August 16

Public Health Modernization Assessment Supplemental Report

Oregon Public Health Modernization

CLHO / Kelly McDonald, LLC

Overview

In June 2015, the Oregon Legislature passed the Public Health Modernization Act (HB 3100), requiring the Oregon Health Authority (OHA) to outline a 10-year plan for implementing newly established foundational elements for governmental public health. The new framework ensures a public health system that is working efficiently and effectively to protect the health of all Oregonians and prevent the spread of disease. The framework identifies a common set of Capabilities and Programs that ensure a critical and uniform level of service across the state.

HB 3100 requires all local public health authorities and the OHA Public Health Division to undergo an assessment of current capacity and expertise in order to identify the gaps in our public health system. The assessment will also help quantify the resources required to implement the minimum core elements established by the framework. The timeline established for the assessment was fairly aggressive but unavoidable, as it followed legislatively mandated deadlines designed to move the work of HB 3100 forward.

The OHA engaged a contractor, Berk Consulting, to design and roll out the modernization assessment. With prior experience implementing a similar evaluation of state and local public health authorities in the state of Washington, Berk was well positioned to provide a clear understanding of Oregon's public health system, including resources required to meet the foundational elements established by HB 3100.

Public Health Modernization Assessment

Local public health authorities (LPHAs) were asked to score their capacity and expertise for each of the 11 Foundational Capabilities and Programs. The assessment tool provided a 1-5 number scale and asked LPHAs to score themselves based on how well they currently meet the roles and deliverables of each area, as defined in the *Public Health Modernization Manual*.

Foundational Programs

- Communicable Disease Control
- Environmental Public Health
- Prevention and Health Promotion
- Clinical Preventive Services

*Basic **areas of public health expertise and activity** essential to assess, protect, and improve the community's health.*

Foundational Capabilities

- Assessment and Epidemiology
- Emergency Preparedness & Response
- Communications
- Policy & Planning
- Leadership & Organizational Competencies
- Health equity & Cultural Responsiveness
- Community Partnership Development

*Critical, **knowledge, skills, and abilities** necessary to carry out public health activities efficiently and effectively.*

To quantify the resources needed to modernize the local public health system, LPHAs were asked to do two things: (1) report on current spending for each of the Foundational Capabilities and Programs and (2) estimate how much additional funding would be required to fully meet the new framework.

The assessment was made available to LPHAs on January 19, 2016. The deadlines were set in two waves, with half of the tools due by March 1, 2016, and the remaining half due by March 15, 2016.

Assessment Process and LPHA Investment

The modernization assessment proved to be a significant undertaking for Oregon's local public health authorities. The aggressive timeline coupled with a new framework and an extensive review of capacity, expertise, and costs would have been a challenge had it been the *only* focus of staff efforts. Of course, during this same time period LPHAs were also tasked with carrying out their regular public health activities and operational requirements, such as the annual school exclusion cycle, outbreak investigations, county budget reviews, and personnel/staffing issues and hiring. Several LPHAs were also focused on triennial reviews, accreditation activities and site visits, and various grant proposals and reporting requirements. Additionally, many health departments experienced technical delays of several days or longer before gaining access to the tool. This loss of critical work time compounded the strain of the project.

While the self-assessment portion of the tool was fairly straightforward, the methodology for reporting current spending and future estimates was particularly challenging. These efforts were complicated by a requirement to break up costs into sub-categories, called functional areas. Each of the 11 Foundational Capabilities and Programs were comprised of two to five functional areas, totaling 40 separate functional areas across the 11 Capabilities and Programs. For example, Communicable Disease Control program costs were separated according to the following areas:

- Communicable disease surveillance
- Communicable disease investigation
- Communicable disease intervention and control
- Communicable disease response evaluation

Future spending projections were also required to be broken up according to the same 40 categories. Given that LPHAs do not budget, or track in any way, their costs according to these breakdowns, this work took considerable time and, depending on the size of the health department, required coordination and input from several key staff members.

