DRAFT

PUBLIC HEALTH MODERNIZATION

STATEWIDE REPORT

COALITION OF LOCAL HEALTH OFFICIALS

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AIMHI Meeting Background

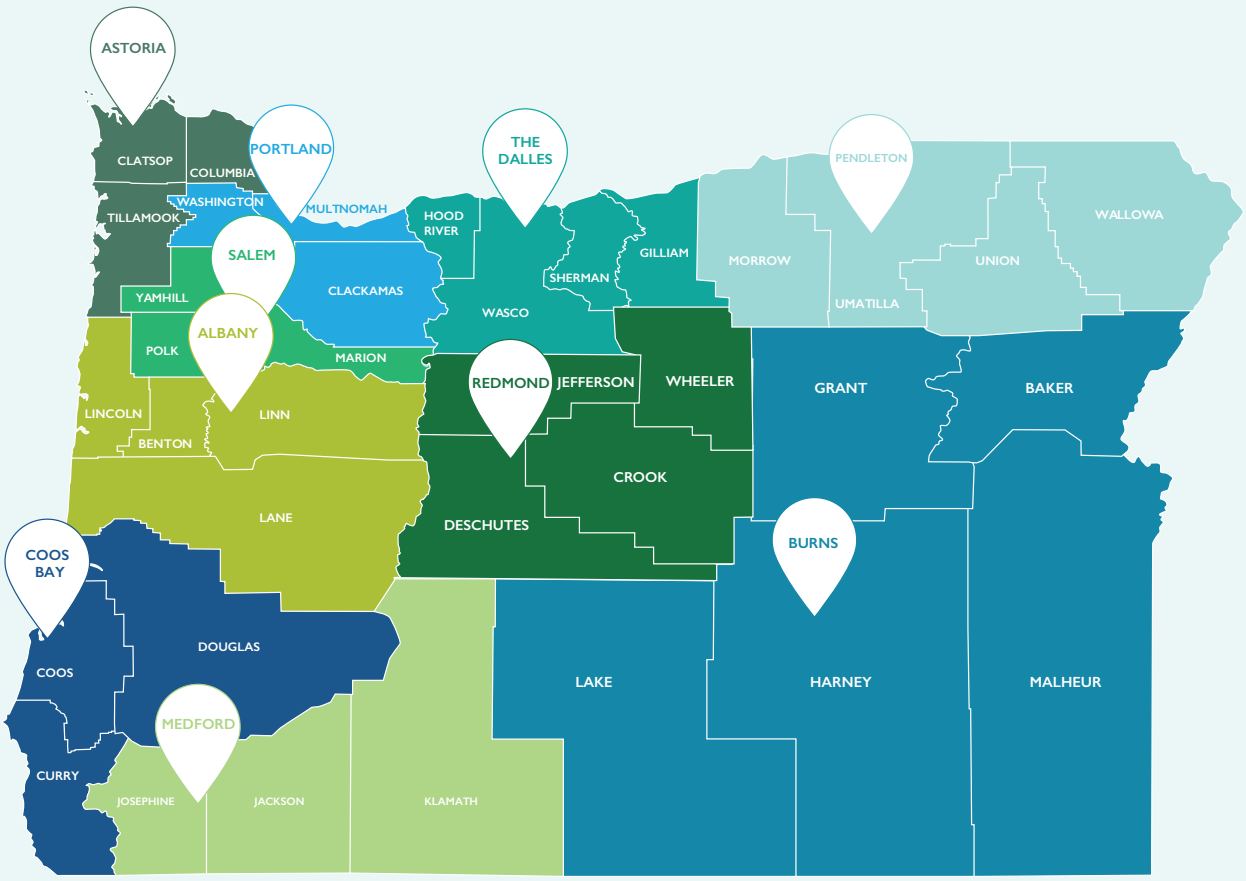
In 2015, the Oregon State Legislature passed groundbreaking legislation providing a statutory framework to rebuild and modernize Oregon's public health system.

Public health modernization will update our public health system to be more efficient, effective, and will create greater accountability and better health for all Oregonians. As a way to accomplish this, Oregon Law (ORS 431.131-148) establishes a framework of foundational public health services based on a national model. State and local public health departments will work to implement this framework over the next ten years.

To support this implementation work, the Public Health Division of the Oregon Health Authority and the Coalition of Local Health Officials applied for and received a grant from the Robert Wood Johnson Foundation to support Oregon's work to modernize the public health system. This project, called **Aligning Innovative Models for Health Improvements** or **AIMHI**, focuses on preparing communities for transitioning to a modernized public health system. Under this funding, ten community AIMHI meetings occurred throughout Oregon in the following cities: Burns, Redmond, The Dalles, Salem, Albany, Medford, Coos Bay, Portland, Astoria, and Pendleton.

The purpose of these meetings was to educate communities on the new model for public health and facilitate feedback about creating new partnerships for improved health.

