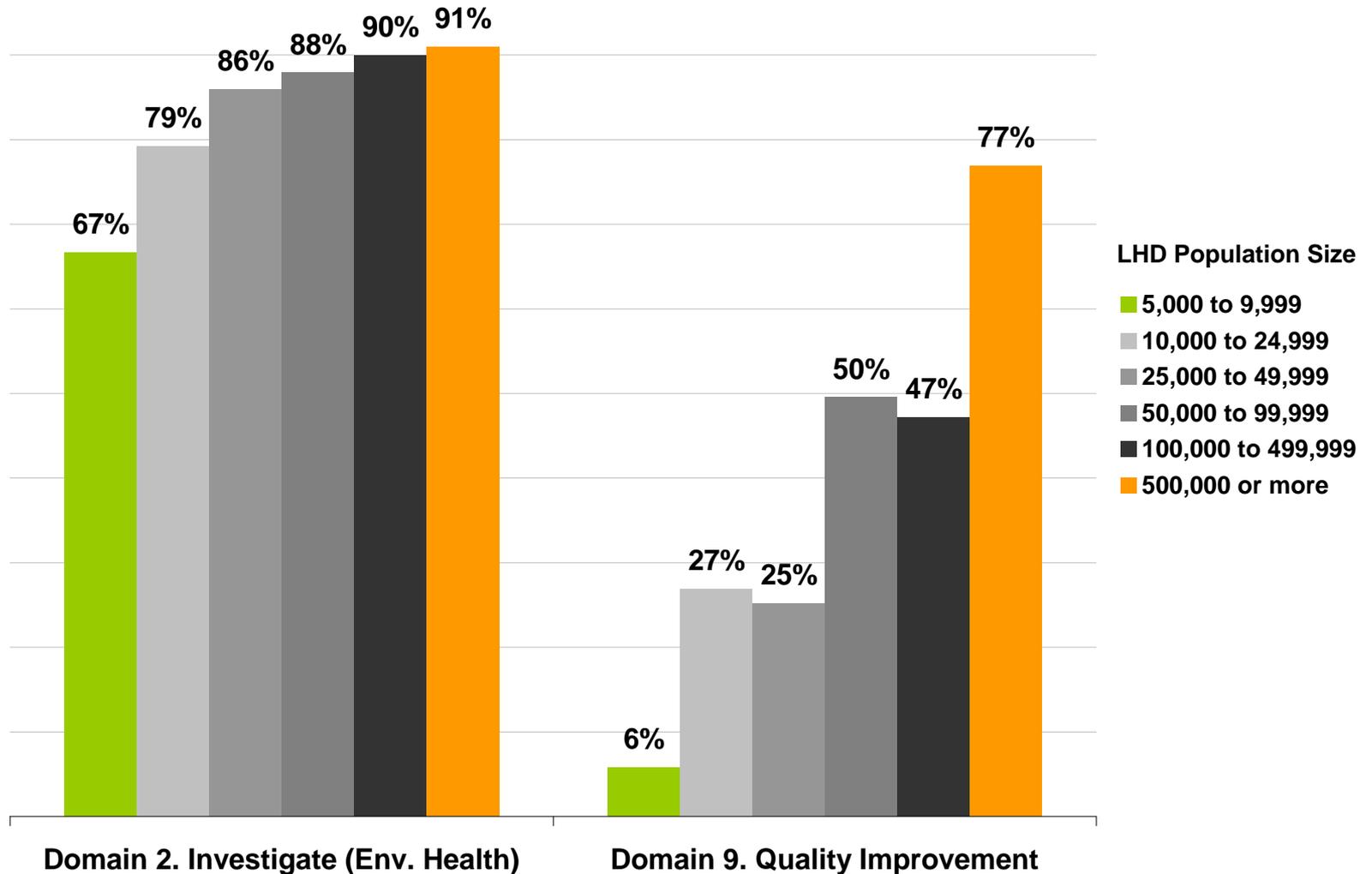


# Total Domain Scores



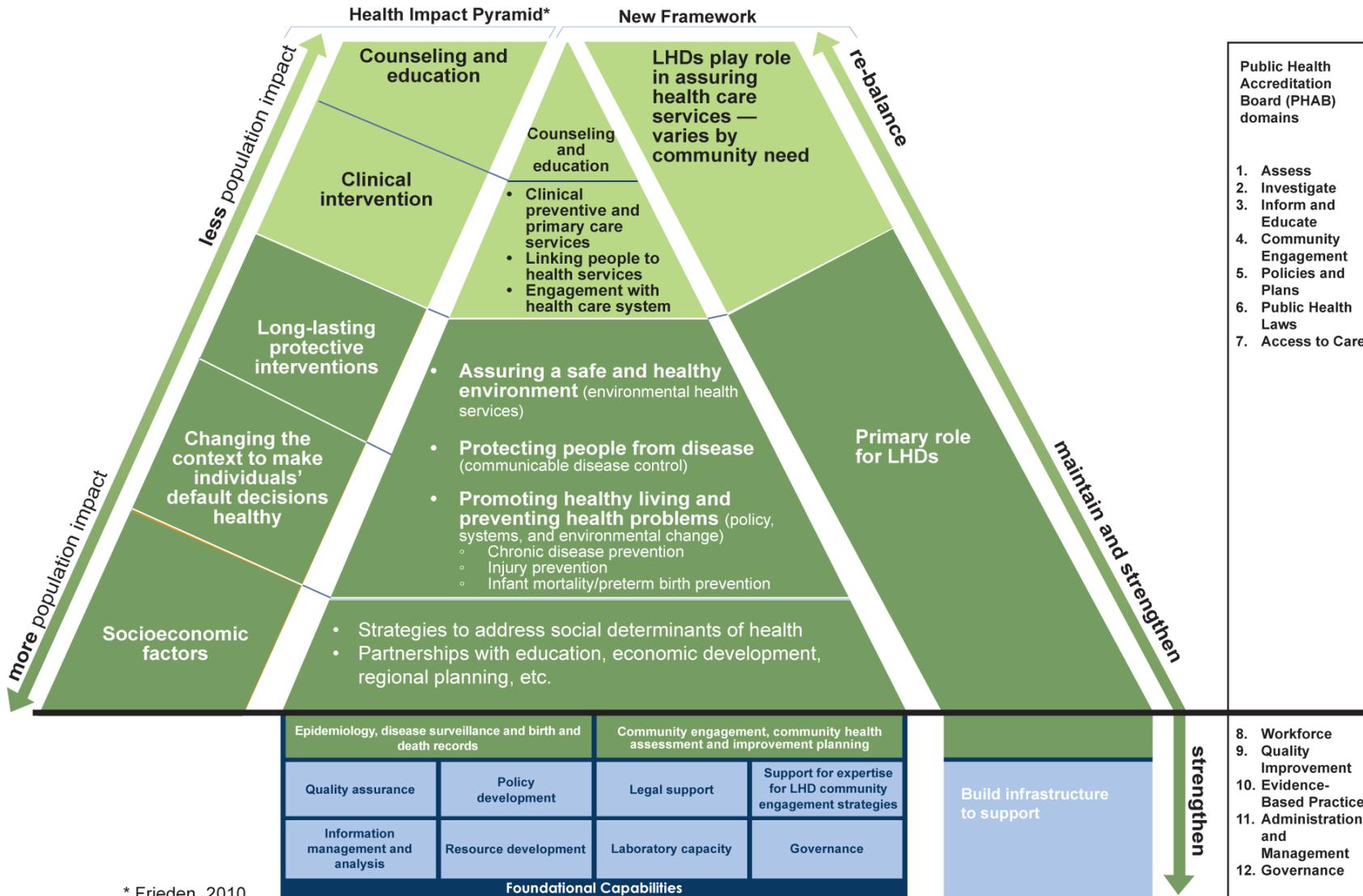


# Total Domain Scores, by LHD Population Size: Investigate & Quality Improvement Domains





# Health Impact Pyramid\* and Proposed Ohio Local Public Health Framework



\* Frieden. 2010



# #3

- The Ohio Minimum Package of Local Public Health Services should be used to guide any future changes in funding, governance, capacity building, and quality improvement.



