

**Future of Public Health Services Task Force
4/16/14 – Meeting Summary (Draft)**

Portland State Office Building
800 NE Oregon Street
Portland, OR 97232
10:00 – 1:00 pm

Tammy Baney	Gary Oxman	Liz Baxter
Charlie Fautin	Alejandro Queral	Nichole Maher
Carrie Brogoitti	Jennifer Mead	Carlos Crespo
John Sattenspiel	Sen. Laurie Monnes Anderson	
Eva Rippeteau		

Task Force Members Not in Attendance:

Rep. Jason Conger	Sen. Bill Hansell
Rep. Mitch Greenlick	

Meeting Summary

- **Roll was taken; a quorum was present (Tammy Baney)**
 - Chair Tammy Baney called the meeting to order. Attendees were advised that there would be several times during the meeting in which to give public comment.
 - Chair Baney met with Association of Oregon Counties on Friday; there are many people who are interested and care about what comes out of this meeting.
 - Chair Baney reviewed what has taken place in the task force meetings to date:
 - o January: began to understand Governmental Public Health and what it looks like on the ground from local public health department representatives.
 - o February: were briefed on the transformation landscape in Oregon.
 - o March: Overview of public health financing.
 - o In April (today): County public health financing overview and hear about options for delivery of public health services.
 - The March 16, 2014 Meeting Summary was approved.

- **County Public Financing, Public Health Director in Crook County; Chair of the Coalition of Local Health Officials (Muriel DeLaVergne-Brown)**

Muriel DeLaVergne-Brown provided an overview of county level funding across the state.

- The local health department receives a document that is populated with what the grants are going to be, what the IGAs are across the state, and what programs are available. The county fills in the expected revenue from those programs.
- As an example, Crook County administers a wide range of services beyond the core services and works with other agencies and departments that provide services Crook County cannot. Based on the reports that come in, Crook County looks at the general fund, the State IGA, fees and donations, and revenue from other funds. The revenue generated support the required programs, overtime and supports staff.
- The counties invest a large amount of money into public health. Many times the general fund supports the mandated programs and special programs in the community.
- Counties may organize their health department a little differently but they all have mandated services to provide and have more in common than not. The use of county general funds creates the flexibility needed. Counties are being asked to do more and more with CCOs , including community health assessments and community health improvement plans.
- All jurisdictions have the opportunity to improve health. Public health is local. In 2011 there was an article that they did a study from 1993 to 2005 and they found that every 10% increase that was put into local dollars, there was significant decrease in infant death, decrease in lots of chronic disease conditions.

Questions and Comments:

1. Could we get a snapshot of the money that is “categorical” so we can have a complete picture of it?
2. There are many public entities that benefit from improved health in the community. There are many other players, including private entities, that have sufficient resources and benefits from a healthy community. They should be at the table.
3. County accounting systems are unique to that county and in some counties, items such as IT, county central services, finance, and payroll are paid for differently. It is not possible to do a per capita cost analysis of each county due to those unique properties.
4. It would be nice to see a pie chart that represents obligations that most health systems have and how that plays out in different communities.

- **Approaches to Delivering Governmental Public Health Services (Part Two) –Dave Fleming**

David Fleming, MD is Director and Health Officer for Public Health-Seattle & King County. Previously, David has served as the Deputy Director of the Centers for Disease Control and Prevention (CDC). He has published scientific articles on a wide range of public health issues and has served on a number of Institute of Medicine and federal advisory committees, and as the State Epidemiologist of Oregon.

Dave has been invited to present on Washington State's approach to delivering governmental public health services and provide his expertise on the details of the process in Washington that lead to a new model for delivering governmental public health in the state.

- Public health financing system in the country is profoundly broken in a number of ways. Most public health funding that comes to the state and local health departments is categorical.
- Health is not mentioned in the constitution, so the federal government doesn't have the responsibility for health. Nobody has the responsibility for ensuring people have health equity in the system. Everyone is spending money in little categories and is not looking at what the other funders are doing to see if there is overlap and duplication.
- One of the key recommendations from the Institute of Medicine's report (For the Public's Health: Investing in a Healthier Future) was that all levels of government should endorse the need of a minimum package of public health services that includes foundational elements.
- In Washington and across the country, the public health system has been chronically underfunded for several decades. In recent years the country has gone through a recession so there have been huge reductions in state and local budgets, and a state public health funding crisis in Washington.
- Washington passed a bill that created a motor vehicle excise tax to fund public health and for a short time that created a dedicated, sustainable financing source for public health. When the excise tax was repealed the public health funding went away which created a significant problem. The state then dedicated \$60 million dollars per biennium for local public health.
- In the past couple of legislative session in Washington a large number of legislators have gone after that money saying we don't know what this does, and this isn't where we want to spend money on and as a consequence the public health system in Washington needed to articulate what the public health needs in the state are and how this money is used.
- Through a stakeholder process, Washington has defined key aspects of the public health system in regards to what the public health system most do and how much it would take to fund that minimum system. Some key points from that process include:
 1. Embrace categorical funding
 2. Define what public health is. What needs to be started somewhere that can be used everywhere? What is the foundation for the public health system to work? What is it in Oregon that every county health department needs to be able to do?
 3. Be brutally specific. In defining costs, you can calculate how much it will take to provide this service, do a cost analysis, and perhaps another local health office could offer it.
 4. Who is delivering the service is not important as long as those services are delivered.
 5. Recognize that in all cases there are programs that are mandated and often there are fees associated with those programs.
 6. What core capabilities necessary for a functioning health system?