As LPHA assessment work progressed, it became clear that the health departments were investing significant resources in the process and that it might be helpful to capture the costs that this investment represents. There were obvious tangible

costs, such as staff time, but also more intangible losses related to the opportunity costs associated with prioritization of assessment work over other activities and services. It was also apparent that the design of the tool did not allow for critical processes, partnerships, and other shared services to be captured or included in the subsequent assessment report.

CLHO developed a follow-up survey in order to capture costs associated with the assessment, as well as to better document the shared services, community collaborations, and other partnerships that were not included in the tool. The results were intended to compliment the assessment report by providing an expanded view of the work carried out within Oregon's local public health system. This survey was rolled out in May 2016 and was fully completed by 31 of Oregon's 34 LPHAs (91%).

Time and Resources Invested by LPHAs

The LPHAs were asked to report the number and type of staff who participated in the assessment process. In total **over 330 LPHA staff members** were involved in the local public health modernization assessment statewide. The number of LPHA staff participants involved per health department ranged from 1-20 individuals. Understandably, the smaller LPHAs reported fewer staff involved. For some LPHAs, just one or two staff members participated, typically the public health director and finance staff. The larger LPHAs reported much more involvement from program coordinators, nursing supervisors, health officers, and research analysts. Several LPHAs also utilized the time of AmeriCorps VISTA volunteers.

LPHA staff participation: 330+
Range per LPHA: 1 – 20 staff members

The compressed timeline combined with the complex nature of the tool's requirements meant that some public health tasks and services had to be postponed or addressed with reduced capacity. While some activities could be placed on hold until the assessment process was complete, there were many time-critical tasks that could not be postponed, such as outbreak investigations, accreditation site visits, triennial reviews, staffing crises, and other local public health emergencies.

LPHAs were asked to list activities or services that *were* postponed or otherwise compromised during the assessment process. Most commonly reported were county budget review activities, mandatory county training, mandatory reporting tasks, and deferral of clients in need of clinical services.

Due to the tight timeline and critical tasks and services that could not be postponed, many LPHAs reported spending significant hours on the assessment outside of their regularly scheduled work time in order to adhere to the deadline. Two-thirds of

LPHAs reported working on the assessment outside of regularly scheduled hours. Combined, these LPHAs reported over 330 hours of assessment work during the evenings, weekends, or other non-regular workdays. The range for number hours spent outside of regularly scheduled work time varied between LPHAs, from a low of six hours to as many as 62.

LPHAs were asked to report the total amount of staff time required to complete the modernization assessment. Using conservative estimates, LPHAs reported over **2,500 hours of work**, representing **an investment of $200,000 or more**, not including additional costs related to printing or travel to meet with LPHA staff from other jurisdictions. The range of hours reported by individual LPHAs was quite broad, from 10 hours for one very small health department to as many as 600 from one of the largest. The majority of LPHAs reported a range of 50-100 hours invested.

Total hours: 2,500+
Range per LPHA: 10 – 600 hours
Over **$200,000**

Benefits

Despite the challenges inherent in an assessment of this magnitude, LPHAs reported numerous benefits resulting from the process. Some used the assessment as an opportunity to build understanding among staff about the new public health modernization framework. Others reported that the assessment expanded their thinking around partnerships and potential shared work with other jurisdictions and community partners. Nearly 80% of LPHAs reported that the assessment helped them identify specific program areas or capabilities that need additional resources. This understanding will allow LPHAs to prioritize their efforts as they develop plans to implement the new framework, based on findings from their assessment. It also presents a starting point for discussions with other LPHAs, as they seek to identify opportunities for shared services across local public health jurisdictions.

Cross-Jurisdictional Sharing

The modernization assessment results provide an understanding of current LPHA capacity and expertise in the foundational programs and capabilities. It also delivers useful estimates for current and potential future spending. What it does *not* provide is a comprehensive view of the partnerships and shared services that LPHAs utilize to meet the elements described within the new framework. The assessment simply did not lend itself to that type of reporting. The tool did leave optional space to list partners with whom the shared services have a financial allocation. This allowed for the inclusion of some sharing, but it left out the more informal collaborative efforts that make up the bulk of cross-jurisdictional sharing across the state.

