HB 2348 (2013): Task Force Report
Future of Public Health Services

Modernizing Oregon's Public Health System

September 2014

Oregon Health Authority

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Task Force on the Future of Public Health Services

The Task Force on the Future of Public Health Services was created by House Bill 2348 in the 2013 Legislature to study the regionalization and consolidation of public health services, the future of public health services in Oregon, and to make recommendations for legislation.

Task Force membership

As required by HB 2348, the Task Force is made up of 15 members appointed by the Legislature, Governor, director of the Oregon Health Authority (OHA) and director of the Department of Human Services (DHS).

Task Force members are:

Governor appointees
Tammy Baney – Commissioner, Deschutes County, Task Force Chair
Liz Baxter – Director, Oregon Public Health Institute, Task Force Vice-Chair
Carrie Brogoitti – Public Health Administrator, Union County
Carlos Crespo –Professor of Community Health and Director, School of Community Health, Portland State University
Charlie Fautin – Public Health Administrator, Benton County
Nichole Maher – President, Northwest Health Foundation
John Sattenspiel – Chief Medical Officer, Trillium Community Health Plan

At-large members appointed by OHA and DHS directors
Jennifer Mead – Healthy Aging Coordinator, Department of Human Services
Gary Oxman – former Multnomah County Public Health Officer
Alejandro Queral – Director of Systems Planning and Performance, United Way of the Columbia-Willamette
Eva Rippeteau – Political Coordinator, Oregon AFSCME Council 75

Legislators
Rep. Jason Conger (R-Bend)
Rep. Mitch Greenlick (D-Portland)
Sen. Bill Hansell (R-Pendleton)
Sen. Laurie Monnes Anderson (D-Gresham)

Executive sponsor
Lillian Shirley - Public Health Director, Oregon Health Authority, Public Health Division

Committee staff
Cara Biddlecom, Renee Hackenmiller-Paradis, Stephanie Jarem, Catherine Moyer, Jeffrey Scroggin, Michael Tynan – Oregon Health Authority Staff
Diana Bianco – Artemis Consulting

Executive summary

Oregon is a leader in its innovative approach to health system transformation, which aims to provide better health and better care at a lower cost. This transformed health system requires a strong governmental public health system designed to support individuals outside of the clinical setting where they live, learn, work and play.

There is growing recognition that the community environment is as important to health outcomes as medical intervention. Addressing the social determinants of health — improving educational opportunities, stable housing, improving access to healthy foods and creating walkable communities — are interventions that improve the public's health. While it is clear that addressing the social determinants of health is not the sole responsibility of governmental public health, it is critical that public health departments embrace new tools and train or retrain a workforce with appropriate skills in order to achieve measurable goals that improve population health.

An effective public health system requires a focus on new health challenges, which include emerging and traditional infectious diseases and an increase in chronic diseases. Responding to this shift in disease trends requires a different approach in both the clinical and community settings. Influencing the quality and length of life requires a greater focus on the systems, policies and program changes that will reduce the prevalence of chronic diseases. There is also a need for governmental public health to be prepared to react and respond to known and unknown public health threats. This includes working to prevent, detect and respond to traditional and emerging infectious diseases and to increase the ability of state and local public health agencies to respond appropriately to disease outbreaks, natural and man-made disasters, and other public health incidents.

Oregon's current governmental public health system is primarily funded through county general funds and through categorical federal grants, which are often limited in flexibility and not always responsive to local need in Oregon. Because these federal funds are specific in project scope, these investments do not allow governmental public health to focus strategically on the types of public health programs that can help everyone in Oregon achieve optimal health. Any serious consideration of modernizing the public health system in Oregon must include a dedication of robust and sustained state funding to a core package of public health programs and capabilities. However, the current state investment into the public health system consistently ranks below the national median for per capita funding with Oregon currently ranked 46th in the country for per capita funding ($13.37 compared to a median of $27.40).

For these reasons, Oregon needs a modern public health system that can effectively and efficiently these protections for everyone in Oregon.

The Task Force on Future of Public Health Services (Task Force) was created by House Bill 2348 (2013) with the directive of providing recommendations for the future of public health. As indicated in HB 2348, the Task Force focused on recommendations that:

- Create a public health system for the future.
- Explore the creation of regional structures to provide public health services that are consistent with the distribution of population and established patterns of delivery of health care services.
- Enhance efficiency and effectiveness in the provision of public health services.
- Allow for appropriate partnerships with regional health care services providers and community organizations.
- Consider cultural and historical appropriateness.
- Are supported by best practices.

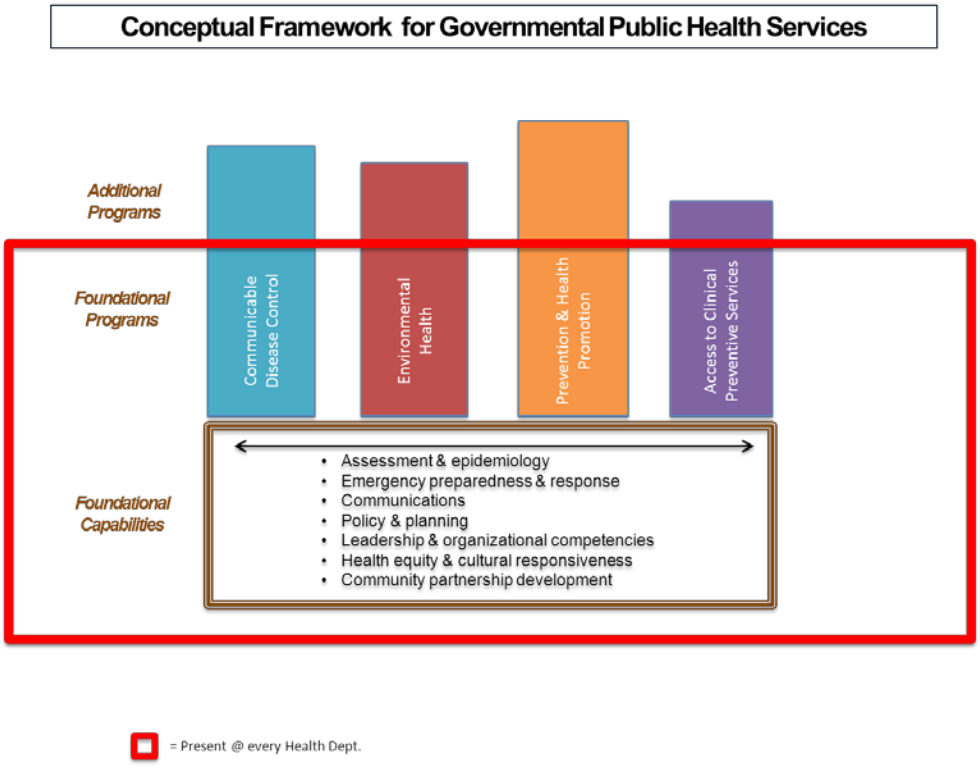
The Task Force developed recommendations that will modernize Oregon's governmental public health system. These changes focus on the need to achieve sustainable and measureable improvements in population health; continue to protect individuals from injury and disease; and be fully prepared for the governmental public health system in Oregon to respond to public health threats that may occur. The Task Force identified a framework set of Foundational Capabilities and Programs that are needed throughout the state and local public health system. These include a set of core staff capabilities and programmatic activities that should be delivered throughout Oregon at both the state and local level. The Task Force believes that implementation and full operationalizing of the Foundational Capabilities and Programs will achieve this modern public health system.

The Task Force concludes that to begin to modernize the governmental public health system, legislation is necessary to establish the foundational capabilities as the minimum requirements for governmental public health in Oregon and charge the Oregon Public Health Division, in coordination with key partners, with developing a timeline, detailed implementation plan and budget for implementation of the Foundational Capabilities and Programs throughout the state.

Specifically the Task Force recommends:

- The Foundational Capabilities and Programs be adopted in order for Oregon's public health system to function efficiently and effectively, pending further refinement to allow for successful implementation.

- Significant and sustained state funding for the governmental public health system be identified and allocated for proper operationalization of the Foundational Capabilities and Programs.
- Statewide implementation of the Foundational Capabilities and Programs occur in waves over a timeline to be determined after additional details of the current gaps in Foundational Capabilities and Programs are assessed.
- Local public health will have the flexibility to operationalize the Foundational Capabilities and Programs through a single county structure; a single county with shared services; or a multi-county jurisdiction.
- Improvements and changes in the governmental public health system be structured around state and local metrics, and that these metrics are established and evaluated by an enhanced Public Health Advisory Board, which will report to the Oregon Health Policy Board.



Background

The Oregon Health Authority (OHA), under the authority of HB 2348 (2013), established the Task Force on the Future of Public Health Services (Task Force) to study the regionalization and consolidation of public health services and the future of public health services in Oregon and to endorse recommendations in a report to the Legislative Assembly no later than October 1, 2014.

The Task Force was charged with providing recommendations for the future of public health. As instructed in HB 2348, the Task Force focused on recommendations that:

- Create a public health system for the future.
- Explore the creation of regional structures to provide public health services that are consistent with the distribution of population and established patterns of delivery of health care services.
- Enhance efficiency and effectiveness in the provision of public health services.
- Allow for appropriate partnerships with regional health care services providers and community organizations.
- Consider cultural and historical appropriateness.
- Are supported by best practices.

The recommendations are aimed at achieving sustainable and measureable improvements in population health delivered through governmental public health across Oregon. Collaboration and possible integration with Oregon's health care transformation should be considered, and recommendations should promote the goals of Oregon's triple aim: better health, better care and lower costs.

Transformation landscape in Oregon

The health delivery system in Oregon is transforming the way services are delivered through the Oregon Health Plan for better health, better care and lower costs. Instead of responding to trends over the last several years with one of the conventional approaches to reducing health care spending—reducing provider payments, the number of people covered, or covered benefits—Oregon has chosen a fourth pathway: improve the delivery system for better efficiency, value and health outcomes. Oregon has developed the Coordinated Care Model for this transformation; it is built on the triple aim (better health, better care, lower costs), and implemented in Medicaid through coordinated care organizations (CCOs). The model can be broken down into six basic concepts:

1. Do what works. Use best practices.

2. Have shared responsibility for health among providers, patients and health plans.
3. Measure performance.
4. Pay for outcomes and health.
5. Provide information so that patients and providers know price and quality.
6. Maintain costs at a sustainable level.

The Coordinated Care Model was the logical next step for Oregon's health reform efforts that began in 1989 with the creation of the Oregon Health Plan (OHP). The Coordinated Care Model design grew out of recognition that the services people need are not integrated, leading to poorer health and higher costs. Mental health, substance use and oral health were fragmented and insufficiently tailored to meet the diverse needs of Oregon's population. There is a sense of urgency in the state to rein in these costs or they will continue to overwhelm state, business and personal budgets.

