Future of Public Health Services Task Force
Public Comment on draft implementation proposal

Attached are the seven public comment documents received on the draft implementation proposal through September 5, 2014.

Comments were received from the following groups or individuals:

1. Morgan Cowling, Coalition of Local Health Officials (CLHO)
2. Marni Kuyl, Washington County Health and Human Services Director
3. Kathleen O'Leary, Washington County Health & Human Services
4. Pamela Hutchinson, Marion County Public Health Division Director
5. Katrina Rothenberger, Polk County Public Health Administrator
6. Paul Morgan, Chair Umpqua Health Alliance Community Advisory Council
7. Oregon Office of Rural Health

Coalition of Local Health Officials

To: Task Force on the Future of Public Health
Fr: Morgan Cowling, CLHO
RE: Coalition of Local Health Officials public comment on Implementation Proposal

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Thank you for the opportunity to provide feedback on the Implementation Proposal.

On August 27th the Coalition of Local Health Officials held another webinar with over 20 local health officials from around the state participating. The Coalition sent out the Implementation Proposal for feedback and we have received comments from numerous health departments after the webinar.

Here is a summary of the important comments we have received.

General Comments:

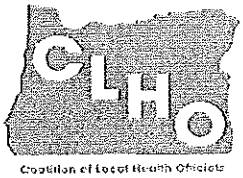
The Coalition of Local Health Officials endorsed the Conceptual Framework at our August monthly meeting. There is interest and excitement across Oregon's local health departments in getting policy-makers engaged in transforming and funding the public health work in Oregon that will support Health System Transformation, Early Learning reform and ultimately improve the public's health.

Technical Assistance – There was quite a bit of discussion about the technical assistance. For this venture with additional cross-jurisdictional sharing local public health may need additional non-public health technical assistance (mediation, legal, facilitation). Also, there are very knowledgeable public health experts within local public health – figuring out a way to leverage that knowledge to build the system should be factored in to the plan.

Local Focus and Flexibility – Local health officials appreciate the local decision-making and flexibility that the Implementation Proposal provides. This would allow local communities to determine which pathway would be right for their community.

Timeline – There needs to be clarity about the implementation timeline. The Implementation Proposal only provides criteria and discussion of the first wave. There was real concern from local health officials that a long timeline for implementation would continue creating "have" and "have not" communities across Oregon. Logistically it may be very challenging for two different local public health systems to be running simultaneously.

Coalition of Local Health Officials



Funding – There should be a clearly stated recognition that implementing the Conceptual Framework will take additional resources. Neither the Oregon Public Health Division nor local health departments have the necessary resources (even assuming additional cross-jurisdictional sharing) to implement the Conceptual Framework. We think there is an understanding of this concept by the Task Force members (and thank you) but want to make sure that is clear in the final report.

Final report – Right now there are three important documents for the final report – the Conceptual Framework, the Implementation Proposal and the Operationalizing the Framework. We would recommend that public comment be re-opened when the final report is released to make sure there is ample opportunity to comment on the document when all of the pieces are put together.

Governance/ Structure:

Overall, there needs to be additional clarity in the new structure. There are lots of mono-directional arrows but the reality is that much of the public health work is work that we do together and decisions should be made together.

State-Level Governance Needs – Outlines the main tasks of the state-level governance and has language about "approval" and "oversight" and "advocacy." The question "What is the Authority of PHAB 2.0?" needs to be answered before the duties can be outlined.

CLHO 2.0 – This current document does include a place where the governmental public health system comes together as peers to problem solve public health challenges, or address emerging public health threats. CLHO 2.0 or "State and Local Partnership" area is an important feature within the structure. As the local public health system is changing so should the CLHO 2.0. Duties and responsibilities could include:

- State and local agree which of the responsibilities within the framework are state and which are local – A place to answer the question how do we, state and local public health, function effectively and efficiently together with new duties and responsibilities?
- Determining minimum level to which you must deliver or assure capabilities and programs within the Conceptual Framework.

PHAB 2.0 – It is unclear what the responsibilities and authority of this group are. Does it have decision-making authority or does it make recommendations to the Oregon Health Policy Board? Or does it make recommendations or advise the Public Health Division Director?

Coalition of Local Health Officials

Clarity of roles, purpose, and advisory vs. decision-making authority would also help clarify who should sit on the PHAB 2.0. Here were suggestions for members to consider and questions raised by local health officials:

- Need more representation from other public health system partners including non-CCO medical providers like hospitals, or providers, etc.
- If the goal is to better link with Early Learning work there should be an Early Learning Council member or provider on the PHAB 2.0
- Statewide representation - There was LOTS of feedback about ensuring that the representation on PHAB 2.0 was statewide.
- Local public health technical experts in addition to Oregon Public Health Division (OPHD) technical experts (although if this is advisory to the OPHD should OPHD members be ex-officio?)

