



Executive Summary

Public Health Futures

Considerations for a New Framework for Local Public Health in Ohio

Purpose

Recognizing the need to critically assess the feasibility of sustaining 125 local health departments (LHDs) and to develop proactively new approaches to improving effectiveness and efficiency, the Association of Ohio Health Commissioners (AOHC) established the Public Health Futures Project in 2011 to explore new ways to structure and fund local public health. The project has guided AOHC members through a critical look at the current status of local public health and a careful examination of cross-jurisdictional shared services and consolidation as potential strategies for improving efficiency and quality.

This process prompted members to clarify the role of local public health in Ohio by defining a Minimum Package of Local Public Health Services and to assert a vision that upholds the values of community engagement, quality, accountability, efficiency, and public health science. In order to attain this vision, Ohio's local public health infrastructure will need to be strengthened. This report presents a decision framework that will help LHDs to explore the use of cross-jurisdictional sharing and voluntary consolidation as tools to bolster foundational capacities (such as quality improvement, information management, and policy development) and to assure basic public health protections in all Ohio communities. The report also provides a set of recommendations designed to address the complex financial and political challenges facing LHDs in order to better position local public health as a vital leader in improving Ohio's health outcomes.

Objectives

The Public Health Futures Project Steering Committee, made up of 17 AOHC members from a wide variety of LHDs (urban and rural, city and county departments, and all regions of the state), identified the following objectives for the project:

1. Describe the current status of Ohio's 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 a set of criteria for assessing new models of collaboration or consolidation.
4. Identify and assess potential models of collaboration and consolidation and the factors that would contribute to successful implementation of those models.
5. Foster consensus among LHDs to prioritize a small number of preferred frameworks.
6. Create a decision-making guide for LHDs to use when moving forward with a new framework.



Methods

AOHC contracted with the Health Policy Institute of Ohio (HPIO) to conduct research, facilitate a consensus-building process among members, and prepare this report. HPIO and the Steering Committee used the following methods to meet the project objectives:

Current Status of Ohio's Local Health Departments

- Review of descriptive information about Ohio LHDs
- State-level regulatory scan and review of relevant standards and policies (e.g., Public Health Accreditation Board standards, Affordable Care Act, State Health Improvement Plan)
- Online survey of AOHC members regarding current collaboration

Stakeholder Considerations, Lessons Learned, and Guiding Concepts

- Key-informant interviews with Steering Committee members and state-level policymakers
- Targeted review of research literature related to public health systems, local government reform, and models for collaboration and consolidation

Consensus and Recommendations

- Series of consensus-building meetings: AOHC all-members meeting in March 2012, five regional district meetings in April 2012, and Steering Committee meetings in May and June 2012
- Steering Committee development and approval of recommendations in June 2012

Current status of Ohio's local health departments

Structure and governance

- Public health is governed and administered at the local level in Ohio. The system is decentralized, resulting in significant variability across LHDs in terms of population size served, per-

capita expenditures, and capacity.

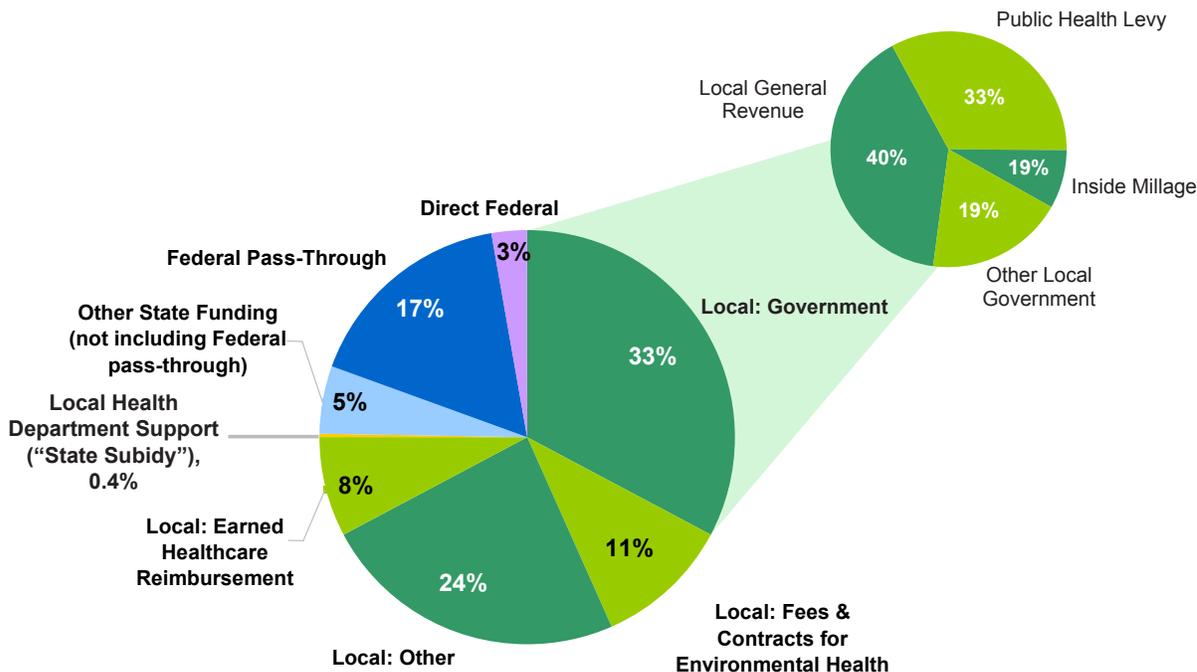
- Ohio law allows for three different types of health districts—city, general, and combined. Currently, about three-quarters of Ohio LHDs (71%) are “general” or “combined” districts that encompass all or part of a county. The remaining 29% are comprised of a single city. Ohio does not currently have any LHDs that encompass two or more counties.
- Three-quarters of Ohio counties have only one LHD, while the remaining quarter of counties have up to five LHDs operating within their borders.
- Ohio is home to many LHDs that serve small population sizes. More than half of Ohio LHDs serve fewer than 50,000 residents.