Figure 1: AIMHI 2016-17 Meeting Locations



AIMHI Meeting Structure

Ten six-hour, in-person meetings were sponsored by the Coalition of Local Health Officials and facilitated by their contractor, the Rede Group. All of Oregon's 36 counties were assigned (based on geographic proximity) to one of ten regional meetings sites. Meeting planning took place in summer of 2016 with local health agency administrators, CLHO staff, and the Rede Group collaborating on the meeting objectives and agendas. Local health department administrators from all 34 local health agencies supported the meetings through assisting with agenda development, inviting local partners, and presenting information during the meetings. Each meeting was a blend of short presentations and group discussion. Local health department administrators invited community members, partners and local officials to attend the meetings, as is shown in the second attendance compilation.

Attendance

The planned meeting schedule was disrupted by weather events that necessitated last minute cancellation and rescheduling of 4 of the 10 meetings. Despite the changing schedules, meetings were well attended by a diverse array of community partners.

Table 1: AIMHI Meeting Information

Location	Date	Attendance
Burns, OR	10/21/2016	29
Redmond, OR	11/01/2016	61
The Dalles, OR	11/03/2016 & 11/21/2016	44
Salem, OR	1/20/2017	47
Albany, OR	1/25/2017	68
Medford, OR	1/27/2017	22
Coos Bay, OR	1/30/2017	30
Portland, OR	2/06/2017	84
Astoria, OR	2/10/2017	50
Pendleton, OR	2/17/2017	18
Total		453

Table 2: Types of AIMHI Meeting Attendees by Sector

Types of Attendees by Sector	Attendance
Local Public Health Department Staff	172
Community Based Organization	56
Local Public Health Department Administrators	33*
CCO's	33
State Public Health Department Staff	22*
Local Government Elected Officials	28
Healthcare Providers	28
Other	24
Higher Education	19
Primary Education	9
Tribal Government	8
Local Public Health Advisory Board	6

*People who attended multiple AIMHI meetings were counted once.

Meeting Themes

Themes Analysis

The following analysis outlines the most prominent themes from the AIMHI meetings: challenges to modernization, opportunities in cross-jurisdictional sharing, and current cross-jurisdictional sharing happening between county public health departments.

Rede used two criteria to analyze themes; one was the number of meetings in which a theme emerged and the second was the number of times a particular theme was found in meeting notes across all ten meetings. Both of these analyses are presented in this report.

Figures 1 & 2 represent the number of times a particular theme was found and excerpted from meeting notes, while the overall themes analysis of this report were identified by the number of meetings in which a particular theme emerged.

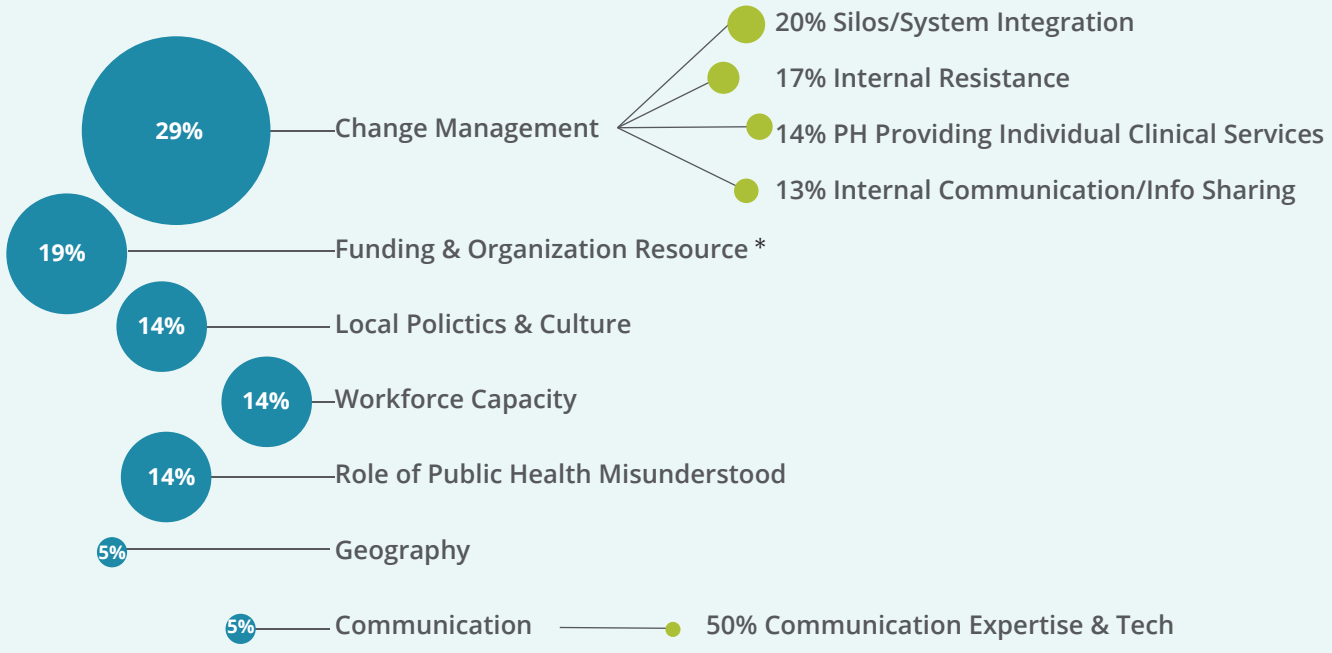
Challenges to Implementing Modernization

During the regional AIMHI meetings, participants were asked to consider and discuss challenges that local health agencies currently face or may potentially face while implementing public health modernization.