To capture this information, the CLHO survey asked LPHAs to provide greater detail on the types of collaboration, shared services, and other partnerships that allow them to deliver essential public health services. Most LPHAs reported some level of collaboration and sharing with other jurisdictions. Some of the most commonly cited partnerships include:

- **Community health assessments**. Cross-jurisdictional partnering for community health assessments occurs in many regions throughout the state. These efforts also include partnerships with Coordinated Care Organizations (CCOs), Early Learning Hubs, local hospitals, and other community organizations.

- **Communicable disease surveillance and sharing**. Several regions hold regular conference calls to share local outbreak information and collaborate on investigations that spread across jurisdictional boundaries. Some of these partnerships include formal agreements to share access to Orpheus, an electronic disease surveillance system, for case investigation and follow up.

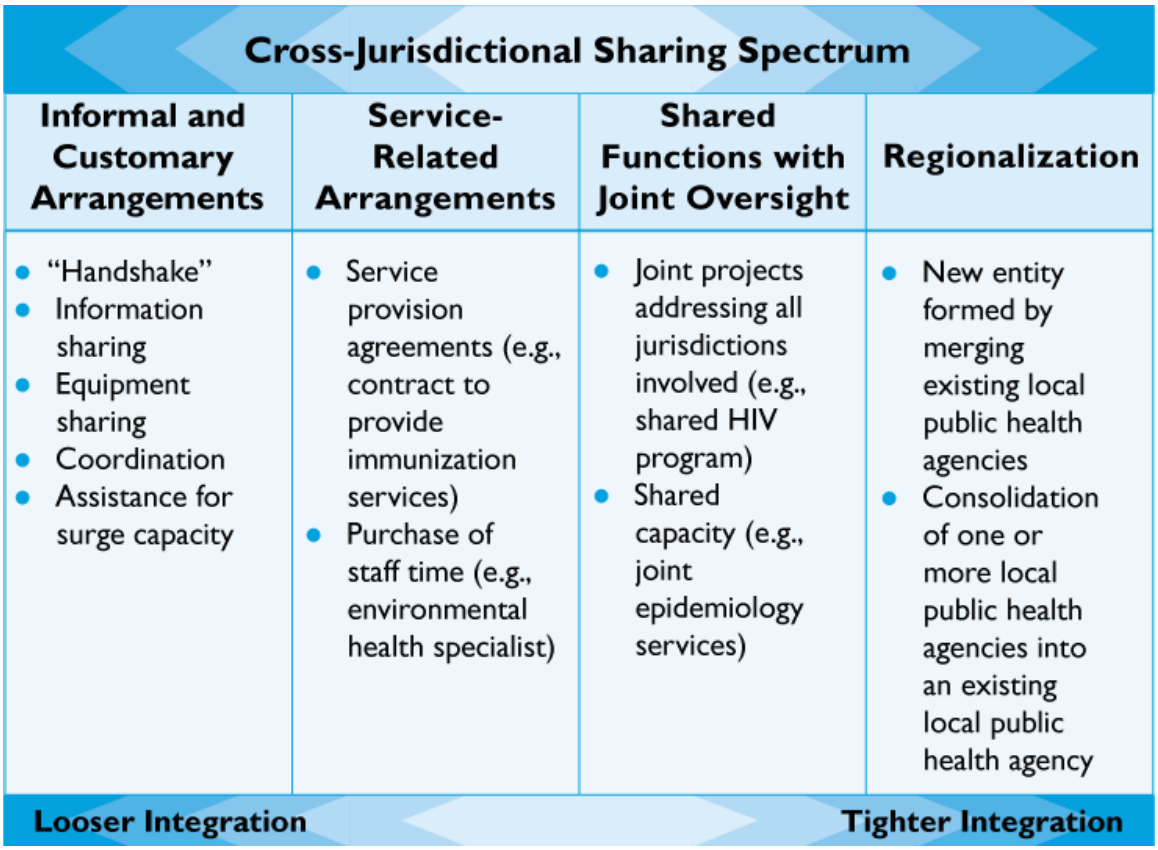
- **Environmental health sharing**. Several rural jurisdictions share environmental health staff to ensure that mandated restaurant, water, and other inspections are carried out as required.