The future of governmental public health in Oregon will share many of the Coordinated Care Model concepts and attributes and will align with Oregon's larger health system transformation. In addition to supporting health system transformation, governmental public health must maintain its separate and unique role in public health protection which falls outside the health care delivery system. As Oregonians gain increased access to care as a result of Oregon's reforms and the Affordable Care Act, the governmental public health system must also adapt to improve outcomes and remove redundancy through enhanced flexibility, coordination and integration. For this reason, the foundational elements of governmentally assured public health require coordination and alignment with existing health system transformation initiatives.

Public health in Oregon

History and current structure

The Oregon public health system comprises federal, state and local agencies, private organizations and other diverse partners working together to protect and promote the health of everyone in Oregon. Oregon's Public Health Division (OPHD) is housed within the Oregon Health Authority (OHA), which is the organizational home for the state government's health care programs, including Medical Assistance Programs (i.e., OHP), the Public Employees' and Oregon Educators Benefit Boards, and Addictions and Mental Health Programs.

The public health system is responsible for three main functions:

1) Assessment of the public's health in Oregon through data collection and investigations of disease;
2) Development of policies and programs that support improved health outcomes; and
3) To assure those policies and programs are achieving the intended purpose.

Oregon has a decentralized public health system meaning that fiscal, administrative, ownership and authority of public health lies with local public health departments rather than the state. There are 34 public health departments in Oregon — 33 county-jurisdiction departments and one public health district (covering Wasco, Sherman, Gilliam counties).

Oregon laws relating to the administration of public health programs span a time frame of over 100 years, and many of the laws were written at a time before the emergence of the current and modern government system in the state. Currently, the laws reflect the form of governance that existed at the time they were enacted by the Oregon Legislature. Few reflect the form of governance that exists today. These laws represent public health services that past Oregon Legislatures decided were essential. However, the fact that these laws were enacted over such a lengthy period has contributed to inconsistent provision of those services.

In the current system, some key public health activities and programs are administered by the state component of the system, the OPHD. Others are delivered in collaboration with the 34 local health departments, which have statutory authority to protect the public's health in their counties (see ORS 431.405, 431.410 and 431.416).

Each of the 34 public health departments are required to assure that the five mandated services in statute are provided or available in the community. The OPHD and the Conference of Local Health Officials (CLHO) negotiated a list of 10 programs that would meet the statutory definition and each public health department must assure are delivered in their county[1]. Many health departments provide more than the mandated services, while some health departments face difficulty in assuring essential services.

[1]Five mandated services: 1) Epidemiology and control of preventable diseases and disorders; 2). Parent and child health services, including family planning clinics as described in ORS 435.205; 3) Collection and reporting of health statistics; 4) Health information and referral services; and 5) Environmental health services
Ten Programs to Achieve Mandated Services: 1) Communicable disease investigation and control; 2) Tuberculosis case management; 3) Immunizations; 4) Tobacco prevention; 5) Emergency preparedness; 6) Maternal and child health services; 7) Family planning; 8) Women, infants and children services; 9) Vital records; and 10) Environmental health services

Funding

Each local public health department has a two-year funding contract with the OHA (Financial Assistance Agreement) that includes program elements for funding dispersed by the OPHD. The vast majority of these dollars provided to counties by the OPHD are federal dollars in the form of grants and cooperative agreements from federal agencies.

In addition to Financial Assistance Agreement (FAA funds), counties invest general fund resources into programs when there is not enough funding to meet the community need and to provide other prevention interventions when there is no state or other funding to support these activities. Additionally, some public health programs are supported by fees. However, the state investment to local public health departments consistently ranks below the national median for per capita funding with Oregon currently ranked 46th in the country with a funding level of $13.37 compared to a median of $27.40 (see Appendix D for a full list of state per capita contributions to governmental public health).

The future of public health

This is an unprecedented period of change and opportunity for governmental public health nationally and in Oregon. Oregon's health system is undergoing significant transformation, driven by the need to create more integrated, efficient and effective approaches to prevention and primary care. In light of health system transformation, an assessment of the role of governmental public health is needed. The future and ongoing role of governmental public health should be determined in relationship to the larger health system of which both clinical health care and public health must be integral parts, along with nonprofit and for-profit organizations in the community.

The major health challenge facing Americans in the 21st century is the increase in chronic disease. Responding to this shift requires a different approach in both the clinical and community settings. Influencing the quality and length of life will require a greater focus on the systems, policies and program changes that will reduce the prevalence of chronic diseases. However, there is also a need for public health to be prepared to react and respond to known and unknown public health threats. This includes working to prevent, detect and respond to traditional and emerging infectious diseases and to increase the ability of state and local public health agencies to respond appropriately to disease outbreaks; natural and man-made disasters; and other public health incidents.

There is growing recognition that where people live, learn, work and play can be as important to health outcomes as medical intervention. Addressing the social determinants of health — improving educational opportunities, assuring stable housing, improving access to healthy

foods and creating walkable communities — are public health interventions, and governmental public health departments need to embrace new tools and train or retrain a workforce with new skills in order to achieve new goals.

The decentralized system in Oregon results in significant variability across Local Health Departments (LHDs) in terms of population size served, per capita expenditures and capacity. The five mandated services and 10 programs listed in statute are broadly interpreted and therefore vary significantly in their delivery and funding priority from county to county. This has contributed to a public health system in Oregon that can look, feel and function at significantly different levels depending on where in the state you live.

In addition to the system challenges, public health in Oregon faces many resource constraints. Relative to other states, Oregon ranks quite low in terms of median annual per capita LHD expenditures and state public health expenditures. Oregon has traditionally been successful in obtaining federal funding for public health. But the priorities for federal funding do not always align with the health needs of everyone in Oregon.

Changing circumstances require governmental public health officials to be deft and flexible — in the face of current financially-austere times and in future times of adequate funding — in order to meet traditional and changing public health needs. Public health departments must possess foundational public health capabilities — those skills necessary to provide basic public protections critical to the health of their communities, such as clean air, safe food and water, and prevention of infectious diseases or bioterrorism, while adapting to and effectively addressing changing health threats.

The recognition of these circumstances and the challenges in continuing to provide governmental public health services within the current system prompted the passage of HB 2348 that established and charged the Task Force with providing recommendations for the future of governmental public health.

Task Force process and work products

The Task Force held 10 meetings from November 13, 2013 to September 10, 2014. Meetings included presentations from state and local public health department staff, community partners, Oregon Health Policy Board members, representatives from the Early Learning Council, public health organizational experts, and others (see Appendix E for a full list of presenters). The opportunity for public comment was available at every meeting. All meeting

materials, including summaries, are available on the Task Force website (http://public.health.oregon.gov/About/TaskForce).

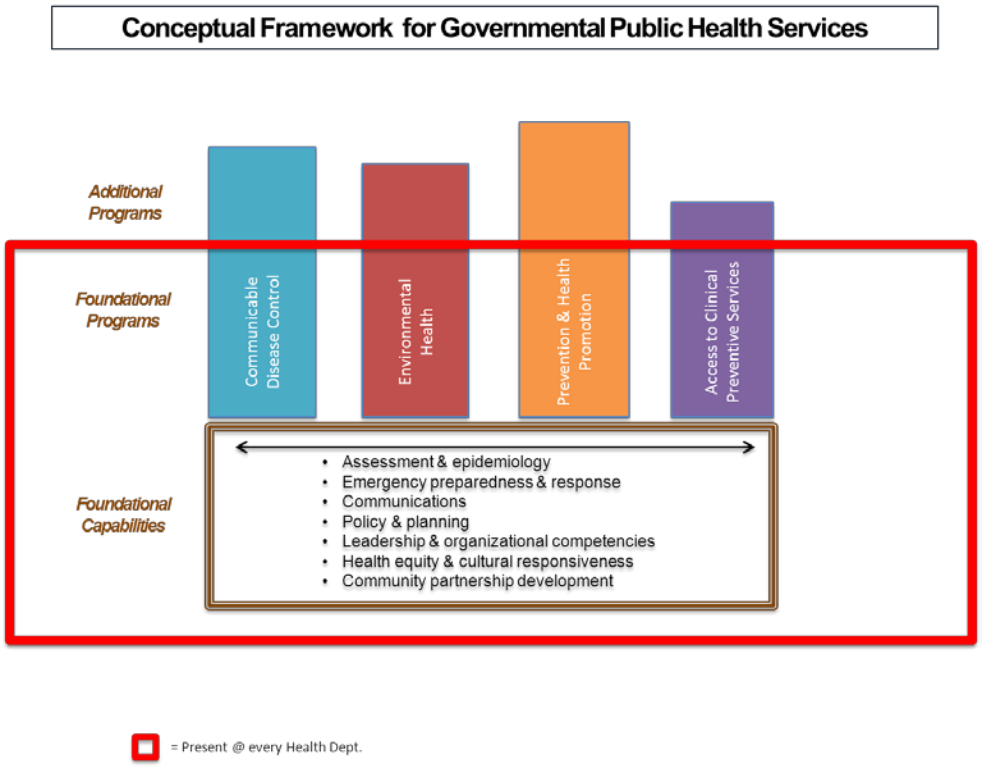
The focus of the January, February, March and April meetings was to develop a shared knowledge of the current governmental public health system in Oregon including statutory requirements, governance structures and financing at both the local and state level. Additional discussion topics included health system transformation implementation, social determinants of health and health equity, and approaches to delivering governmental public health services in other states, including Washington. In addition to the presentations, the Task Force developed the Task Force Charter (Appendix F) and agreed to a set of Guiding Principles to use throughout the Task Force duration (Appendix G)

Themes emerging from these presentations and discussions provided the foundation for the coming months including:

- Funding is a consistent challenge for governmental public health. Oregon will need innovative ways to reduce the burden on local governments without simply finding more money.
- Because categorical funding is unlikely to change, Oregon should embrace these funding streams to the extent possible while seeking opportunities to be innovative and allow for the flexibility necessary to address leading health issues in Oregon.
- There is a need to leverage health system transformation in order to improve population health and use the innovations and flexibilities in the system to support public health.
- The activities undertaken by governmental public health apply to the entire population of a jurisdiction or state and are focused on improving the health status and well-being of the population.
- Governmental public health needs to be as upstream as possible, with a focus on changing policies, systems and environments to not only improve health, but also impact the social determinants of health.
- Governmental public health objectives cannot be achieved without close collaboration between governmental public health and Oregon's system for delivering personal medical care services.