Implementation Pathways:

Only locally focused – The Conceptual Framework implementation should be a state and local – governmental public health venture. However, the focus of the Implementation Proposal is solely focused on pathways, criteria, and funding of the local public health system. There is no mention of how the Oregon Public Health Division will also be transforming to implement the conceptual framework.

Additional pathway suggestions -
A single county could join an additional district in a 2nd or 3rd wave.

Criteria:

Only the first wave – The criteria, and the whole document, only speak to the first wave. It is unclear how we get from wave one to the whole state adopting the Conceptual Framework. There needs to be a plan and timeline for reform not just of one wave but of the whole system.

Timeline suggestion- 2015-2017 – First two years set up the new governance structure, set health outcomes, performance measures and metrics. CLHO 2.0 and OPHD work to operationalize the Conceptual Framework and make recommendations to PHAB 2.0 on state and local work and minimum implementation requirements.

Seed funding from the state legislature could help fund local assessments and start working on cross-jurisdictional sharing opportunities.

2017-2019 – Two years – implement the Conceptual Framework by wave from wave 1 through 4 over two years to ensure the whole state has implemented the framework.

Funding:

Incentive-based funding approach – There was an appreciation of the incentive-based funding approach to help both incentivize local investment and state investment into local health departments.

Metrics for performance and incentives- Our members emphasized the importance of developing outcomes and metrics for which health departments will be evaluated by. It was strongly suggested that the Implementation Proposal acknowledges and begins to outline how metrics and outcomes will be developed, as this a large body of work.

Penalties for non-performance – While we appreciate the need for accountability and movement toward outcomes establishing financial consequences for not meeting metrics or benchmarks, this would only mean the community's health is the loser. There should be an approach that includes accountability while ensuring that essential public health protections and services for the community are not impacted.

We appreciate the work and service of the Members of the Task Force.

From: Marni Kuyl <Marni_Kuyl@co.washington.or.us>

Sent: Wednesday, September 03, 2014 11:20 AM

To: Future Taskforce

Subject: Comments

Overall I am very pleased with the conceptual direction and the flexibility provided for local solutions to health issues identified through CHNA. The concepts are aligned with health transformation, accreditation and population based services, while at he same time allows locals to prioritize services and go beyond the foundational capabilities through local investment and partnership.

Many thanks for the opportunity to comment and thanks to the Task Force for their commitment and work.

Strengths of the plan:

* PH systems approach

* Local flexibility

* Local decision making

* Multiple pathways for local health departments to choose from

* State General Fund (SGF) investment in PH

* Coordination across governmental PH, medical care systems, early childhood systems and community goals to improve the public's health

Issues or concerns:

* The implementation plan does not include any introduction to foundational PH services, nor an overview of the end goal. It implies that LHJs will need to demonstrate they meet foundational capabilities either as single local GPH departments, through shared service agreements or by forming districts, but never clearly states if that is the expectation.

* There needs to be a statement about the linkage to accreditation. Does accreditation imply you meet foundational capability? Will measures we re-create a State system of accreditation?

* The writing needs editing, there are typos and there is a lot of bureaucratic language that

is vague and confusing.

* Foundational services as a framework does not necessarily lead LHJs towards more population-based or evidence-based services. the framework is vague enough (basically anything can fit) that LHJs can choose to continue to do exactly what they currently do now- a risk could be there will be no "public Health transformation"

* While there is language about a PH systems approach, PH reform in this document is only centered on local PH. Where is the state PH reform?

* The timeline is unclear. Understanding that this is phased or waved roll-out, doing that in

2-3 years is preferable in order to maintain momentum and equitable funding across all of the LPHA's. Later adopters should be penalized financially

* Governance remains very unclear. CLHO's role needs to be strengthened in the implementation.

* The arrows are mono-directional and should be bi-directional. Expect local PH to "lead up" as that leadership is crucial / valuable to successful PH system reform. A systems approach needs bi-directional leadership, problem-solving, and mutual respect.

* Technical assistance is implied coming from state PH only. Local technical assistance experts are key to successful implementation. Please do not miss the wisdom and experience of our local PH leaders who are connected to their communities.

What is missing:

* Technical assistance other than PH content. For example, mediation, legal TA, contracting. . .

* Investments in PH beyond additional SGF. This is linked to reform at the state PH level.

Existing federal and other funding should be evaluated for more equitable distribution between state and local PH.