- a. Cross-cutting ability to have, collect and analyze information and present it to the public.
 - b. Communicate; to provide information in such a way that allows people to communicate to you.
 - c. Policy Development; a legislative liaison.
 - d. Community partnerships development.
 - e. Organizational Competency: IT, facilities, human resources
- There were some fairly consistent trends: for the smaller jurisdictions they put in lower costs and were more efficient. The larger jurisdictions would go with what they were spending rather than what they needed. The two leading causes of death in the state are tobacco associated disease and obesity. Based on that, it was decided there needed to be a base program for both available everywhere. It was important to get the biggest return for the money to create the program capability that would serve everyone. The end result was that \$48 was needed per capita to meet the minimum.
 - There is an inescapable increased cost of doing business in smaller jurisdictions and there are some affordable costs in smaller jurisdictions. If you want to keep locally a service that arguably could be done more efficient regionally, you are welcome do to that but the core financing that is available to you that will be part of your local determination to put in the extra dollars.
 - We are trying to switch the discussion out to let's figure out how we can assure things are happening without having to beg borrow or steal from categorical funding.
 - This has Washington create a vision of where we want to be going. It helped to use common language to understand what we needed to get there. In reality what we want in health departments of different sizes is assurances that are there for everyone and recognize that additional important services that are locally relevant.

Questions and Comments:

1. Did you do any calculations on return of investment? No.
2. In Public Health we are we are good at measuring outcomes; we are not so good in measuring incomes. We should be measuring the comparable rate of how we spending the money, not a per capita basis because there are so many variables.
3. How have you been able to use the various resources more effectively. Answer: We are a victim of our categorical funding. We have jointly decided to fund a single community health assessment for health departments for accreditation.
4. We might be able to measure the core capacity of organizations in the state.

5. Can you discuss categorical funding more? It seems to me that before we embrace categorical funding we need to determine where we are now.
6. We have to identify the overlap; there are specific requirements.
7. There are two ways to do categorical funding. One is that they say jump and we say how high. The other is they say jump and then adapt to categorical funding.

Facilitated lunchtime discussion – Diana Bianco

A facilitated discussion was had amongst the task force members, focused on the following prompts:

- What are the emerging issues that we should consider and address as we discuss Oregon's future public health system? (i.e. funding not always aligned with needs, etc). What are the problems we are trying to fix?
- What are the foundational services that governmental public health should provide in Oregon?
- What are the foundational capabilities?

Summary of Issues Identified:

1. Categorical Funding
2. Shared Understanding of what we are trying to achieve
3. Shared Understanding of the Process to get to that shared understanding
4. CCO Integration and Overlap [see handout/diagram]
5. Identifying SHARED Outcomes
6. Inclusion of Health Disparities, inequalities and cultural competence
7. Don't forget about Legislative Mandate to Examine Regionalization and Consolidation
8. Include mechanism for Public Dialog, Feedback, and Buy-in
9. Capitalize on Existing (Effective) Partnerships

The task force did not feel that they were yet able to answer the 2nd and 3rd questions and further, Senator Monnes Anderson reminded the task force of the legislative language requiring the task force to consider the regionalization and consolidation of public health services in their work. Staff will come to the May meeting with a straw proposal for foundational elements of a public health system and include definitions of the different parts.

Public Comment:

- Bonnie Bailey, Benton County Public Health Planning Advisory Committee, reading from a statement that Judy Sundquist wrote, expressing the interest of the Benton county Public Health Planning & Advisory Committee in the work of the task force and awaiting the

recommendations. The committee will review the recommendations when they are available and provide feedback.

- Patricia Neal, Public Health Advisory Committee, Lincoln County – CCOs are insurance companies and do not provide services directly. Public Health is a provider of services; cannot see how you can regionalize due to total differences in services.
- Bill Blank – I have heard talk about the future, innovation, and at my age, I am 70. Are you inviting the future of Oregon's health care – the future generations of health care – doctors, nurses, etc. that will be involved in this/ are you inviting them to these meetings? Chair Baney – I take that as we need to be sure we are.

The next meeting will be held May 12, 2014 at St. Charles Medical Center in Bend from 8:30am – 4:00pm