Based on the presentations and discussions during the first Task Force meetings, a model of a minimum package of public health services that included foundational elements was developed for discussion at the May all-day work session in Bend. This model was ultimately developed into a guidance document that outlines the Foundational Capabilities and Programs contained in the Conceptual Framework for Governmental Public Health Services (see Appendix A).

The Conceptual Framework for Governmental Public Health Services builds on recommendations put forward in the Institute of Medicine's 2012 report *For the Public's Health: Investing in a Healthier Future*, and on work done in Washington, Ohio and other states on identifying the core foundational elements of a public health system. Oregon's framework includes a number of program-specific skills and activities beyond those that are cross-cutting and also need to be considered "foundational" to governmental public health departments. These foundational elements are broken down into cross-cutting Foundational Capabilities and specific areas of public health expertise within Foundational Programs.



The Task Force defined Foundational Capabilities as the critical knowledge, skills and abilities necessary to carry out public health activities efficiently and effectively. These Foundational Capabilities are needed to identify and analyze public health problems, and to address these problems through public health programs and policies. They are key to protecting and improving the community's health, and achieving effective and equitable health outcomes. Foundational Capabilities include:

- Assessment & Epidemiology;
- Emergency Preparedness & Response;
- Communications;
- Policy & Planning;

- Leadership & Organizational Competencies;
- Health Equity & Cultural Responsiveness; and
- Community Partnership Development.

Foundational Programs are basic areas of public health expertise and activity essential to assess, protect and improve the community's health. These programs can be appropriately implemented at the state or local levels or as a state/local partnership. Foundational public health programs are considered the baseline services of our public health system. Foundational Programs include: communicable disease control, environmental public health, prevention and health promotion, and access to clinical preventive services.

In the context of the Conceptual Framework for Governmental Public Health Services, Additional Programs are defined as public health programs and activities that are implemented in addition to foundational programs. Additional Programs are implemented to address specific identified community public health problems or needs. Additional public health programs are supported by the Foundational Capabilities and may be supported by and integrated with Foundational Programs.

The Task Force agreed that for Oregon's public health system to function well, the Foundational Capabilities and Programs need to be present broadly in Oregon's state and local health departments. The benefits must be available to everyone in Oregon: these benefits are essential governmental public health capacities.

The Task Force established a plan for how to operationalize the Conceptual Framework including governance, structure changes and regionalization. After discussion and refinement of several options, the Task Force decided an **implementation by wave** would be the most feasible way of to move forward with implementation of the Foundational Capabilities and Programs (see Appendix B).

In addition, the Task Force developed a proposal for a governance structure, options for funding and criteria to select participants for the initial wave of implementation. In the **implementation plan** (see Appendix C), a repurposed PHAB 2.0 would serve an essential governance role by providing oversight, policy direction and guidance for implementation and continued delivery of the Foundational Capabilities and Programs.

Prior to implementation by wave, population health outcome measures would need to be established by the PHAB 2.0 governance group. PHAB 2.0 establishes the activities, personnel and skills needed to assure foundational elements at both the local and state level. The

Foundational Capabilities and Programs will be defined with enough detail and clarity to allow for local and state public health to determine gaps and assure their provision.

State and local governmental public health agencies receive direction from the governance group as to what shall be assured at the state versus local levels, and what shall be assured in partnership between state and local governmental public health. Technical assistance is provided to governmental public health to assess what foundational capabilities are currently in place, determine gaps and develop a plan to assure the foundational capabilities are available.

Local public health authorities apply for the first wave to implement the Foundational Capabilities and Programs as 1) a single county, 2) a single county with cross-jurisdictional sharing, or 3) a multi-county district. The first wave of implementation begins with a limited number of counties that meet the identified criteria (see Implementation Plan, Appendix C). These entities receive ongoing training and technical assistance. The processes undertaken and implemented by local public health authorities are rigorously evaluated to determine effectiveness and level of efficiency gained within the governmental public health system. Implementation processes are refined through ongoing Plan Do Study Act cycles.

Regardless of the implementation pathway chosen, successful implementation will require coordination and planning with community partners as outlined in the Foundational Capabilities. These partners include, but are not limited to: CCOs, community health NGOs, early learning hubs, Aging and Disability Resource Connections, academic institutions, community based organizations, medical care providers, etc.

The Task Force recommends that the statewide implementation of the Foundational Capabilities and Foundational Programs happen in waves over a timeline to be determined after additional details of the current gaps in Foundational Capabilities and Programs are assessed.

Development of an accurate timeline for implementation statewide will require additional analysis of the current skills and resources available to implement the Foundational Capabilities, a realistic assessment of additional state and local financial resources to support this future public health structure, and analysis of possible changes to existing statute.

Given the high level at which the Task Force has been working, there are details that will need to be addressed prior to a statewide implementation of the Conceptual Framework. The areas that need additional details and research include, but are not limited to:

- The structure and function of the OPHD in a modernized public health system.
- The structure and function of the CLHOs in a modernized public health system and its interaction and relations with the OPHD.
- The PHAB 2.0's role as the governing authority that provides oversight for Oregon's public health system.
- An implementation timeline is developed within the first two years of adoption of the Conceptual Framework, and includes incentive structures and criteria for wave participation.

Potential pitfalls or concerns

Implementation of the Foundational Capabilities and Programs will not be successful without significant state funding for state and local public health departments. Meaningful and successful implementation will require identification and dedication of ongoing and sustainable state funds to governmental public health in order to achieve population health outcomes for everyone in Oregon.

In addition, implementation of the Foundational Capabilities and Programs will not be successful without appropriate partnerships. One of the foundational capabilities detailed in the Conceptual Framework is community partnership development. Governmental public health cannot succeed in isolation — establishing, nurturing and growing partnerships throughout every community will be essential for improvements in population health.

Conclusions

The Task Force concludes that legislation is necessary to establish the Foundational Capabilities as the minimum requirements for governmental public health in Oregon and charge OHA, in coordination with key partners, with developing a timeline, detailed implementation plan and budget for implementation by wave of the Foundational Capabilities and Programs throughout the state.

Specifically the Task Force recommends:

- The Foundational Capabilities and Programs be adopted in order for Oregon's public health system to function efficiently and effectively, pending further refinement to allow for successful implementation.
- Significant and sustained state funding for the governmental public health system be identified and allocated for proper operationalization of the Foundational Capabilities and Programs.
- Statewide implementation of the Foundational Capabilities and Programs occur in waves over a timeline to be determined after additional details of the current gaps in Foundational Capabilities and Programs are assessed.
- Local public health will have the flexibility to operationalize the Foundational Capabilities and Programs through a single county structure; a single county with shared services; or a multi-county jurisdiction.
- Improvements and changes in the governmental public health system be structured around state and local metrics, and that these metrics are established and evaluated by an enhanced PHAB 2.0, which will report to the Oregon Health Policy Board.

Appendices

A. Conceptual Framework for Governmental Public Health Services
B. Operationalizing the Framework for Governmental Public Health Services: Implementation by Wave
C. Future of Public Health Task Force Implementation Plan
D. Per Capita State Investment in Public Health
E. List of meeting presenters
F. Task Force Charter
G. Task Force Guiding Principles

Appendix A
Conceptual Framework for Governmental Public Health Services

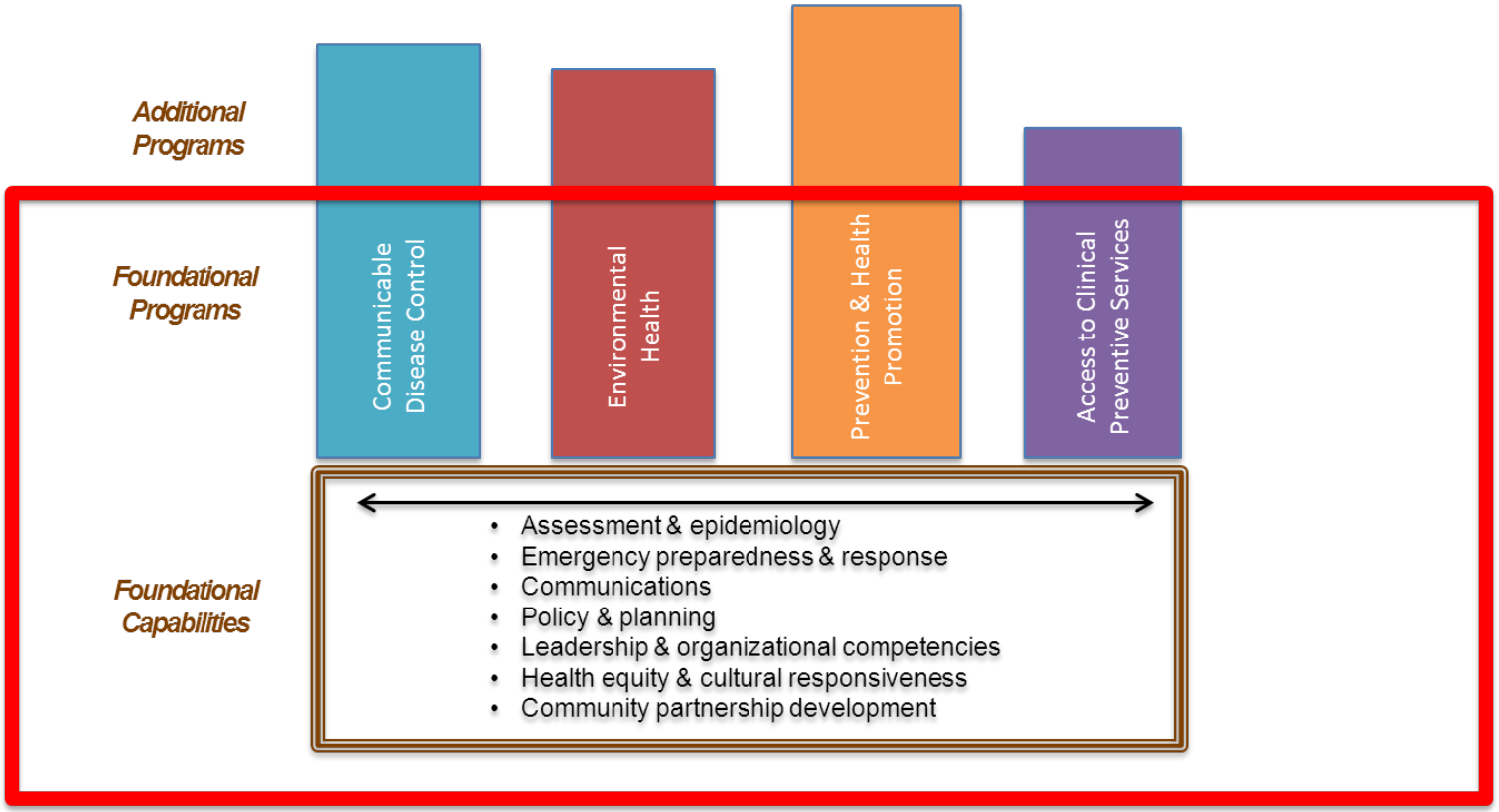
Public health is defined as "a set of organized interdisciplinary efforts to protect, promote, and restore the public's health. It is the combination of assessment, policy development and assurance that is directed to the maintenance and improvement of the health of all the people through collective or social actions."[2] In this regard, governmental public health aims to improve the health of the entire population and to reduce health inequities among population groups. Governmental public health departments and health districts are responsible for activities that include, but are not limited to, preventing, identifying and responding to disease outbreaks and epidemics; establishing and maintaining standards for environmental health protections; and promoting healthy behaviors through policy, systems and environmental changes. The activities undertaken by governmental public health apply to the entire population of a jurisdiction or state and focus on improving the health status and well-being of the population. While this document focuses on governmental public health, it is clear these objectives cannot be achieved going forward without close collaboration between governmental public health and Oregon's system for delivering personal medical care services.