Funding

- LHDs face many resource constraints. Relative to other states, Ohio ranks quite low in terms of median annual per capita LHD expenditures (33rd) and state public health expenditures (41st), and in obtaining federal funding for public health (50th for CDC funding, 39th for HRSA funding).
- Local funding (fees, levy funds, and other local government sources) provides about three-quarters of LHD revenue overall, although these local sources vary widely by jurisdiction. For example, only 39% of LHDs reported local public health levy revenue in 2010. Local funding can also be inconsistent over time because it is vulnerable to local political conditions.
- State-generated funding provides a relatively small portion of LHD revenue. Local Health Department Support (“state subsidy”) provided less than 1% of LHD revenue in 2010 and other state sources provided 5%.
- Combining federal pass-through funds, state grants and contracts, and the state subsidy, 22% of LHD revenue flows through the state. However, only



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



Source: 2010 Annual Financial Report, provided by ODH March 2012

one-quarter of that state-controlled portion is generated from state coffers, while three-quarters of the funds come from federal sources.

- Funding for local public health is extremely complex and fragmented. There appears to be considerable misalignment between current funding streams and the services that LHDs are mandated and expected to provide.

Current collaboration and future opportunities

- Since 1919 when the current system was established, the number of functioning LHDs has decreased from 180 to 125 through voluntary unions (city-county mergers) and contract arrangements. Contract arrangements have been far more common than full consolidations.
- LHDs have engaged increasingly in a range of collaborative arrangements over the past ten years, including "pooling" funds for shared services and

contracts between LHDs to provide services.

- According to a 2012 survey of AOHC members, the vast majority of LHDs are currently sharing some services with other jurisdictions, including "pooled funding" and contracts with other LHDs. The types of services that are shared the most are epidemiology, HIV testing, lead assessment, and STD testing and treatment.
- Administrative functions (information technology, human resources, purchasing) and expertise (subject matter experts, leadership and policy development, and accreditation and quality improvement guidance) appear to be the areas in which health commissioners are most interested in sharing services in the future. Respondents reported little current sharing in these areas, possibly because there have been few grant-funded incentives to collaborate in these areas.



Economic and policy environment

- In the past few years LHDs report experiencing widespread job losses and program cuts. In 2009, 72% of LHDs reported loss of staff and 85% reported cuts to at least one programmatic area.
- Like all local government agencies in Ohio, LHDs are grappling with the challenges of “leaner government.” Furthermore, the Ohio Department of Health has experienced a reduction in staff and can no longer provide as many functions for LHDs as it did in the past.
- Accreditation for state and local health departments is a new process launched in 2011. Although accreditation is voluntary, Ohio LHDs are now required to conduct annual “improvement standard” self-assessments using the Public Health Accreditation Board measures. The accreditation standards delineate the essential functions of public health, providing a new tool for assessing LHD capacity and performance. They also present a new opportunity to re-examine the relationship between public health governance structures and financing and contemporary agreed-up standards of essential public health services.
- The Patient Protection and Affordable Care Act of 2010 (ACA) has several potential implications for public health. Most significantly, public health’s traditional role in assuring access to care will be affected by decreases in the number of uninsured Ohioans and changes to the health care delivery system. The ACA presents challenges and opportunities for LHDs and will require careful coordination with the broader health care system.