An analysis of these discussions revealed four main themes among the challenges. Although the frequency a theme was mentioned may have varied from meeting to meeting, each of these themes were brought up in all (10/10) of the AIMHI meetings was:

1. Internal change management and systems change concerns;
2. Lack of funding and organizational resources;*
3. Workforce capacity; and
4. A lack of local understanding and buy-in for population level approaches focused on policy, systems and environmental change

Figure 1: Challenges to Implementing Modernization



*The strength of this theme may be artificially low as attendees were encouraged not to focus solely on funding and resources.

Change Management (10/10 meetings)

Over 118 excerpts specific to change management and systems change were found in our analysis of the 10 AIMHI meetings. Numerous subthemes also emerged. In at least 7 of the 10 AIMHI meetings, attendees expressed concerns about: internal resistance to change; "siloed" work environments and difficulty with systems integration; public health providing individual and clinical services, and internal communication and information sharing.

Change Management Sub Themes:

+ ***Silos/System Integration (9/10 meetings)***
  Participants expressed concerns about the ability to integrate the current system of "silos" within public health and the health services field in general. Concerns around siloes within health departments (e.g. between programs), within the statewide public health systems (e.g. between state and local health departments) and among state local partners (e.g between public health and primary care) were all noted, as one participant stated:

  "Public health professionals sometimes convey that silos are external constructs, imposed on the system, but there are cultures within programs, within the public health department, that reinforce silos; this can get in the the way of solutions."

  –Portland AIMHI meeting attendee

+ ***Internal Resistance (9/10 meetings)***
  Among the strongest themes within the challenges discussions, were concerns about internal resistanceof public health department staff. Participants noted that public health modernization may necessitate large shifts in public health practice which will in turn affect individual job duties; for some employees, the emotional stress of change can externally affect job performance and morale. Stress may be compounded by philosophical differences of opinion about public health service priorities in the given environment.

  "Public health staff buy-in is difficult, because it feels like staff is just being dragged along instead of actively participating in the change."

  –Portland AIMHI Meeting attendee

+ ***Public Health providing individual and Clinical Services (7/10 meetings)***
  Participants were concerned about the possibility or expectation of a shift from providing clinical services to population-based services. Some participants were concerned that with a shift, some individuals may not receive the necessary care because there are "no other providers in the community" that can offer the same type or quality of care. Others were concerned about negative public perception that would accompany a shift from clinical to population-level services.

  "It's hard to ensure that people are going to be taken care of if the public health departments aren't providing services."

  –The Dalles AIMHI meeting attendee

  "It will be challenging to move away from a direct service model to a population health model."

  –Coos Bay AIMHI meeting attendee

+ ***Internal Communication and Information Sharing (7/10 meetings)***
  Participants spoke to barriers related to understanding modernization throughout the public health system. Comments focused on flaws in the current communication structure and practice between the local health agencies and the state health agency and between local health agencies.

  "It will be challenging to manage change both internally and externally so that staff, partners and community members know what public health does, the role of public health, and the purpose it serves."

  –Portland AIMHI meeting

Funding and Organizational Resources (10/10 meetings)

Funding and organization of resources were the second strongest* theme identified through the AIMHI meetings on the challenges to modernization implementation, and was identified in 10 of the 10 AIMHI meetings. Participants at all meetings identified a lack of adequate funding and resources to be a significant barrier to implementing modernization within local public health agencies, as one participant explained:

"Local public health agency funds are inadequate, and these holes in funding have to be made up somewhere or another which usually means funds get cut everywhere and LHDs can't meet goals for public health."

–Burns AIMHI meeting

Workforce Capacity (10/10 meetings)

Workforce capacity was a challenge that was brought up in each of the 10 meetings, with participants identifying that workforce resources were low, but even when the financial resources are available there might not be enough qualified people to hire to do the needed work.

"How can the public health system move anymore without additional bodies to do the work, which requires funding?"

–The Dalles AIMHI Meeting

Local Politics and Culture (10/10 meetings)

Local politics and culture was identified as a challenge to modernization in 10 of the 10 AIMHI meetings. Participants identified many barriers to public health in regarding local politics in their jurisdictions, including difficulty communicating with local elected officials as well as challenges with clashing agendas. As one participant pointed out:

"We have talked about how local politics is working against public health reform. The public health department wants an upstream approach but we have advocates against that."

–Astoria AIMHI meeting

External Communication (10/10 meetings)

Communicating with external partners, elected officials and the public at large was cited in all 10 meetings as a significant barrier. Participants were concerned about how to frame messages to effectively convey the role of public health and to explain public health modernization. Some county health agency representatives noted that they are not experts in strategic communication and do not have resources at their disposal for developing strategic communication efforts. Others pointed to a lack of technology and infrastructure for reaching all sectors of a community to share messages.

"Local public health agencies aren't good at and don't know the best way to frame public health's case to the legislature."