The Conceptual Framework for Governmental Public Health Services is a narrative and visual description of the core, foundational elements of a governmental public health system. It is the role of governmental public health — through the combined efforts of state and local public health and in collaboration with coordinated care organizations (CCOs), community partners and others — to assure these functions. It is the role of governmental public health to maintain a population-wide perspective on improving, protecting and monitoring the health of everyone in Oregon.

This document builds on recommendations put forward in the Institute of Medicine's 2012 report *For the Public's Health: Investing in a Healthier Future* and on work done in Washington, Ohio and other states identifying the core, foundational elements of a public health system. As with those works, this draft framework includes a number of program-specific skills and activities beyond those that are cross-cutting and also need to be considered "foundational" to governmental public health departments.

[2] Institute of Medicine (1988). *The Future of Public Health*. Washington, DC: National Academy Press.

Conceptual Framework for Governmental Public Health Services



= Present @ every Health Dept.

FOUNDATIONAL CAPABILITIES

- DEFINITION: Foundational capabilities are critical knowledge, skills and abilities necessary to carry out public health activities efficiently and effectively. They are needed to identify and analyze public health problems, and to address these problems through public health programs and policies. They are key to protecting and improving the community's health, and achieving effective and equitable health outcomes. For Oregon's public health system to function well, these foundational capabilities need to be broadly present in our state and local health departments: they are the essential capacities.
- Foundational capabilities include:
    - Assessment & Epidemiology;
    - Emergency Preparedness & Response;
    - Communications, Policy & Planning;
    - Leadership & Organizational Competencies;
    - Health Equity & Cultural Responsiveness; and
    - Community Partnership Development.

FOUNDATIONAL PROGRAMS

- DEFINITION: Foundational programs are basic areas of public health expertise and activity essential to assess, protect and improve the community's health. These programs can be appropriately implemented at the state or local levels or as a state-local partnership. However these programs are implemented, their benefits must be available to all Oregon's residents and visitors. Foundational public health programs are considered the baseline services of our public health system.
- Foundational programs include: communicable disease control, environmental public health, prevention and health promotion, and access to clinical preventive services.
- When available, best practices should be used to provide or establish a foundational capability or program. When evidence is lacking or an evidence-based practice is not appropriate for a given community, there also needs to be room for innovation to develop new or improve upon best practices.

ADDITIONAL PROGRAMS

- DEFINITION: Public health programs and activities implemented in addition to foundational programs to address specific identified community public health problems or needs. Additional public health programs are supported by the foundational capabilities and may be supported by and integrated with foundational programs.

- Additional programs are of two fundamental types:
    1. Enhancement or expansion of a foundational program. For example, a jurisdiction might decide it is important for the local health department to provide testing and/or treatment for certain sexually transmitted disease beyond those addressed by the foundational communicable disease program. This kind of program may not be necessary in other jurisdictions based on differing needs and/or other organizations' roles, or commitment of resources to conduct related services.
    2. A new program to address a need not addressed by a foundational program. For example, a county might direct its health department to implement a program in partnership with the local CCO and other medical providers to reduce drug overdose and other harms resulting from prescription pain killers.

FOUNDATIONAL CAPABILITIES - *BASIC ELEMENTS*

Assessment & epidemiology

This core capability includes the knowledge, skills and abilities to gather and analyze data to produce clear and usable understanding of the causes and contributors to important diseases, premature death and injury in the state. The focus of these activities may be statewide for all Oregonians, for a selected community or a specific population that may be at additional risk. Elements of this capability include the capacity to:

- Identify and respond to disease outbreaks and epidemics.
- Conduct and assess core health behavior surveys (e.g. Behavioral Risk Factor Surveillance Survey [BRFSS], or school-based youth surveys).
- Collect and maintain vital records (birth and death certificates).
- Use data from sources such as vital records, administrative data sets, electronic health records, insurance data, hospital data, and nontraditional community and environmental health indicators.
- Analyze and provide timely, accurate statewide and locally-relevant data on the burden and cause of diseases, disability and death.
- Analyze and respond to information based on reports to the notifiable conditions list and provide rapid detection when needed.
- Analyze key health indicators for a state or community health profile.
- Prioritize and respond to data requests. Translate data into basic information and reports that are accurate, statistically valid and usable by the requester.
- Identify conditions and causes of death, injury and diseases that disproportionately affect certain populations, including race, ethnicity or socioeconomic status.
- Conduct a basic community health assessment with partners and identify health priorities arising from that assessment. Use this data to develop community health improvement plans. Evaluate public health programs.

Emergency preparedness & response

This core capability ensures the ability to protect the public by being able to respond to the public health aspects of natural and man-made disasters and emergencies. Elements for this capacity include the knowledge, skills and ability to:

- Develop, exercise, improve and maintain preparedness and response plans.
- Communicate and coordinate with medical care, emergency management and other response partners.
- Activate staff for emergency events and recognize if public health has a primary, secondary or ancillary role in response activities.
- Activate emergency response personnel and communications systems during a public health emergency.
- Maintain and execute a continuity of operations plan that includes access to resources for emergency and recovery response.
- Issue and enforce emergency health orders.
- Be notified of and respond to potential public health events at all times.
- Address needs of vulnerable populations in an emergency.

Policy & planning

This core capability includes the ability to identify, develop, implement and maintain policies necessary to protect and improve the public's health. Elements for this capacity include the knowledge, skills and ability to:

- Serve as a primary and expert resource for using science and best practices to inform the development and implementation of public health policies.
- Provide guidance, participate in leadership and coordinate planning among partners to support development, adoption and implementation of public health policies.
- Develop policy options as needed to protect and improve the health of the population in general or specifically for adversely-impacted populations.
- Understand and use the principles of public health law for improving and protecting public health.
- Analyze and disseminate findings on the intended and unintended public health impacts of policies and systems.
- Develop, implement, monitor/evaluate and revise a community health improvement plan. These plans must be developed with partners, including CCOs, hospitals, behavioral health providers, schools and other community partners.

Communications

This core capability is based in the ability to communicate effectively with the diverse members of the public as well as a wide variety of governmental, business, and other NGOs to achieve the

identified public health outcomes. Elements for this capacity include the knowledge, skills and ability to:

- Engage in two-way communication with members of the public through various communication channels.
- Effectively use mass media and social media to transmit and receive routine communications to and from the public.
- Communicate with a wide variety of community and organizational audiences in a manner that is culturally and linguistically appropriate.
- Develop and implement proactive health education/health prevention strategies (e.g. health warnings in the event of disease outbreak, informational public service announcements, focused social media prevention messages).
- During a disease outbreak or public health emergency, provide accurate, timely and understandable information, recommendations and instructions to the public through the media and other channels.

Leadership & organizational competencies

This core capability includes the ability provide leadership, direction and effective implementation to achieve public health goals and objectives. These competencies within all health departments are essential for effective and efficient action as well as good stewardship of public resources. Basic elements of this capacity include:

- **Organizational leadership and governance** that defines the strategic direction and goals for public health, provides executive decision-making and direction for the agency and is able to align and lead internal and external stakeholders and leaders to achieve public health goals.
- **Access and appropriately use public health law principles** and legal services in planning, implementing and enforcing public health initiatives, including relevant administrative rules and due process.
- **Performance management and quality improvement** – maintain a performance management system to promote and monitor organizational objectives and sustain a culture of achievement and quality improvement. It emphasizes the knowledge, skills and abilities to implement new and revised activities and processes to achieve each health department's objectives.
- **Information technology** – implements and maintains the hardware and software needed to support the health department's operational needs. In doing this, it is critical to appropriately manage confidential health information and other protected personal information.
- **Maintain effective workforce** –maintain a competent workforce, through recruitment, retention, training and succession planning to ensure continuity of operations. This includes:
    - Enhancing workforce capacity by providing ongoing continuing education and other training opportunities.

    - Developing partnerships with institutions of higher education to continually build the public health workforce.
    - Ensuring all public health staff, officials and boards of health have training in public health.
    - Making efforts to ensure that public health staff, officials and boards of health reflect the community being served and the changing demographics in Oregon.
- **Financial management, contract and procurement services** – ability to operate an effective overall financial system according to established accounting and business practices. Specific areas include budgeting, financial tracking, billing and auditing. This includes the ability to secure grants and other external funding, to distribute funds to other governmental and NGO partners, and to manage all funds as required by local, state and federal law.

Health equity & cultural responsiveness

This capability includes the knowledge, skills and abilities that promote understanding of factors within each culture that impact health and a commitment to achieving equitable outcomes for all populations in our communities. Basic elements for this capacity include:

- A commitment to attaining health equity in all programs and supporting policies to promote health equity. This requires recognizing and addressing health inequities to realize the highest level of health for all people.
- Transparent and inclusive communication with internal and external stakeholders (members and organizations of culturally-defined communities, staff, partner organizations, etc.), as well as the public at large.
- Community access to data and to participation in community health planning processes.

Community partnership development

This core capability includes the ability to foster, leverage and maintain relationships with government and NGO partners both within and outside the governmental public health system. These partnerships are important to achieving the triple aim, realizing health equity and supporting other goals of public health. Elements for this capacity include the knowledge, skills and ability to:

- Convene and sustain strategic relationships with traditional and nontraditional partners and stakeholders to collectively advance health. These relationships should be at the overall organizational level (not limited to a specific public health activity or program).
- Engage community members in developing and monitoring a community health improvement plan that draws from community health assessment data and establishes a plan for addressing public health priorities.
- Foster structures that support genuine community involvement and partnerships.
- Develop, strengthen and expand connections across disciplines, including partnerships with the health care delivery, education systems and external groups with an interest or governance of public health including, boards of health, public health advisory boards and elected officials.