# #4

- All LHDs should become eligible for PHAB accreditation.
  - This is not the same as **being** accredited.



# #5

- LHDs that meet Minimum Public Health Package standards should be prioritized for grant funding in their jurisdiction.



## #6

- The biennial LHD Health Improvement Standards reported to ODH via the Ohio Profile Performance Database should serve as the platform for assessing LHD provision of the Minimum Package. The PPD may need to be updated periodically to capture the core public health services and foundational capabilities.



# #7

- AOHC supports a review of current laws and regulations to determine if/where mandates might be revised or eliminated to repurpose existing funds and advocate for elimination of mandates that do not align with the Minimum Package of Public Health Services.

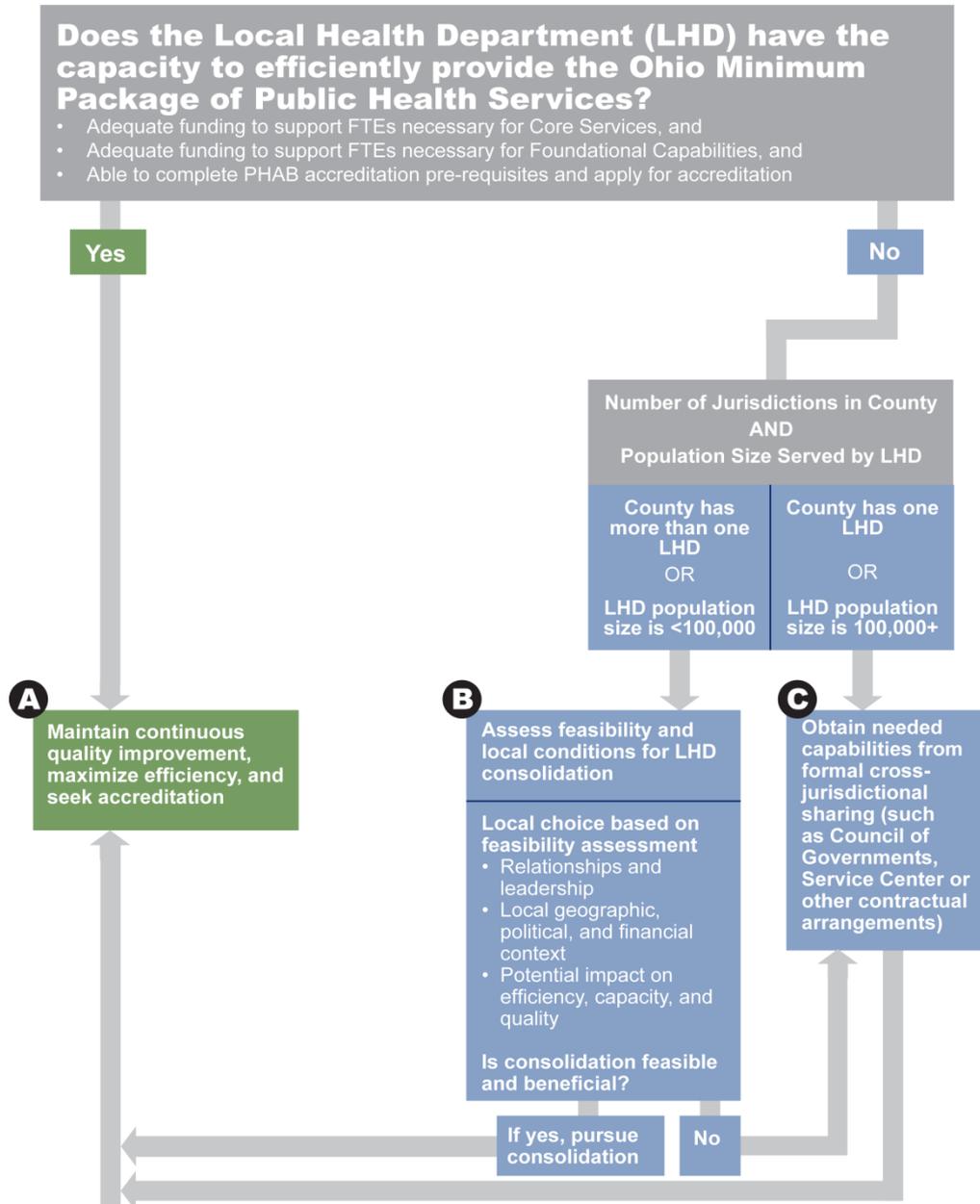


# #8

- Decisions about the jurisdictional structure of local public health in Ohio should be based upon LHD ability to efficiently and effectively provide the Minimum Package of Public Health Services. Additional factors to consider:
  - population size served by the LHD
  - number of jurisdictions within a county
  - local geographic, political, and financial conditions. (see structure diagram and checklist)



# Local Public Health Structure Analysis





# #9

All LHDs should assess:

- Their ability to provide the Minimum Package of Public Health Services,
- The potential impact of cross-jurisdictional sharing (CJS) or consolidation on their ability to provide those services, and
- The feasibility of and local conditions for CJS or consolidation.



# **Checklist for assessing feasibility for CJS or consolidation**

- Relationships, leadership, purpose
  - History of collaboration
  - Trust, personal relationships, leadership
  - Clarity of purpose
- Local geographic, political, and financial context
  - Geographic density, dispersion, and size
  - Customer service and public visibility
  - Community identity and engagement
  - Naturally-occurring regional boundaries
  - Demographics
  - Local funding
  - Local political support



# Feasibility checklist, continued

- Potential impact on efficiency, capacity, and quality
  - Service provision
  - Foundational capabilities
  - Accreditation and quality
  - Efficiency
  - Personnel
  - Health care service reimbursement
  - Federal and state funding



# #10

- Most LHDs, regardless of size, may benefit from CJS. However, LHDs serving populations of <100,000 in particular may benefit from pursuing CJS or consolidation to ensure adequate capacity to provide the Minimum Package.