Stakeholder considerations

HPIO conducted 25 key-informant interviews in January and February 2012. The key-informants represented two distinct groups:

- *Local Public Health Group* (n=18): Public Health Futures Steering Committee members and AOHC staff (Executive Director).
- *Statewide Policy Group* (n=7): Senior officials from the Ohio Department of Health and the Governor’s Office of Health Transformation; experts on “leaner government” and shared services; and representatives from academic public health.

The following themes emerged as strong messages and areas of consensus across both groups of stakeholders:

- Nearly every key informant believes that the *time is right* for a systematic approach to develop a model for the future. Almost all felt that figuring this out may be difficult, but is necessary.
- There is broad agreement that the new model should define a *minimum standard of health protection*. Most informants believe that the new model needs to address ways of organizing, funding, and providing capacity to support such a standard as a high priority.
- Everyone in the Local Public Health group reported that they are *already doing a great deal of collaborating* within the public health system. All but a few view this positively and most are motivated to do more for reasons other than pure necessity. Only a few were negative or skeptical about collaboration in general; these respondents tended to view resource sharing as a necessity related to factors beyond their control.
- *Motivations are high and interest in new approaches is pervasive* among representatives of nearly all types of



jurisdictions and sizes. Informants pointed to many examples of success in their current collaboration, along with acknowledging that there are probably more efficient ways to organize and do things together.

- Nearly everyone prefers that *next steps taken should be initiated from within the public health system*, rather than being imposed externally.
- *Deciding what are truly local needs* was a common theme, as is figuring out how to address these needs within a new model.
- Most interviewees urged that the future model should *prioritize services and activities that public health can do and others systems cannot or do not do*.
- Most believe that public health should be *more connected with and do more partnering with the broader health care system*.

Lessons learned

Results of an AOHC survey on LHD collaboration and a review of the research literature on shared government services identified the following factors associated with successful collaboration:

- Mutual trust and a history of collaboration
- Strong commitment from top-level leadership
- Partnerships between communities with similar demographics and/or ability to customize to local needs for each community; equity for all partners, while being sensitive to unique local needs
- Success at increasing efficiency and/or cost reductions
- Ability to maintain services that are needed and expected by the community but are no longer feasible for one LHD to provide.
- Achieving clarity of purpose about the reasons for engaging in collaboration
- Weighing the costs of collaboration,

including transactional costs, and anticipating systems and business process barriers

Consensus and recommendations

The purpose of the Public Health Futures project is to develop a proposed model for Ohio’s local governmental public health system that includes a mechanism for governance and sustainable financing, considers cross jurisdictional sharing and/or regionalization, enhances quality and assures value. While *cross jurisdictional sharing and/or regionalization* were initially the primary focus of the project, it became clear during the consensus-building process that *enhancing quality and assuring value* were equally—if not more—important. Recognizing that mechanisms for governance and financing are means not ends, AOHC members voiced the need to first describe a vision for what local public health should be doing, and then to develop a framework for *how* to fulfill that vision. To that end, the Steering Committee developed the following vision statement.

Vision for the Future of Local Public Health in Ohio

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.



Rationale for the recommendations

The Steering Committee's recommendations aim to address the following challenges and opportunities related to the *role of public health*:

- Maintain the communicable disease prevention and environmental health protections that have historically been the core function of local public health.
- Respond to increasing recognition that public health has a strong role to play in preventing chronic disease and that the population health approach is critical to improving health outcomes.
- Re-balance public health's role in providing clinical services within the new healthcare landscape, and modernize payment and quality systems when medical services and care coordination are provided.
- Ensure that local public health is positioned to help achieve the outcomes prioritized in the State Health Improvement Plan and Local Community Health Improvement Plans in order to improve the overall health of Ohioans.