- Foster a culture of listening and an environment that honors the wisdom and multiple intelligences of communities with the greatest health disparities. Communities of diverse geographic, income and ethnic background often have the most practical, insightful and responsive strategies to improve health outcomes. The health of our state can only improve from listening and engaging these communities as assets and resources.

FOUNDATIONAL PROGRAM – *BASIC ELEMENTS*

Communicable disease control

Communicable disease control programs work to promptly identify, prevent and control infectious diseases that pose a threat to health of the public. These diseases include well-known infections, as well as new ("emerging") and reappearing infections, pandemics and intentionally-caused infections (e.g., bioterrorism). Key activities of this foundational program include the knowledge, skills and ability to:

- Recognize, identify and respond to communicable disease outbreaks.
- Maintain a list of diseases that must be reported to public health.
- Conduct (as part of the public health laboratory), receive and analyze laboratory results and physician reports for notifiable conditions according to local, state and national law.
- Conduct disease investigations and interventions using the Oregon Investigative Guidelines.
- Support recognition of outbreaks and illnesses of public health importance including rare and severe disease.
- Conduct community-based prevention of communicable diseases.

Environmental health

Environmental health protects the public from illness, disability and death caused by exposure to physical, chemical or biological factors in the environment. Sources that can expose a large number of people (e.g. restaurants, drinking water) are especially important. Because of their historical long success, environmental public health interventions are not always recognized. But traditional environmental health efforts need to continue in order to maintain current results and also to evolve practices to take advantage of the latest scientific evidence. Core programmatic activities include:

- Public health laboratory testing and analysis.
- Licensure, inspection and education of operators of:
    - Restaurants and other food service establishments;
    - Recreation sites, lodging and swimming pools;
    - Septic systems;
    - Drinking water systems;
    - Radioactive materials and equipment (e.g. x-ray machines, tanning beds);
    - Animal bites and vector illnesses; and
    - Hospitals and other medical facilities.

- Environmental health hazard prevention and investigation activities that are able to provide timely and accurate information and recommendations on exposures and related health impacts to the public, health care providers and others as appropriate. Examples include, but are not limited to, identification and response to foodborne illness incidents, environmental toxics such as pesticides, lead and radon, and air quality issues related to air toxics, wildfires and other pollutants.
- Participate in land use planning and sustainable development activities to encourage policies and actions that promote positive health outcomes. Areas for this work include housing and community development, recreational facilities and transportation systems.

Prevention and health promotion

Prevention and health promotion seeks to prevent disease before it occurs, detect it early or reduce disability when prevention isn't fully effective. The leading causes of death and disease include chronic diseases, which can be prevented or managed in part by creating healthier community environments. These changes are often most effectively supported through changes in policies, the built and natural environment, and community systems. Based on data on current and anticipated future needs, the following activities are likely to be important focuses of prevention and health promotion for the next several years:

- Reducing risk for heart disease, diabetes and other chronic conditions through tobacco use prevention and control, improving nutrition and increasing exercise/physical activity.
- Decreasing the occurrence and impacts of intentional and unintentional injuries and deaths such as suicide and motor vehicle crashes.
- Improving oral health.
- Improving reproductive, maternal and child health using prevention activities that create healthy and safe children, families and communities.

Programmatic activities should follow expertise and best practice guidelines for preventing the leading causes of death, disease and injury in Oregon. These programs will maintain core capability at a population-wide level and have the ability to:

- Identify and implement evidence-based policy, systems and environmental changes that will improve related health outcomes at a population-wide level.
- Develop and implement strategic goals and coordinate activities among partners.

Access to clinical preventive services

Clinical preventive services, such as immunizations, prenatal care, and screening for preventable cancers and sexually transmitted infections, are important for reducing preventable deaths and disability, and for improving the population's health. These services are aimed at preventing illness and/or detecting illnesses in early, more treatable stages.

A key role for the public health system is to ensure Oregonians receive recommended cost-effective clinical preventive services. Key activities include:

- Assessing access to cost-effective, high impact preventive care services.
- Ensuring access to laboratory services.
- Addressing barriers to access and use of preventive services through partnership with the medical care delivery system and communities.

SOURCES:

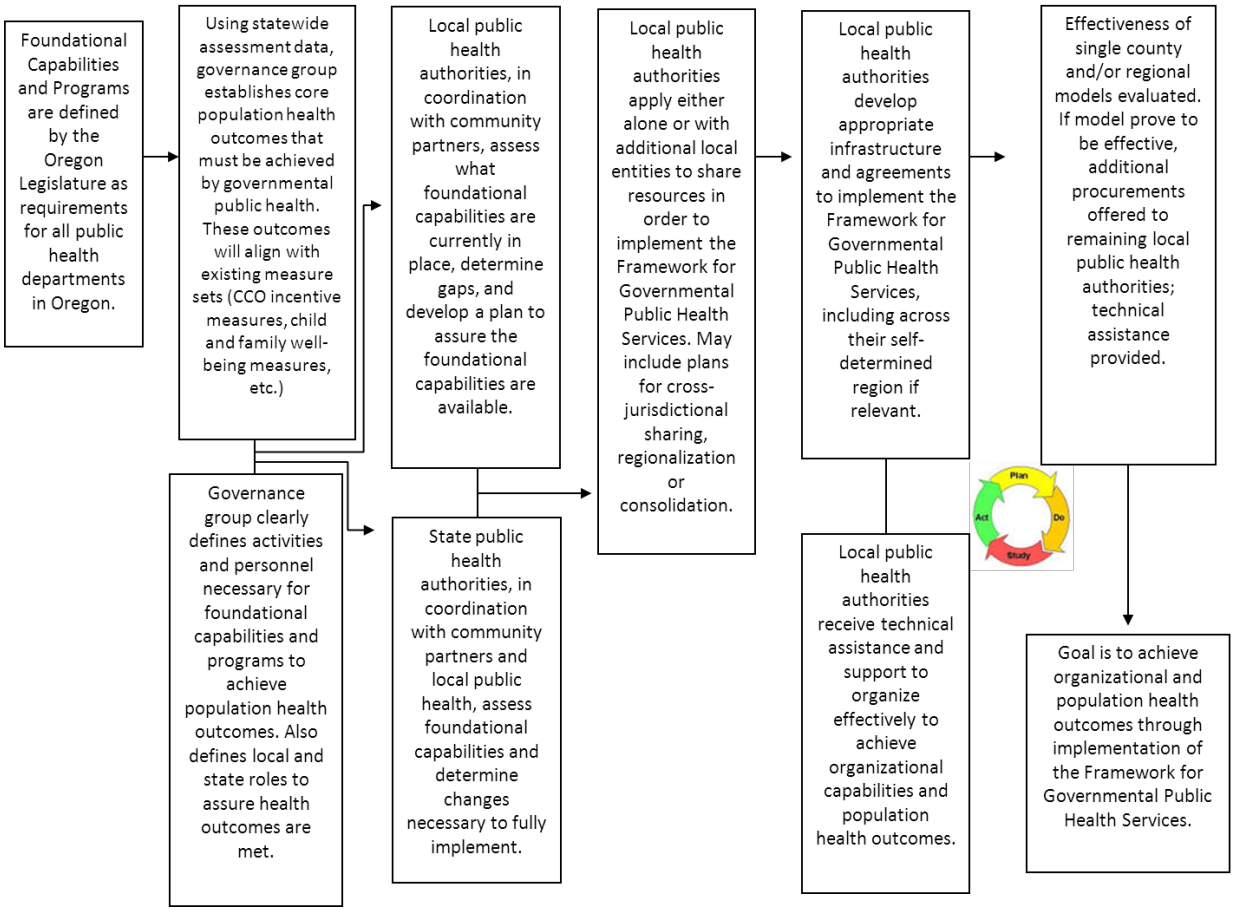
Institute of Medicine. *For the Public's Health: Investing in a Healthier Future*. Washington, DC: The National Academies Press, 2012. http://iom.edu/Reports/2012/For-the-Publics-Health-Investing-in-a-Healthier-Future.aspx

RESOLVE - Public Health Leadership Forum. *Defining and Constituting Foundational "Capabilities" and "Areas" Version 1 (V-1).* March 2014. www.resolv.org/site-healthleadershipforum/files/2014/03/Articulation-of-Foundational-Capabilities-and-Foundational-Areas-v1.pdf

Association of Ohio Health Commissioners, Inc. *Public Health Futures: Considerations for a New Framework for Local Public Health in Ohio*. June 15, 2012. www.aohc.net/aws/AOHC/asset_manager/get_file/70105?ver=435

Appendix B

Operationalizing the Framework for Governmental Public Health Services: Implementation by Wave



In this model:

1. Population health outcome measures for governmental public health to achieve through implementation of the Framework for Governmental Public Health Services are established by the governance group.
2. The governance group establishes the activities, personnel and skills needed to assure foundational elements at both the local and state level. The governance group will define the foundational capabilities and programs with enough detail and clarity to allow local and state public health to assure provision and determine if gaps exist. Information is provided to governmental public health agencies about the definitions of foundational capabilities and programs; state and local governmental public health agencies receive some direction from the governance group as to what shall be assured at the state versus local levels, and what shall be assured in partnership between state and local governmental public health. Technical assistance is provided to governmental public health to assess what foundational capabilities are currently in place, determine gaps and develop a plan to assure the foundational capabilities are available.

3. Local public health authorities apply for the first wave of implementing cross-jurisdictional sharing, regionalization or consolidation to achieve the Foundational Capabilities and Programs included in the Conceptual Framework for Governmental Public Health Services. The procurement begins with a limited number of counties, defined either by capacity or other characteristics (primarily urban, primarily rural, etc.). These entities receive ongoing training and technical assistance.
4. Processes undertaken and implemented by local public health authorities are rigorously evaluated to determine effectiveness and level of efficiency gained within the governmental public health system. Implementation processes are refined through ongoing Plan Do Study Act cycles.
5. If proven successful, additional procurements are opened to local public health authorities, who also receive ongoing technical assistance and support.
6. Local public health authorities provide the Foundational Capabilities and Programs described in the Conceptual Framework for Governmental Public Health Services and meet identified health outcomes.

Appendix C

Future of Public Health Services Task Force
IMPLEMENTATION PLAN

The focus of this implementation plan — in combination with the foundational capabilities and programs — is establishing a new approach to providing Governmental Public Health (GPH) services in Oregon within the context of health system transformation, early learning reform, and community partnership. The public health system prevents and protects individuals from disease; promotes healthy behaviors; and identifies and responds to public health threats and emergencies. This requires taking a "public health system" perspective that aligns approaches and bridges differences in state/local, public/private, health care/population health, and interdisciplinary perspectives. The proposal promotes appropriate and efficient integration and coordination of GPH, medical care systems, early childhood systems, community goals, activities and leaders to improve the public's health for people of all ages.