- **Technical assistance and other support**. LPHAs offer varying levels of assistance to each other on a regular basis, including general programmatic or operational advice, resource sharing, partnering for staff training, or job shadowing for new staff. These collaborative relationships provide a foundation from which future cross-jurisdictional discussions can build.

- **Emergency preparedness**. Regions throughout the state partner to hold preparedness exercises and to ensure that critical resources will be available in the event of a large-scale bioterrorism event or natural disaster.

The **Cross-Jurisdictional Sharing Spectrum** on page 6 helps put these shared services into a helpful context. The various sharing arrangements allow LPHAs to increase their level of integration across the continuum.

The spectrum includes four main categories of sharing. The left side of the spectrum presents the more informal agreements, such as simple handshake agreements, coordinated programmatic efforts, and assistance with surge capacity. Moving across the spectrum to the right, the formalization and scope of integration increases, up to full-scale consolidation or mergers of local health departments. Each category along the spectrum represents different opportunities for increased efficiencies and effectiveness. They are all valid and valuable approaches for allowing collaboration across jurisdictional boundaries in order to deliver foundational public health services.



Source: Center for Sharing Public Health Services. Adapted from: Kaufman, N. (2010) which in turn was adapted from Ruggini, J. (2006); Holdsworth, A. (2006).

In Oregon, we currently see examples of cross-jurisdictional sharing that span the spectrum, from loosely integrated, informal arrangements to the full consolidation of local public health agencies. The majority of sharing falls on the left side of the spectrum, as **informal and customary arrangements**. Examples of this work include regular communication and coordination of communicable disease events, cross-jurisdictional partnering for preparedness exercises or other training opportunities, and collaborative community health assessment efforts.

Several regions across the state partner to provide environmental public health services. These **service-related arrangements** allow small, rural LPHAs to contract with a larger entity to ensure that mandated inspections and other activities be carried out as required. One Eastern Oregon region has a similar arrangement for immunization services. Their agreement allows one LPHA to administer vaccines to residents in a neighboring jurisdiction because of its closer proximity.

At least one region in Oregon has established a more formal shared arrangement to carry out regional health assessment activities. This partnership between Lincoln, Benton, and Linn counties falls into the column titled '**shared functions with joint oversight'** and also includes participation from the regional Coordinated Care Organization.

The tightest integration of local public health services occurs between Wasco, Gilliam, and Sherman counties. In 2009, the three LPHAs **regionalized** to form the North Central Public Health District. The District fulfills statutes pertaining to the responsibilities and duties of local public health authorities and is overseen by a Governance Board that reflects the interests and geographic considerations of the participating entities.

Although the bulk of Oregon's cross-jurisdictional work currently falls on the left, or more informal, side of the Spectrum, this leaves numerous opportunities for further collaboration between jurisdictions. LPHAs can capitalize on the strong working relationships that already exist with neighboring counties to discuss and explore opportunities for additional sharing arrangements that build regional capacity in the Foundational Capabilities and Programs.

Future shared work

While the modernization assessment provided space to identify potential future shared services, limitations with both the tool and the process did not allow for many LPHAs to do so. When asking LPHAs to identify potential partners, the tool focused exclusively on costs. Consequently, the full range of collaboration and partnering—such as those that fall on the left-hand side of the Cross-Jurisdictional Sharing Spectrum above—were not assessed for. Most importantly, the aggressive timeline simply did not allow for an exploration of potential future shared services. These discussions will take significant time and may involve a large and diverse group of people, including LPHA staff, administration, and local elected officials.

While one region held a very high-level discussion about potential future cross-jurisdictional work, the shared positions identified are contingent upon additional funding and many subsequent meetings with appropriate staff and county officials. Other regions throughout the state collectively recognized the need for such discussions; there simply was not enough time to begin them during the assessment process. Given that time constraints did not allow for opportunities to identify future regional work throughout the state, this is clearly an area where more attention is needed.