# #11

- LHDs in counties with multiple LHDs should consider the feasibility of voluntary consolidation.



# #12

Statutory barriers to voluntary multi-jurisdictional consolidation and cross-jurisdictional sharing should be removed, such as allowing for:

- Multi-county levy authority
- Consolidation of non-contiguous cities or counties
- Addressing other barriers identified in feasibility analyses



# #13

- All LHDs should have adequate funding to maintain the Minimum Package of Public Health Services. AOHC should continue the work of the PHF Financing Workgroup to identify cost estimates for the Minimum Package (Core Services and Foundational Capabilities) by November 2012.



# #14

- ODH and LHDs should work together to shift the focus from managing fragmented program silos and funding streams toward improving and coordinating state and local organizational capacity to effectively deliver the Minimum Package.



# #15

- AOHC should advocate for block grants or direct contracts when possible so that communities can implement programs based on health assessment priorities.



# #16

- AOHC should work to assure that local health departments are able to obtain fair reimbursement from public and private payers for eligible services (includes efforts to streamline insurance credentialing).



# #17

AOHC should explore new mechanisms for improving the stability and sustainability of federal, state, and local funding, such as:

- Dedicated percentage of inside millage in lieu of local levies,
- Standardized cost methodology to establish fees for programs where no explicit fee-setting authority currently exists,
- Increasing Local Health Department Support to LHDs to support Foundational Capabilities,
- Excise taxes (e.g., tobacco, sugar-sweetened beverages, medical transactions), and
- Integrated health care delivery reimbursement.



# #18

- AOHC should seek funds to support feasibility assessments, transition planning, and incentives necessary for LHDs to implement the new framework (such as submitting a proposal to the RWJF Center for Sharing Public Health Services grant program).



# #19

- AOHC should convene a meeting with state health policy leaders to formally present and discuss the recommendations of the Public Health Futures final report and to collaboratively plan strategies and action steps to advance forward progress toward the vision for the future.



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With the Association of Ohio Health  
Commissioners Public Health Futures  
Steering Committee