It is the intention of the Task Force that the following details are critical and must be worked out prior to implementation of the Conceptual Framework for Governmental Public Health Services (Foundational Framework). This implementation plan provides guidance to inform the additional work that remains to be completed before the Foundational Framework can be implemented. Given the high level at which the Task Force has been working there are details that will need to be addressed prior to a statewide implementation of the Foundational Framework. The areas that need additional details and research include, but are not limited to:

- The structure and function of the Oregon Public Health Division (OPHD) in a modernized public health system.
- The structure and function of the Conference of Local Health Officials (CLHO) in a modernized public health system and its interaction and relations with the OPHD.
- The Public Health Advisory Board 2.0's (PHAB 2.0) role as the governing authority that provides oversight for Oregon's public health system.
- An implementation timeline is developed within the first two years of adoption of the Foundational Framework, and includes incentive structures and criteria for wave participation.

GOVERNANCE

See Figures 1, 2, and 3 at the end of the document for schematic representations.

1. For GPH transformation to succeed and to maintain a public health system perspective, appropriate sharing of governance is necessary. Inclusion of three perspectives is essential: 1) Community which includes medical care community, community members and organizations, and early childhood community; 2) State governmental public health, and 3) Local governmental public health.
2. There are two underlying governance needs:
    a) To embrace a public health system perspective that is statewide in its scope, and

b) To address local governance challenges that arise from the differing implementation pathways described below. Adoption of a given pathway by a county or region will occur in the context of differing community situations with regard to operational approach, local political culture, history, community resources and other factors. As a result, it is appropriate to offer flexible governance approaches that allow for some variation while maintaining overarching commonalities across all localities to ensure a strong statewide public health system.

State-level governance needs

The main tasks of state-level governance are:

- Participation in and adoption of a statewide community health assessment (CHA).
- Approval of Community Health Improvement Plan, including prioritization of health improvement outcomes arising from the statewide CHA.
- Approval and policy-level oversight of plans to address statewide health improvement outcome priorities.
- Monitoring of progress towards meeting a) health improvement outcome targets, and b) foundational capability targets
- Approval of funding/resource distribution proposals.
- Advocacy for and actively pursue funding/resource support with the legislature, the governor, and external funders including federal funding.
- Coordination and collaboration with federal partners.
- Foster innovation and provide visionary leadership in collaboration with other statewide reform priorities such as early learning and health system transformation
- Assure appropriate demographic representation and diverse expertise, including representation from rural and frontier counties on PHAB 2.0

State-level governance structure

Central to the approach is an expansion and repurposing of the PHAB 2.0.

1. Expansion
    a) Group size as specified in ORS 431.195 (n=15) seems adequate.
    b) PHAB-2.0 membership must include appropriate demographic representation and diverse expertise, including representatives from rural and frontier counties. Additionally, PHAB 2.0 should have representation from the following groups:
        - At least one CCO representative
        - At least one non-CCO health system representative
        - Local public health (PH) administrator
        - Local PH association (CLHO)
        - Academic PH representative
        - State PH technical expert staff
        - State health officer
        - A local health officer
        - Population health metrics expert
        - Representative of front line PH worker

- OPHD Director, ex-officio
- Remaining to be determined by governor

2. Repurposing
    a) Address "State-level governance needs" identified above.

Local governance structures

Notes

1. It is assumed that local governance approaches will be customized to address, a) the challenges of the chosen local implementation pathway, and b) the unique circumstances and arrangements of the community.
2. Local governance has some tasks that parallel those of state-level governance. It also has some distinct tasks, largely related to implementation, and related monitoring and modification of implementation.

Local governance tasks

- Participation in and adoption of a local community health assessment (CHA).
- Prioritization of local health improvement outcomes (i.e., beyond common statewide outcomes).
- Policy and operational-level oversight of plans to address statewide health improvement outcome priorities.
- Approval, and both policy and operational-level oversight of plans to address local health improvement outcome priorities.
- Monitoring of progress towards locally meeting, a) health improvement outcome targets, and b) foundational capability targets.
- Acceptance and policy-level accountability for funds provided by the state, local government and other funders.
- Advocacy for and actively pursue funding/resource support with local government, and other local external funders.
- Involvement of a local entity with knowledge of public health issues in the community that can serve an advisory function.
- Actively coordinate with local CCOs (CACs) and early learning hubs

IMPLEMENTATION PATHWAYS

Assumptions:

Technical assistance will be available to help determine current gaps in foundational capabilities and to ensure localities are able to implement the Foundational Capabilities and Programs within an established timeline.

All implementation pathways mandate coordination and planning with community partners as outlined in the Foundational Capabilities. These partners include, but are not limited to: CCOs, community health NGOs, early learning hubs, Aging and Disability Resource Connections, academic institutions, community based organizations, medical care providers, etc.

Local health authorities (LHAs) and their local health departments (LHDs) will submit an application to determine their eligibility to receive funding and assistance to support implementation of the Foundational Capabilities and Programs. The goal of the implementation plans will be to achieve population health outcomes determined by PHAB 2.0. LHAs and LHDs will receive funding and technical assistance for implementation. There are three primary pathways that localities could propose to implement the Foundational Capabilities and Programs. All of these pathways are intended to allow for significant local flexibility.

1. *Single county*. A single county may implement the Foundational Framework approach in a way that the local health department (LHD) is solely responsible for assuring that foundational capabilities and foundational program services/activities are available within that jurisdiction. While community partners are still critical in this pathway, jurisdictional governance rests with a single LHA (e.g., board of county commissioners, county judge). Program services/activities that the state has been identified as having primary responsibility will remain under state responsibility.

2. *Single county with shared features*. A single county may implement the Foundational Framework approach in a way that the LHD is primarily, but not solely responsible for foundational capabilities and foundational program services/activities. However the LHD shares responsibility for certain operations (e.g., communicable disease control program, tobacco control program) or supports (e.g., epidemiology, health officer, health education) with other jurisdictions (state/OPHD or other LHDs) or other organizations. Jurisdictional governance rests with the LHA with participation of other entities in governance as specified in intergovernmental agreements (IGAs) or other contracts.

3. *Multi-county district*. Two or more counties may implement the Framework for Governmental Public Health Services through forming a legally binding partnership (e.g., IGA or similar mechanism). The operating organization ("district") created by the IGA is solely responsible for foundational capabilities and foundational program services/activities in all participating counties. The operating organization may rely on a variety of approaches to sharing responsibility for services and supports (e.g., a single district structure, a consortium with certain services and supports provided by one or more specified counties, or other structures as determined by the participating LHAs). Jurisdictional governance is shared among the LHAs of the participating counties with terms of sharing defined by the negotiated intergovernmental agreement. Under this implementation pathway, counties can also join an existing health district.

CRITERIA: Choosing participants for ongoing implementation

- Desire one or more qualified applicants for each Implementation Pathways
- Balance of sizes of jurisdictions
- Balance of rural and urban jurisdictions
- Varying levels of current availability of foundational capabilities/programs and a spectrum of current/historical comprehensiveness of GPH services:
    - Basic services only
    - Basic plus limited additional services
    - Comprehensive services
- Geographic balance
- A spectrum of current/historical local investment levels:
    - Low
    - Medium
    - High
- Existence of a local resource that will serve an advisory role for implementation and continued delivery of foundational capabilities and programs.

FUNDING AND INCENTIVES

Goals of funding approach are to:

1) Develop an accountable public health system that encourages shared responsibility by NGO partners to achieve health improvement goals.
2) Maintain current local funding and policy/political investment.
3) Increase state funding to support GPH with an emphasis on measuring and paying for performance.
4) Maintain or increase current federal funding and promote flexibility on how federal funds can be used.

Incentive-based approach to funding:

1) Establish an equitable baseline state investment in GPH.
2) Establish an equitable baseline for local investment in GPH while maintaining existing local public health investments.
3) Establish a state match for local investment above the established baseline.
4) Using PHAB 2.0 governance structure, establish consequences for inadequate operational performance, while continuing to assure the public's health through continuity of services. Options could include:
    a) Payback of state funding (base and/or incentive match funds);
    b) Decreased eligibility for state funding for a defined future period;
    c) Establish a quality pool and hold back a percent of state funding to be paid out based on achievement of defined outcome metrics; and
    d) Develop corrective action plans that include technical assistance.
5) Use a global budgeting approach to avoid fragmentation/siloing and promote a focus on achieving foundational capability and health improvement outcomes.

ASSUMPTIONS AND DEFINITONS:

This implementation plan was guided by the following assumptions:

1. Regardless of implementation pathway chosen by a county or district, it is desirable to deliver most GPH services by:
    a. Responding to community context, characteristics and needs; and
    b. Engaging local communities and their leaders participating and investing in public health.
2. All implementation pathways must incorporate "learning organization" principles and mechanisms (e.g., continuous improvement cycles and structured approaches to learning/improvement).
3. All implementation pathways must incorporate accountability by:
    a. Clearing articulating community health problems and plans to address them including specific health outcome goals; using quality improvement techniques that involve monitoring and improving process, programs and interventions; and reporting to the community and its leaders on progress and shortcomings.
    b. Defining financial and organization incentives for successes and mechanism for addressing shortfalls/failures.
    c. Embracing an epidemiologic approach to planning that features robust health data analysis and clear expressions of the causes and potential interventions to address health problems.
    d. Using SMART capability and health improvement objectives (Specific, Measurable, Achievable, Relevant, Time-bound).
4. Initial implementation wave will test and evaluate multiple implementation pathways so future waves can benefit from the lessons learned.
5. Initial wave will:
    a. Be substantial in scale (e.g., 10–30% of state's counties and/or population),
    b. Embrace the diversity of Oregon's communities - rural/urban, small/medium/large populations, etc.).
    c. Be organizationally and financially sustainable through a period long enough to allow implementation at the chosen scale, and for evaluation of process and outcomes.
6. Definitions:
    a. Local health authority (LHA): The entity with political authority and responsibility to provide GPH services in a given county.
    b. Local health department (LHD): The operating department responsible for providing GPH services under the direction of the LHA.