–Albany AIMHI meeting

Misunderstanding of the Role of Public Health (9/10 meetings)

Participants spoke at length about the threat to modernization presented by the general lack of understanding the public has of the role of governmental public health. They noted that often the public believes that public health's role is to provide preventive health care resources (such as vaccines) for people experiencing poverty and to conduct food inspections. Because the public expects public health to provide these services, local elected officials may be similarly indoctrinated.

"It is hard to educate everyone to know what public health provides and the importance of public health."

–Salem AIMHI meeting

Geography (7/10 meetings)

Geography, including the disbursement of populations and the difficulty in transportation across terrain or from long distances, was communicated by participants as being a challenge for public health modernization. The issues brought up about geography were; problems reaching all of the population or environment in a county, issues for rural communities in accessing services, and

*The strength of this theme may be artificially low as attendees were encouraged not to focus solely on funding and resources.

difficulties in representing the interests of a diverse and large population of people.

"We are geographically spread out and there is a limited number of local public health department offices, for folks trying to get to a provider. We just got public transportation in the last year but it is still very limited."

–Pendleton AIMHI meeting

Return on Investment: Immediate and Long Term (7/10 meetings)

Meeting attendees expressed concern over the challenge of providing information about the return on investment of population-based services. Participants worried that it would be difficult to get community member and legislative buy-in without proof of success for services provided by public health.

"If we [local public health departments] tell them [community members] we are going to do some research that doesn't affect them on a daily basis, and start taking away individual services, they won't think anything has improved."

–Burns AIMHI meeting

Opportunities in Cross-Jurisdictional Sharing

Of particular interest during the AIMHI meetings was exploring ways that cross-jurisdictional sharing can be utilized to mitigate the challenges of implementing modernization. As challenges such as lack of funding, resources, and workforce emerged in every meeting, potential solutions were also discussed. Meeting participants were asked to consider potential solutions including cross-jurisdictional sharing and several themes emerged within the construct of foundational capabilities and programs:

- Assesssment & Epidemiology;
- Leadership & Organization;
- Prevention & Health Promotion;
- Policy & Planning;
- Access to Clinical Preventive Services;
- Emergency Preparedness;
- Environmental Health;
- Communication; and
- Communicable Disease.

Assesssment and Epidemiology (10/10 meetings)

Meeting attendants expressed that sharing epidemiological services across counties was feasible and, likely, advisable. Specifically, many counties acknowledged their need for epidemiological services that were not full-time, and utilizing cross-jurisdictional sharing by sharing services or sharing an epidemiologist could be beneficial to increasing these services in their jurisdictions. Moreover, counties who can hire full-time epidemiologist have found value in developing a shared structure.

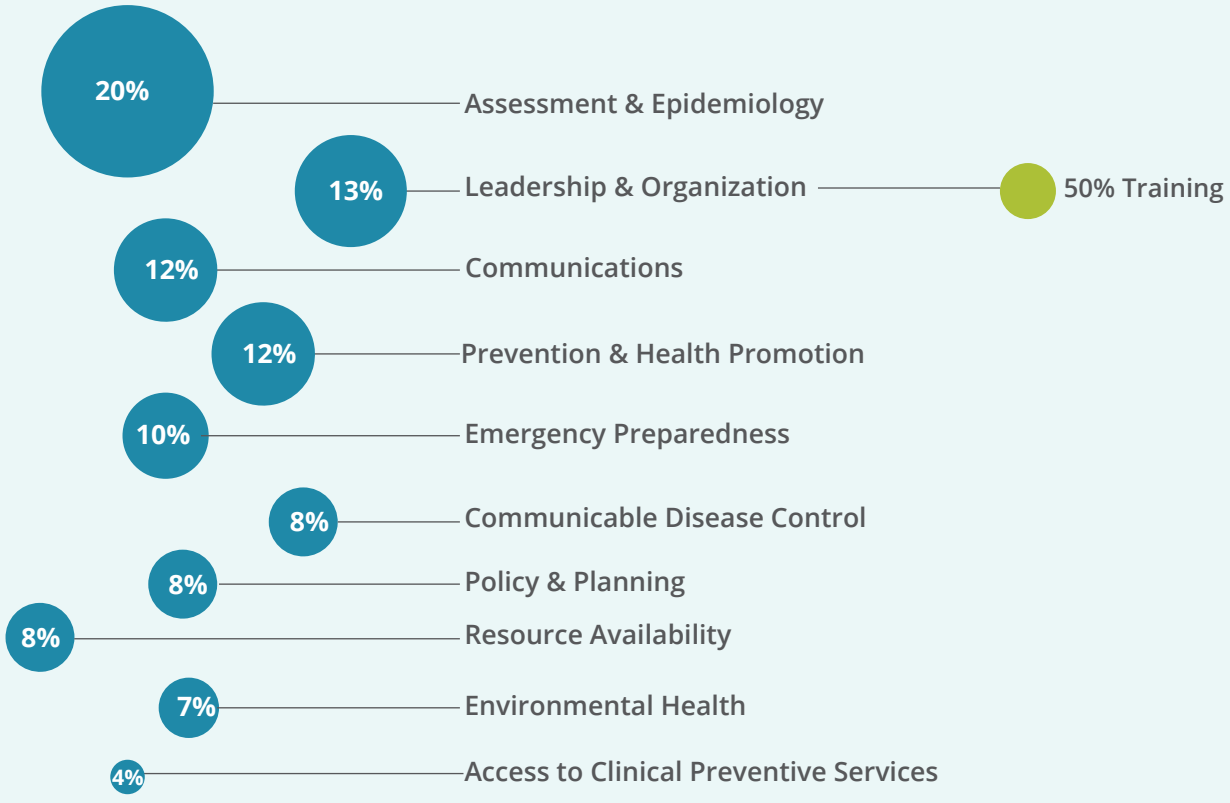
"Our county public health doesn't need a full-time epidemiologist, but if our county could share with other counties and split the time of an epidemiologist, that is an area that cross-jurisdictional sharing would make the most sense."