These recommendations also aim to address the following *financial and structural* challenges and opportunities:

- Strike a balance between local control and statewide standardization. Support continued local community engagement and preserve the amount of funding generated from local sources, while at the same time improving the consistency of performance, quality, and outcomes for all LHDs. Home rule and the heavy reliance on local funding (76% of all LHD revenue) help LHDs to be strongly rooted in their local communities, although this local structure also presents potential barriers to formal cross-jurisdictional sharing and consolidation (e.g., city/county officials' concerns about resource allocation, lack of parity in fee structures, wide variability in LHD per-capita expenditures and services provided, etc.).
- Use cross-jurisdictional sharing and consolidation as tools for building LHD capacity and improving performance. Transitions to cross-jurisdictional sharing and consolidation must balance local choice with a shift toward more formal and efficient models of collaboration, and must critically assess the feasibility of sustaining 125 LHDs, more than half of which serve fewer than 50,000 residents.
- Build political support for increasing—or at least maintaining—funding for local public health.
- Identify initial steps to address the problems caused by the complex, fragmented, and categorical grant-driven funding environment. These problems include:
 - Lack of dedicated funding sources for the Foundational Capabilities needed to support effective services (e.g., quality assurance, information management, policy development)
 - Lack of dedicated funding sources for cross-jurisdictional sharing and consolidation
 - Inability to make long-term investments to improve efficiency and quality due to revenue instability (e.g., competitive grants, local political conditions, changes in funder priorities, etc.), and
 - Misalignment between current funding streams and the services that LHDs are mandated and expected to provide based on current public health science and local community need.



Recommendations

Local public health capacity, services, and quality

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. (see Minimum Package diagram)
2. All local health departments (LHDs) should have access to the skills and resources that make up the Foundational Capabilities in order to effectively support the core services.
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. (see Structure Analysis diagram)
4. All LHDs should become eligible for accreditation through the Public Health Accreditation Board (PHAB).
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 the Ohio Department of Health via the Ohio Profile Performance Database should serve as the platform for assessing LHD provision of the Minimum Package. The Profile Performance Database may need to be updated periodically to capture the Core Public Health Services and Foundational Capabilities.
7. The Association of Ohio Health Commissioners (AOHC) supports a review of current laws and regulations to determine where mandates may need to be revised or eliminated and should advocate for elimination of mandates that do not align with the Minimum Package of Public Health Services.

Jurisdictional structure

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 that should be considered are:
 - a. Number of jurisdictions within a county,
 - b. Population size served by the LHD, and
 - c. Local geographic, political, and financial conditions. (see Structure Analysis diagram)
9. All LHDs should assess:
 - a. Their ability to provide the Minimum Package of Public Health Services,
 - b. The potential impact of cross-jurisdictional sharing or consolidation on their ability to provide those services, and,
 - c. The feasibility of and local conditions for cross-jurisdictional sharing or consolidation.
10. Most LHDs, regardless of size, may benefit from cross-jurisdictional sharing. However, LHDs serving populations of <100,000 in particular may benefit from pursuing cross-jurisdictional sharing 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:
 - a. Multi-county levy authority, and
 - b. Consolidation of non-contiguous cities or counties, and
 - c. Addressing other barriers identified in feasibility analyses.

Financing

13. All LHDs should have adequate funding to maintain the Minimum Package of Public Health Services. AOHC should continue the work of the Public Health Futures Financing Workgroup to identify cost estimates for the Minimum Package (Core Services and Foundational Capabilities) by November 2012.
14. The Ohio Department of Health 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 Community Health Assessment and Improvement Plan 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 (including 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:
 - a. Dedicated percentage of inside millage in lieu of local levies,
 - b. Standardized cost methodology to establish fees for programs where no explicit fee-setting authority currently exists,
 - c. Increasing Local Health Department Support (“state subsidy”) to LHDs to support Foundational Capabilities,
 - d. Excise taxes (e.g., tobacco, sugar-sweetened beverages, medical transactions), and
 - e. Integrated health care delivery reimbursement.

Implementation Strategy

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.



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



Local Public Health Structure Analysis

Does the Local Health Department (LHD) have the capacity to efficiently provide the Ohio Minimum Package of Public Health Services?

- Adequate funding to support FTEs necessary for Core Services, and
- Adequate funding to support FTEs necessary for Foundational Capabilities, and
- Able to complete PHAB accreditation pre-requisites and apply for accreditation

Yes

No

Number of Jurisdictions in County
AND
Population Size Served by LHD

County has more than one LHD
OR
LHD population size is <100,000

County has one LHD
OR
LHD population size is 100,000+

A

Maintain continuous quality improvement, maximize efficiency, and seek accreditation

B

Assess feasibility and local conditions for LHD consolidation

Local choice based on feasibility assessment

- Relationships and leadership
- Local geographic, political, and financial context
- Potential impact on efficiency, capacity, and quality

Is consolidation feasible and beneficial?

C

Obtain needed capabilities from formal cross-jurisdictional sharing (such as Council of Governments, Service Center or other contractual arrangements)

If yes, pursue consolidation

No