Figure 1: Public Health (PH) System Governance - Overview

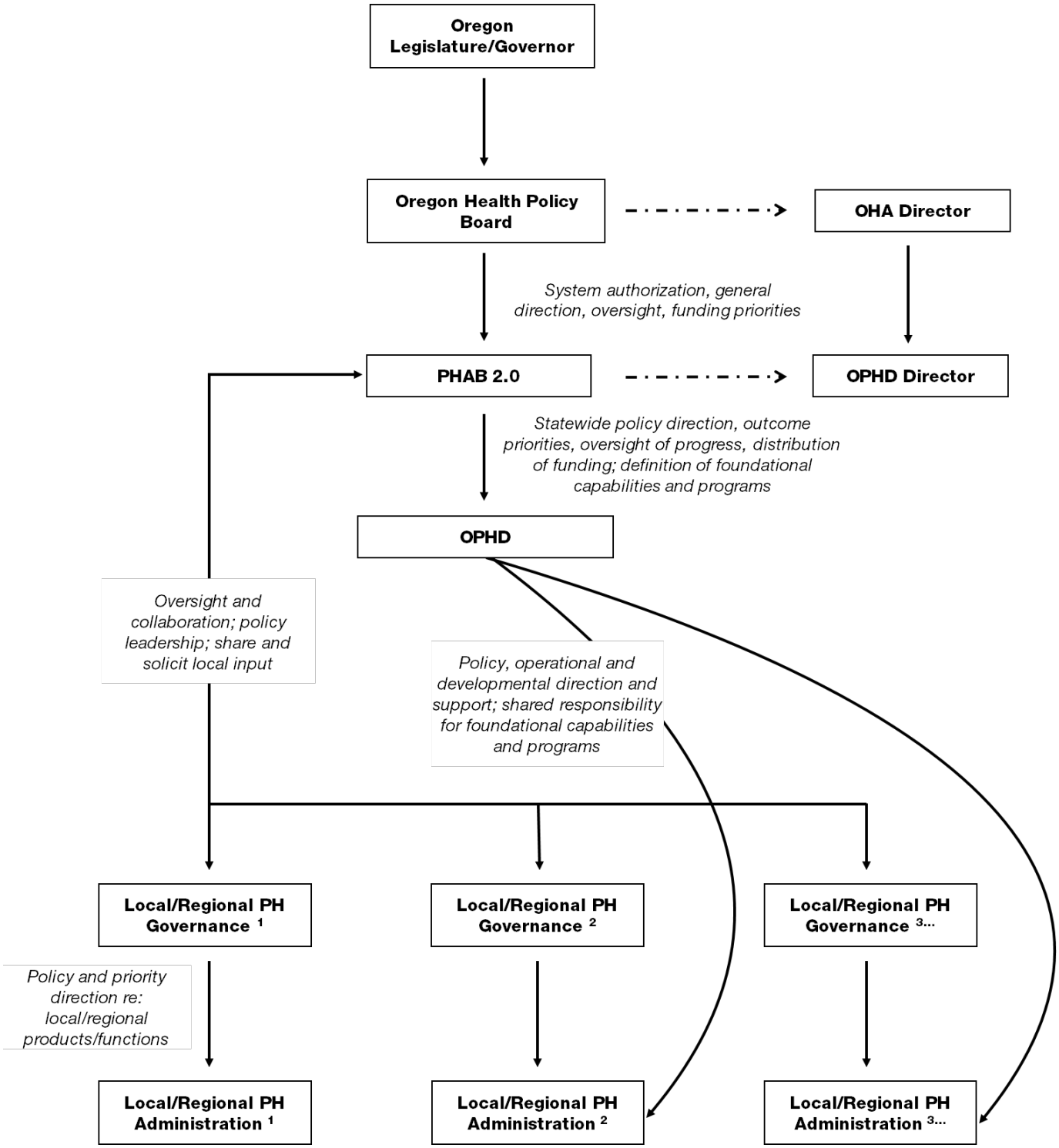


Figure 2: PH System Governance - State Components

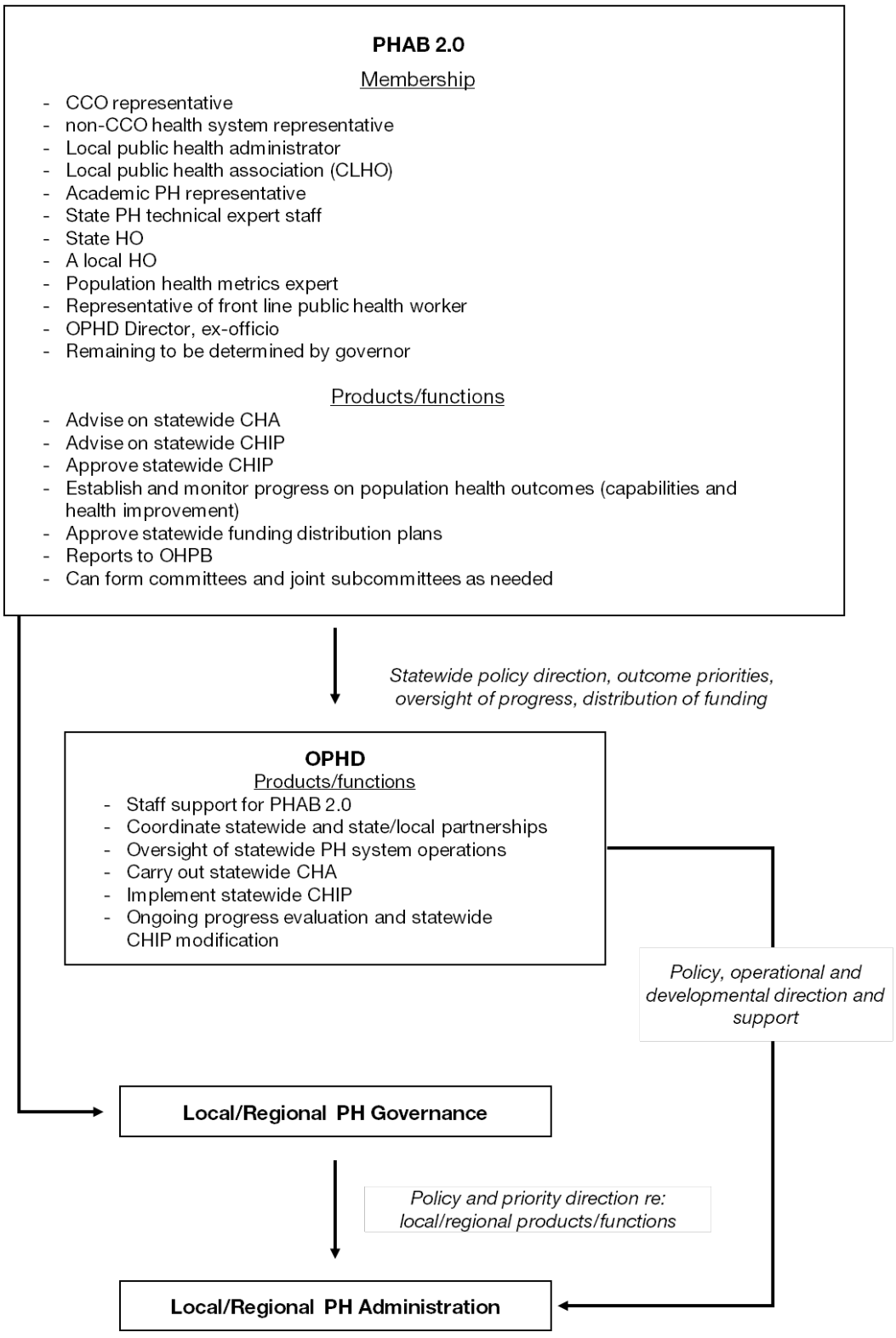
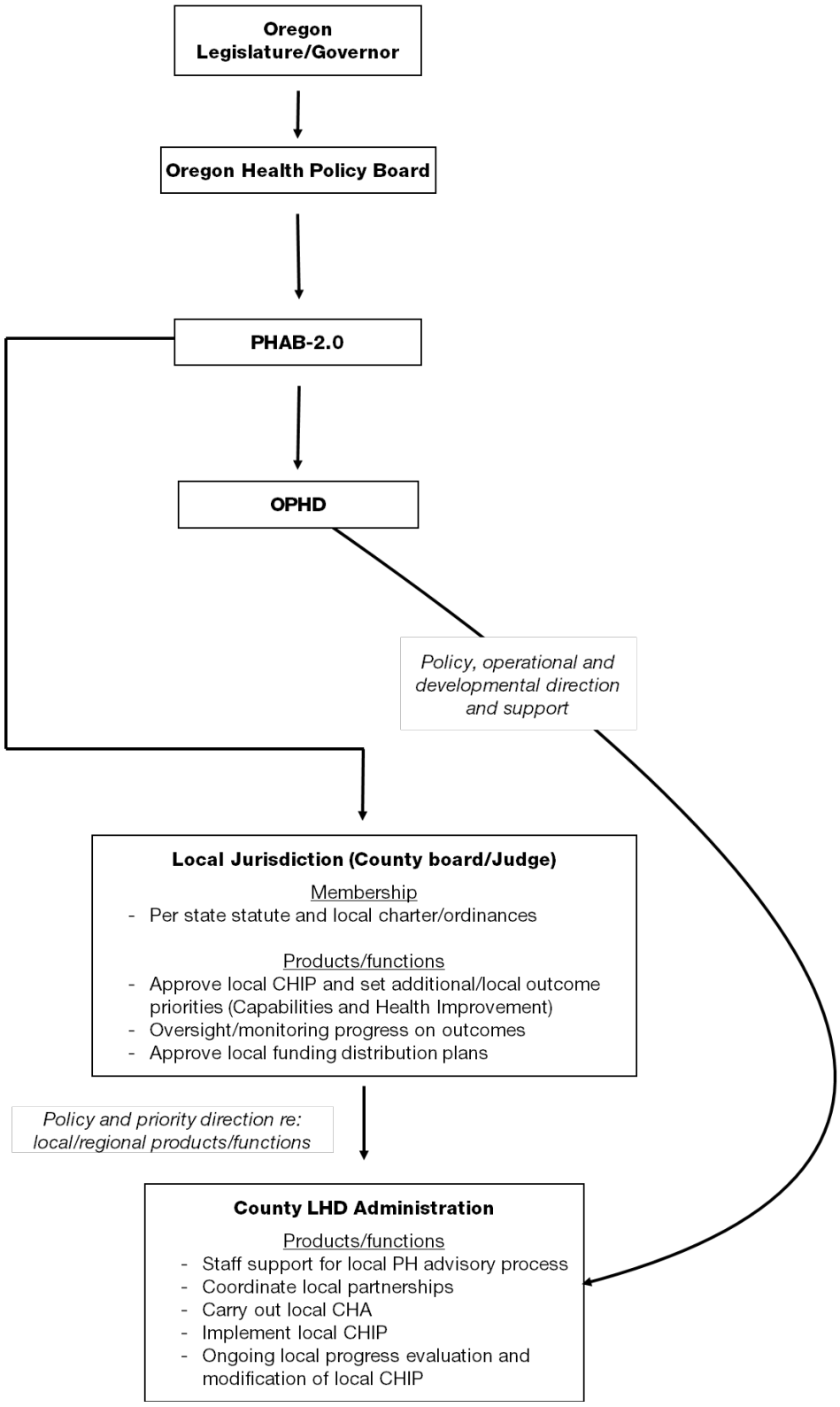