–Burns AIMHI meeting

Leadership and Organization (10/10 meetings)

Utilizing joint committee meetings as well as informal discussions was identified as a way

Figure 2: Opportunities in Cross-Jurisdictional Sharing



that cross-jurisdictional sharing could be used to help counties improve their leadership and organization. One specific way that CJS could help this foundational capability was through regional staff trainings, which emerged as a subtheme in 7/10 AIMHI meetings.

"If county public health agencies collaborated on staff trainings, public health could save so much money, and when you have regional trainings you make connections with others working in public health in other counties."

–Medford AIMHI meeting

Prevention and Health Promotion (9/10 meetings)

Many counties identified that providing prevention and health promotion services and infrastructure was difficult, especially in geographically large communities. Participants asserted that if certain services were shared, such as tobacco and obesity prevention programs, communities that are geographically closer to different jurisdictions than to their own local public health agency would still be able to receive the benefits of the prevention programs and infrastructure. Sharing prevention specialists was also a way in which meeting participants said that they could share services.

"It would be helpful to have greater organizational sharing, specifically for communities on geographic boarders. Counties could work together to create a shared system so all people in the counties, regardless of geography, have access to services, for example obesity and food insecurity prevention."

–Coos Bay AIMHI meeting

Policy and Planning (8/10 meetings)

Sharing policy and planning initiatives, working regionally on health improvement plans, and working across counties on joint advocacy were identified as beneficial ways counties could use cross-jurisdictional sharing to improve policy and planning in local health agencies. In addition, some county health department staff expressed that they would benefit from having a regional shared "expert" in policy change strategy because they lacked expertise themselves.

"Create a joint CHIP between multiple counties as well as the hospitals, FQHCs, and CCOS, have a joint shared plan, and meet regularly to appraise progress."

–Salem AIMHI meeting

Resource Availability (8/10 meetings)

Sharing resources, especially in light of a limited workforce, was a large theme throughout the regional meetings. Many meeting participants acknowledged that even with funding the available public health workforce does not fill the needs of the local public health agencies, but sharing the available workforce between multiple local public health agencies was identified as a way cross-jurisdictional sharing could help fill gaps in local public health agency services. Participants also pointed out that sharing resources by working as a collaboration for grant funds would help with implementing modernization changes.

"Share resources across county public health in order to fill in gaps in services."

–Albany AIMHI meeting

Access to Clinical Preventive Services (8/10 meetings)

Participants expressed a need for shared services in regards to clinical preventive services, especially in locations where the geography and low population density create situations where the local public health agency is the primary provider of clinical preventive services. Attendees noted:

"We need a natural catchment area, we have a northern community that sits almost in a neighboring county and they provide more services to the populous, because it's too far for us to provide services."

–Medford AIMHI meeting

"Cross-jurisdictional sharing can help create opportunities to help ensure that everyone has access to clinical preventive services."

Emergency Preparedness (8/10 meetings)

Participants noted that having cross-jurisdictional sharing arrangements for sharing staff across counties during an emergency or outbreak would be useful as well as having regional meetings around preparedness planning and resources. Also, some participants opined that due to the nature of emergency preparedness work, cross-jurisdictional and cross-sector sharing are the norm.

"Cross-agency or potentially cross-jurisdictional sharing in public health emergencies or an outbreak."

–The Dalles AIMHI meeting

Environmental Health (7/10 meetings)

During the AIMHI meetings the understanding that because the environment doesn't adhere to jurisdictional boundaries, it is important for counties to collaborate around these services. Participants mentioned having regional environmental collaboration groups and sharing environmental health inspection staff could be beneficial.

Communications (7/10 meetings)

Sharing the expertise of a communications director with another county, sharing a media market with one or more other counties, and creating a joint communications plan were all identified by participants as ways to utilize cross-jurisdictional sharing to improve local public health agency's communication.

"Since the needed and preferred messages between counties may differ, the best way to share communication could be to hire a communication expert to share between counties. This person could help with strategy and messaging but the spokespeople would be local."

–Burns AIMHI meeting

Communicable Disease (7/10 meetings)

Resource capacity to respond to an outbreak of communicable disease is a serious concern for many local health agencies that simply do not have extra resources for time-consuming and multifaceted work that ensues upon the occurrence of a communicable disease outbreak in a county. Participants noted that sharing funding, such as pooling funds for use during an outbreak, workforce to supply surge capacity, and data sharing would help counties prevent and respond to outbreaks.