The CLHO survey asked LPHAs to identify opportunities for future shared services that could potentially create efficiencies and improve effectiveness across jurisdictions. Some of the most commonly cited potential future shared services include:

- **Assessment and epidemiology**. Several LPHAs identified a regional approach to data collection and analysis as the most efficient and effective method of fulfilling the elements listed in the new modernization framework. These shared activities would support LPHA planning, policy creation, and decision making across the foundational program areas. A shared position

could also provide support during communicable disease outbreaks, such as help with contact tracing, follow up, and communication with health care providers.

- **Prescription drug overdose grant**. Six regions throughout the state will be collaborating on prevention efforts related to prescription drug and heroin overdose. The project will promote the safety and health of patients while engaging with regional opioid prescriber groups to encourage more cautious prescribing for non-cancer pain and expand access to medication assisted treatment for opioid dependency.

- **Environmental health**. Shared environmental health specialists to prevent, assess, and address emerging environmental public health issues. This will work could include measurement of the impact of environmental health hazards on the health outcomes of priority/focal populations in the region and the promotion of land use planning and sustainable development activities that create positive health outcomes.

- **Emergency preparedness.** Regional efforts to ensure that communities are prepared and able to respond to and recover from public health threats and emergencies. Activities could include the coordination of regional training exercises, engagement of health care providers and local community groups, and improvement of regional communication capacity before, during, and after a large-scale emergency event.

There is great potential for future cross-jurisdictional sharing that moves LPHAs towards more a formalized arrangement. What that arrangement looks like is up to the LPHAs to decide; it could be shared capacity with joint oversight or outright consolidation of local public health agencies. The public health modernization legislation outlined several pathways for local public health authorities to meet the Foundational Capabilities and Programs, all of which are intended to allow for significant local flexibility.

Recommendations

Over the next several years, Oregon's governmental public health system will transition to a new framework. LPHAs will need significant support and technical assistance to undergo a transition of this magnitude. Next steps involve in-depth local and regional discussions that will allow jurisdictions to develop public health modernization implementation plans. To support these efforts and ensure successful engagement of key stakeholders, CLHO makes the following recommendations:

1. There is an obvious need for **improved communication to the LPHAs** about the modernization framework, timeline, and expectations. The assessment

process and subsequent CLHO survey highlighted an uneven understanding that should be addressed by concerted efforts from CLHO and the Oregon Public Health Division (OPHD). CLHO staff needs to work closer with members who are unable to regularly attend meetings. Similarly, OPHD needs to build in regular communication to LPHAs that increases understanding and improves readiness for individual and regional LPHA discussions. These efforts will ultimately support LPHA planning and a transition to the new framework.

2. As a more robust and even understanding of modernization grows across the state, LPHAs and county officials will begin to engage in the planning efforts required to make modernization a reality. They clearly need **more time and opportunity** to explore and embrace the new framework first, particularly as it relates to the potential efficiencies and effectiveness of cross-jurisdictional sharing. This will help ensure that LPHAs embrace modernization before they hold these crucial planning discussions, which will set the stage for a statewide transition to the new governmental public health framework.

3. LPHAs also need more time and opportunity to engage with **local community partners**. The modernization assessment allowed LPHAs to identify gaps in capacity and expertise that certain community partnerships could help bridge. Likewise, there may be services provided by the LPHA that could be shifted to a community partner, thereby freeing up resources to focus on the foundational elements outlined by the new framework. It will take time for communities to understand and explore the opportunities that public health modernization presents.

4. LPHAs need to **build on existing cross-jurisdictional partnerships** to increase regional capacity in the Foundational Capabilities and Programs. There are several areas around the state with already-established lines of communication and collaboration. These relationships will serve as a foundation for upcoming planning discussions by which LPHAs can explore additional opportunities for shared services. These regions can also act as a model for other parts of the state that are exploring cross-jurisdictional partnerships for the first time.

Upcoming local and regional modernization discussions will be as fruitful as the preparation for them allows. While a heavy burden of this process falls to the local public health authorities, CLHO and OPHD can help mitigate the challenges of such discussions by providing ongoing, targeted communication and support. These efforts could pay dividends in the form of well-thought-out, collaborative implementation plans that address statewide population health needs and, ultimately, fulfill the expectations of HB 3100 for a more efficient, more effective, and more accountable public health system.