Figure 3: PH System Governance - Single County Implementation Pathway Components



Appendix D

State Investment in Public Health: Per Capita State Investment in Public Health

State Public Health Budgets			
State	FY 2011-2012	FY 11-12 Per Capita	Per Capita Ranking
Hawaii[2]	$215,793,131	$154.99	1
D.C.	$65,927,000	$104.26	2
Idaho	$143,890,100	$90.17	3
West Virginia	$160,589,232	$86.55	4
Alaska[2]	$59,261,100	$81.02	5
New York	$1,468,595,515	$75.04	6
Alabama	$358,728,139	$74.39	7
California	$2,512,158,000	$66.04	8
Wyoming	$33,852,718	$58.73	9
Massachusetts	$361,079,843	$54.33	10
Arkansas	$150,180,308	$50.92	11
North Dakota[3]	$34,013,780	$48.62	12
Rhode Island	$49,390,630	$47.03	13
New Mexico	$97,144,500	$46.58	14
Kentucky	$191,695,800	$43.76	15
Tennessee	$275,073,200	$42.61	16
Washington[3]	$289,049,500	$41.91	17
Vermont	$26,084,071	$41.67	18
Delaware[2]	$38,153,700	$41.60	19
Nebraska	$72,690,976	$39.18	20
Oklahoma[1]	$148,623,000	$38.96	21
Virginia[3]	$299,156,071	$36.55	22
Colorado	$180,719,799	$34.84	23
Maryland[2]	$175,461,490	$29.82	24
South Dakota[4]	$23,735,633	$28.48	25
MEDIAN $27.40			
Utah	$78,246,700	$27.40	26
New Jersey	$229,203,000	$25.86	27
Connecticut[2]	$88,191,904	$24.56	28
Illinois	$297,253,500	$23.09	29
Maine[2]	$29,708,338	$22.35	30
Florida[2]	$382,052,729	$19.78	31
Montana	$19,552,494	$19.45	32
South Carolina	$90,947,879	$19.25	33
Texas	$478,338,289	$18.36	34
Iowa	$53,688,501	$17.46	35
Indiana	$113,929,495	$17.43	36
Michigan[3]	$172,041,800	$17.41	37
Georgia	$168,715,698	$17.01	38
Louisiana	$70,778,560	$15.38	39
Minnesota[2, 4]	$77,456,000	$14.40	40
Ohio	$166,257,009	$14.40	40
Kansas[4]	$41,479,143	$14.37	42
Pennsylvania[2]	$181,961,000	$14.26	43
North Carolina[2]	$138,126,056	$14.16	44
New Hampshire	$17,794,601	$13.47	45
Oregon	$52,141,850	$13.37	46
Wisconsin	$75,042,700	$13.10	47
Mississippi[2]	$26,521,920	$8.89	48
Arizona	$49,756,500	$7.59	49
Missouri	$36,592,175	$6.08	50
Nevada	$9,042,262	$3.28	51

Notes:

1 May contain some social service programs, but not Medicaid or CHIP.

2 General funds only.

3 Budget data taken from appropriations legislation.

4 State did not respond to the data check TFAH coordinated with ASTHO that was sent out October 26, 2012. States were given until November 16, 2012 to confirm or correct the information. The states that did not reply by that date were assumed to be in accordance with the findings.

Levi J, Segal LM, St. Laurent R, Lang A. *Investing in America's Health: A state-by-state look at public health funding and key health facts.* Trust for America's Health, www.healthyamericans.org. 2013;1–40.

Appendix E

Presentations made before the Future of Public Health Services Task Force

Meeting Date	Presentations
January 21, 2014	**Role of Governmental Public Health in Oregon (and Society)** *Lillian Shirley Public Health Division Director* **How and Why Public Health Departments Work, Panel of Speakers from Oregon Counties** *Marilynn Sutherland, Klamath County Public Health* *Teri Thalhofer, North Central Public Health District* *Muriel DeLaVergne-Brown, Crook County Public Health* *Dana Lord, Clackamas County Public Health*
February 19, 2014	**Social Determinants of Health and Health Equity** *Tricia Tillman, Oregon Health Authority Office of Equity & Inclusion* **Health Transformation Panel Part 1: Historical Context** *Tina Edlund, Oregon Health Authority Acting Director* *Eric Parsons, Oregon Health Policy Board Chair* **Health Transformation Panel Part 2: Implementation** *Cathy Kaufmann, Oregon Health Authority Transformation Center* *Pat Luedtke, Lane County Public Health* *Jennifer Pratt, Oregon Primary Care Association*
March 19, 2014	**Governmental Public Health Financing, Part 1** *Jayne Bailey, Public Health Division Acting Deputy Director* **Governmental Public Health Financing, Part 2: Program Implementation from OHA Public Health Programs** *Cate Wilcox , Paul Cieslak, and Mike Skeels* *Section Managers Public Health Division* **Approaches to Delivering Governmental Public Health Services** *Pat Libbey, Consultant*
April 16, 2014	**County Public Health Financing** *Muriel DeLaVergne-Brown, Crook County* **Approaches to Delivering Governmental Public Health Services—Part Two** *David Fleming, Director and Health Officer King County, WA*
May 12, 2014	**Early Childhood Presentation: Building an Understanding of Oregon's Early Childhood Priorities** *Dana Hargunani, Oregon Health Authority Child Health Director* *Teri Thalhofer, North Central Public Health District*

Appendix F

The Task Force on the Future of Public Health Services Charter

Approved by the Task Force on January 27, 2014

I. Authority

The Oregon Health Authority (OHA), under the authority of HB 2348 (2013), is establishing The Task Force on the Future of Public Health Services to study the regionalization and consolidation of public health services and the future of public health services in Oregon and to endorse recommendations in a report to the Legislative Assembly no later than October 1, 2104.

The Task Force shall focus its work on governmental public health, which works to prevent disease and injury and promote and protect health. The charge of public health includes, but is not limited to, vital records, disease surveillance and evaluation; infectious disease control; outbreak response; immunizations; child and parental health, public health preparedness; regulation of healthcare facilities, restaurants and water systems; and promotion of healthy environments and behaviors. The task force recognizes that there are local, state, and national standards that guide the work of governmental public health.

The goal of the Task Force is to make recommendations which create a public health system for the future, including an exploration of the regionalization and consolidation of public health services. If the task force determines that legislation is necessary, the report shall include recommendations for legislative concepts.

This work is collaborative and carried out through federal, state, local, private and community partners. A strong partnership among Oregon's 34 county health departments and health districts to the Oregon Health Authority is critical to the effectiveness of the public health system.

This charter shall expire on the date of the convening of the 2016 regular session of the Legislative Assembly.

II. Scope

The Task Force is charged with providing recommendations for the consideration of the future of public health. As indicated in HB 2348, the Task Force shall focus on recommendations that:

- Create a public health system for the future.
- Explore the creation of regional structures to provide public health services that are consistent with the distribution of population and established patterns of delivery of health care services.
- Enhance efficiency and effectiveness in the provision of public health services.
- Allow for appropriate partnerships with regional health care services providers and community organizations.
- Consider cultural and historical appropriateness.
- Are supported by best practices.

Recommendations put forth will focus on achieving sustainable and measureable improvements in population health delivered through governmental public health across Oregon. Collaboration and possible integration with Oregon's health care transformation should be considered, and recommendations should promote the goals of Oregon's triple aim: better health, better care, and lower costs.

OHA staff will provide Task Force members materials in advance of scheduled meetings in order to ensure adequate review time and meaningful input.

A majority of the voting members of the Task Force constitutes a quorum for the transaction of business during Task Force meetings.

The Task Force will be asked to approve the final recommendations to the Legislature. This official action by the Task Force requires the approval of a majority of all the voting members of the Task Force.

III. Deliverables

The Task Force will submit recommendations to an interim committee of the Legislative Assembly related to public health before October 1, 2014 in the manner provided by ORS 192.245.

IV. Timing/Schedule

The Task Force will submit or endorse a report to an interim committee of the Legislative Assembly related to public health before October 1, 2014; it will meet at times and places specified by the call of the chairperson or of a majority of the voting members of the Task Force.

V. Chairs and Staff Resources

Chair: Tammy Baney, County Commissioner, Deschutes County
Vice-Chair: Liz Baxter, Executive Director, Oregon Public Health Institute
Executive Sponsor: Lillian Shirley, Director, Oregon Public Health Division

Staff:
OHA, Director's Office: Jeff Scroggin
OHA, Oregon Health Policy and Research: Stephanie Jarem
OHA, Public Health Division: Michael Tynan, Cara Biddlecom, Renee Hackenmiller-Paradis, Sandra Potter-Marquardt, Catherine Moyer

VI. Task Force Membership

GOVERNOR APPOINTEES		
Tammy Baney	Commissioner	Deschutes County
Charlie Fautin	Public Health Administrator	Benton County
Carrie Brogoitti	Public Health Administrator	Union County
John Sattenspiel, M.D.	Chief Medical Officer	Trillium Community Health Plan
Liz Baxter	Director	Oregon Public Health Institute
Nichole Maher	President	Northwest Health Foundation
Carlos Crespo	Director and Professor of Community Health	School of Community Health, Portland State University
AT-LARGE MEMBERS		
Gary Oxman	Former Public Health Officer	Multnomah County
Alejandro Queral	Director of Systems Planning and Performance	United Way of the Columbia-Willamette
Jennifer Mead	Coordinator of Healthy Aging	Department of Human Services
Pending Member	(In Process)	
LEGISLATORS		
Mitch Greenlick	Representative	D-Portland
Jason Conger	Representative	R-Bend
Laurie Monnes Anderson	Senator	D-Gresham
Bill Hansell	Senator	R-Pendleton

Appendix G

The Future of Public Health Services Task Force
February 2014

Summary of principles to guide Task Force recommendations:

- Promoting efficient, effective, accessible, high quality and financially sustainable governmental public health system for Oregon.
- Continuing to serve and collaborate; supporting community priorities.
- Enhancing transparency and flexibility.
- Aligning with Oregon's Health System Transformation and the triple aim better health, better health care and lower costs.
- Focusing on data driven outcomes, health equity and prevention.
- Measuring performance and using best practices.

Oregon Health Authority