"Sharing communicable disease services across counties. Looking as a region and incorporating tribal health departments, such as in prevention of communicable disease and surge response to outbreaks."

–Pendleton AIMHI meeting

Current Cross-Jurisdictional Sharing

Participants were asked to describe current cross-jurisdictional sharing that was happening between their county local public health agency and other local public health agencies. From this information, and subsequent information gathered from local health agency administrators, the Rede Group compiled a cross-jurisdictional sharing library. From the examples in the library, we created a cross-jurisdictional map series on the following pages (Figures 3, 4 and 5) which show the foundational capabilities, programs, and cross-jurisdictional type being shared across the state of Oregon.

(note: At this time, these are not comprehensive maps, a county may have multiple CJS arrangements that fall under the same foundational element, however a particular foundational element is only shown on the map once for any given group of counties.)

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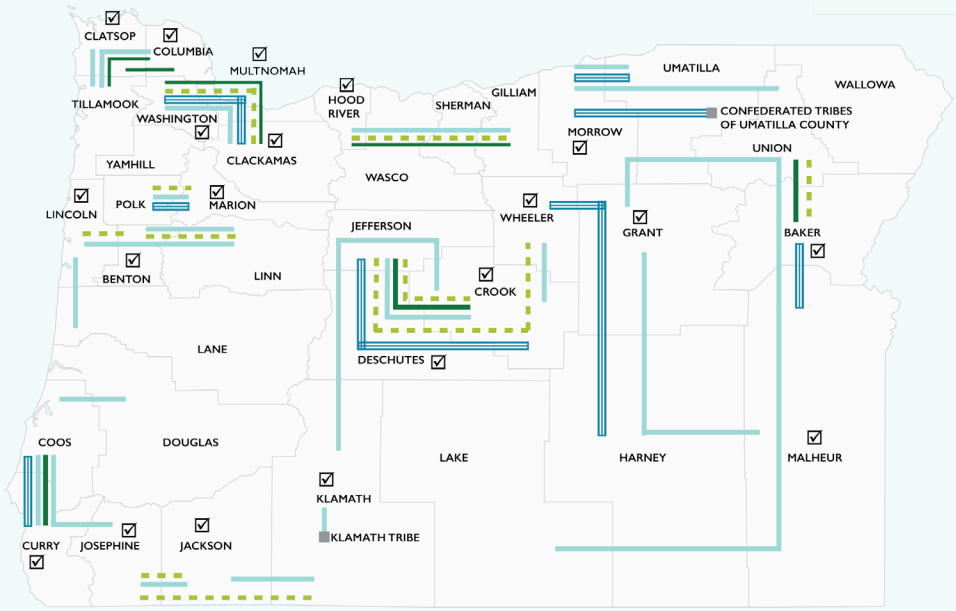
*At least one county in the depicted arrangement has responded to the excel spreadsheet and confirmed that the CJS is happening. If there is not a check mark in your county then we have not received an updated CJS spreadsheet from you.

Figure 3: Cross-Jurisdictional Sharing: Foundational Public Health Programs March 2017



Overview

78 Total Sharing Arrangements

29 Counties/tribes Engaged

11 Environmental Public Health Arrangements

41 Prevention & Health Promotion Arrangements

14 Communicable Disease Control Arrangements

12 Access To Clinical Preventive Services Arrangements

Description:

This map depicts all confirmed cases of cross-jurisdictional sharing occurring between local health departments in the state of Oregon. This map does not represent every instance of CJS happening in the state, instead it puts a single line to represent all sharing arrangements which fall into a single foundational program category. Therefore, there will be more numbers in the overview than there are lines on the map. For example, if Polk and Marion have two sharing arrangements that fall under Environment Public Health, both arrangements will be accounted for in the overview but there will only be one line for that foundational program on the map.

Legend

- Environmental Public Health
- Prevention & Health Promotion
- Communicable Disease Control
- Access to Clinical Preventive Services

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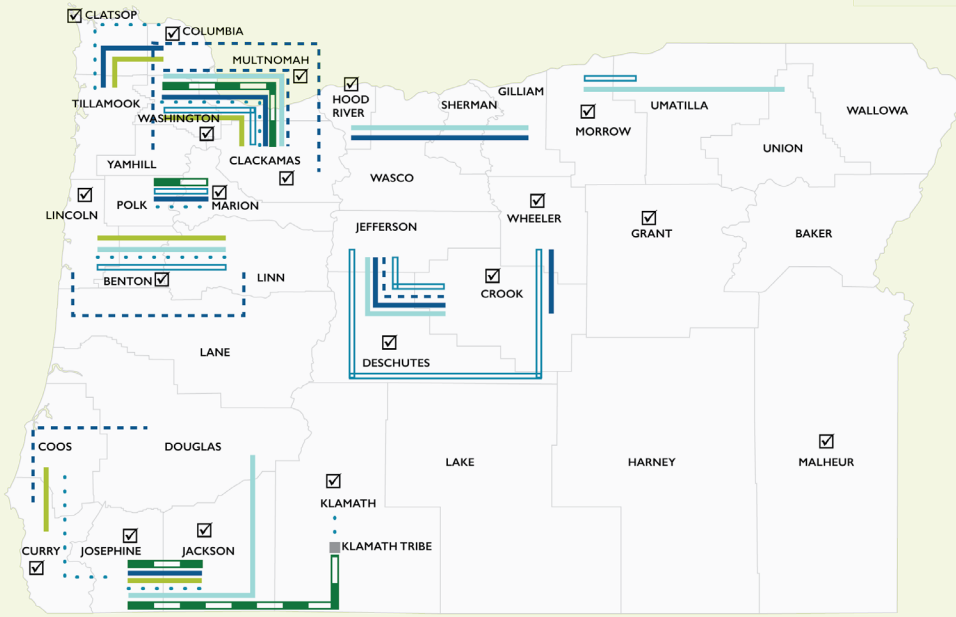
*At least one county in the depicted arrangement has responded to the excel spreadsheet and confirmed that the CJS is happening. If there is not a check mark in your county then we have not received an updated CJS spreadsheet from you.

Figure 4: Cross-Jurisdictional Sharing: Foundational Public Health Capabilities March 2017



Overview

64 Total sharing Arrangements

29 Counties/Tribes Engaged

4 Community Partnership Arrangements

13 Leadership & Organizational Competencies Arrangements

13 Policy & Planning Arrangements

8 Assessment & Epidemiology Arrangements

7 Emergency Preparedness & Response Arrangements

16 Health Equity & Cultural Responsiveness Arrangements

3 Communications Arrangements

Description:

This map depicts all confirmed cases of cross-jurisdictional sharing occurring between local health departments in the state of Oregon. This map does not represent every instance of CJS happening in the state, instead it puts a single line to represent all sharing arrangements which fall into a single foundational capability category. Therefore, there will be more numbers in the overview than there are lines on the map. For example, if Polk and Marion have two sharing arrangements that fall under Communications, both arrangements will be accounted for in the overview but there will only be one line for that foundational capability on the map.

Legend

- Community Partnerships
- Leadership & Organizational Competencies
- Policy & Planning
- Assessment & Epidemiology
- Emergency Preparedness & Response
- Health Equity & Cultural Responsiveness
- Communications

Figure 5:

Cross-Jurisdictional Sharing Spectrum

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Informal & Customary Arrangements	Service-Related Arrangements	Shared Functions with Joint Oversight	Regionalization
48	29	28	1
Instances in Oregon	Instances in Oregon	Instances in Oregon	Instance in Oregon
SPArC tobacco prevention grant (Benton, Lincolon, Lane) Columbia provides medications to a Clatsop worksite that is closer to Columbia (Columbia, Clatsop) Health alerts during outbreaks (Marion, Polk)	Malheur Environmental Health Specialists contractionally shared (Malheur, Baker) Grant County provides Environmental Inspections (Wheeler, Harney, Grant) Formalized Health Officer Sharing (Linn, Benton)	Regional Health Assessment, all counties pay equally for staffing and support (Linn, Benton, Lincoln) Tri-County Mental Health Promotion (Crook, Deschutes, Jefferson) Healthcare Coalition of Southern Oregon (Jackson, Josephine, Douglas)	

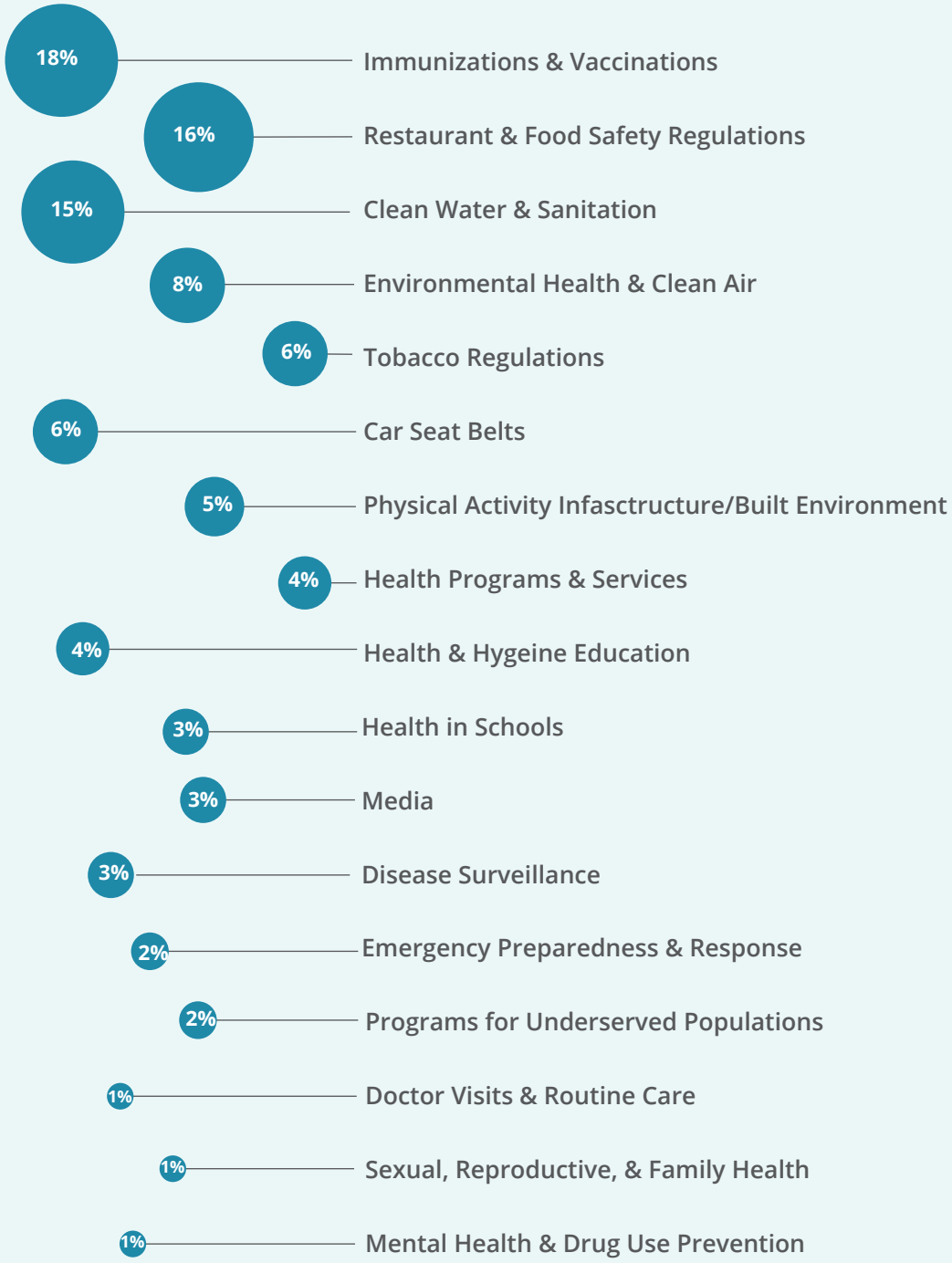
Looser Integration — Tighter Integration

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

Public Health Question Data

Participants at each AIMHI meeting anonymously responded to the question "How have you been personally impacted by public health in the last 24-48 hours?" The data collected from those responses can be seen in Figure 6.

Figure 6: Public Health Question Data



Recommendations

The purpose of this report is to reflect structured discussions about how Oregon can best advance modernization through examining barriers and opportunities that exist in the current climate.

In 2016 Oregon's public health system accomplished a thorough assessment of its strengths and deficiencies at the state and local level. This Statewide AIMHI report and iterant recommendations are not meant to restate the findings in the Public Health Modernization Assessment Report[1] but rather supplement it with community-informed considerations for accomplishing this systematic change.

1. Change Management

Preparing individuals, teams, and organizations for making organizational changes ushered in by public health modernization is necessary if Oregon is to ensure an efficient, respectful transition. In the broadest terms, effective factors for change management include:[2]

- Defining measurable stakeholder aims and creating a health and business case for their achievement (which should be continuously updated)
- Monitoring assumptions, risks, dependencies, costs, return on investment, dis-benefits and, importantly, cultural issues
- Effectively communicating to inform various stakeholders, including public health employees, of the reasons for the change (why?), the benefits of successful implementation (what is in it for us, and you) as well as the details of the change (when? where? who is involved? how much will it cost? etc.)
- Developing an effective education, training and/or skills plan to support employees in transitioning to the new model
- Understanding and countering resistance from employees, aligning them to overall strategic direction of pubic health modernization
- Provide personal counseling (if required) to alleviate any change-related fears
- Monitoring of the implementation of modernization and fine-tuning the implementation plan as required

It appears that some of these items are currently being addressed in Oregon's public health modernization work. For example, much work has been accomplished to define measurable stakeholder aims and develop and present the health and business case for modernization. However, quality change management requires a comprehensive approach. Therefore, change management processes should be quantified and documented at the system and individual local public health agency level. If deficiencies are found, a plan for addressing them should be created.

2. Workforce Capacity

Understanding the workforce implications of modernization is recommended. Local public health agencies shared concerns around the capacity to hire qualified individuals to fill specific positions but it is unclear if a comprehensive review has been accomplished. Concerns often focused on workforce capacity within the realm of environmental public health services however other concerns such as policy expertize and communication expertise also arose; focusing workforce capacity assessment on these areas may be a good first step.

3. Role of Public Health

Continuing to find ways to communicate public health's role and establish a sense of urgency for rebuilding and modernizing Oregon's public health system at the community level remains a significant challenge and an important need. The Coalition of Local Health Officials is currently assisting local health agencies with tools and training to support this need; this effort should be expanded and sustained.

4. Cross-Jurisdictional/Sectoral Sharing

Most local health agencies have been effective in developing and sustaining cross-sector and cross-jurisdictional sharing relationships and continue to innovate in conceiving and implementing arrangements that increase efficiencies and/or add value in delivering high quality public health services. In the coming years, a system-wide effort is recommended to support cross-jurisdictional sharing within the following areas:

- Assesssment and Epidemiology
- Leadership and Organizational Competencies (with an emphasis on training)
- Communications
- Prevention and Health Promotion

1. BERK. 2016. State of Oregon Public health Modernization Assessment Report. https://public.health.oregon.gov/About/TaskForce/Documents/PHModernizationReportwithAppendices.pdf
2. Kotter