Marni Kuyl, MS, RN

Washington County Health and Human Services Director

Robert Wood Johnson Executive Nurse Fellow

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cell (360) 903-7363

From: Kathleen O'Leary <Kathleen_O'leary@co.washington.or.us>

Sent: Wednesday, September 03, 2014 11:01 AM

To: Future Taskforce

Subject: comment on the draft implementation plan

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respectfully,

kate

Kathleen O'Leary, RN, MPH

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TO: Oregon Future of Public Health Taskforce

FROM: Pamela Hutchinson, MPH, RN
Public Health Division Directo

DATE: 9/4/2014

RE: Implementation Straw Draft 8/25/2014

Page 2:
State-Level Governance Needs:

1. **Clarify the title** State-Level Governance Needs. Add "state-wide"
2. **Add word**: Approval of "statewide" community Health Improvement Plan
3. **Add bullet**: "Provide adequate funding to ensure LPHA can meet the foundational capabilities.
4. **Add bullet**: "Ensure adequate funding is passed to local health authority to support progress towards outcome targets"

Page 3:
Local Governance Structures:

1. **Add word:** Notes 3. Iii. – Assure equity of resource availability statewide, **"ensuring consideration of adequate funding to population centers as well as statewide distribution"**

Local Governance Tasks:

1. **Modify words:** Prioritization of local health improvement outcomes (~~ie.~~ Eg. Beyond common statewide outcomes **"as appropriate based on local data and locally chosen health priorities"**).

2. **Comment:** re statement -Advocacy for an actively pursue funding/resource support with local government, and other local external funders. **Intent of statement is not clear. Also, most communities do not have local funders that will fund public health/government. There is an expectation that state/Federal and local funding covers costs and that we should not compete with non-profits.**

3. **Comment:** re statement- Actively coordinate with local CCOs and Early Learning Hub. **Do these entities have the same requirements to coordinate with public health? What does coordinate mean? How do we know that the intent is met?**

Page 4:
Implementation Pathways
Assumptions

1. Comment re statement LAHs and LHDs will receive funding and technical assistance for implementation. **This does not recognize that usually the best technical knowledge of implementation lies at the local level, vs at the state level. State role seems to be to help set a target, local level role seems to be to figure out how to get there. State assistance in bringing in national level speakers experienced in local-level implementation would be helpful**

POLK COUNTY

POLK COUNTY

PUBLIC HEALTH

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TO: Task Force on the Future of Public Health
FROM: Katrina Rothenberger, MPH, Health Administrator for Polk County Public Health
RE: Public Comment on FPHTF Implementation Plan

Thank you for the opportunity to provide feedback on the Implementation Plan.

Polk County Public Health supports the comments submitted on behalf of the Coalition of Local Health Officials and would like to address the following issues:

1. The emphasis on local focus and flexibility is extremely important to Polk County Public Health. We would like to emphasize that the decision regarding specific implementation pathways and their governance structure should be made at the local level and not dictated by the State.
2. While the idea and intent behind incorporating CCOs and ELHs into the public health framework and governance structure is important, additional incentives or regulations should be added to the CCOs and ELHs to work with Local Public Health Authorities. The positive externalities of public health are not always recognized or valued by individual CCOs. Education should be provided to CCOs and ELHs to better understand the role that public health plays in the overall health of the community.

From: Paul Morgan <pmorgan@douglasfast.net>

Sent: Friday, September 05, 2014 2:58 PM

To: Future Taskforce

Subject:Comments on the Draft Implementation Plan 8-29-2014

I appreciate this opportunity to comment on the draft Implementation Plan dated August 29,2014.

* The timeline to review and comment is woefully inadequate based upon the scope and importance of this proposal. Five days is rushing without adequate inspection and reflection. Allow at least one more week for comments.

* Two of the 3 implementation pathways, i.e. Number 2 and 3, in my opinion, will not promote PH but rather will allow it to be dispersed and fractured. This will result in poor service and not achieve the desired outcomes as planned in local CHIPs.

* Pathway #2 is most dangerous if the county wants to divest itself of its PH role like Douglas County. Local governments should not be allowed to divest its obligations to its citizens to promote public health.

* Pathway # 3 is potentially poses a bureaucratic issue that could produce gaps in service and inability of local citizens to obtain proper local care. Having two or more counties doing collective PH will not improve the process.

Thank you for this opportunity.

Paul Morgan

Chair , Umpqua Health Alliance Community Advisory Council

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September 5, 2014

To: Task Force on the Future of Public Health Services

Re: Draft Implementation Proposal

Pease consider these comments from the Oregon Office of Rural Health:

1. The governing board should include representation from different fields, as the majority of what affects health status does not occur within a public health department. Effective public health is community-driven and employs sustainable business practices- the board should include people from fields outside public health (business, technology, food supply, agriculture, other major employers, etc). Oregon should involve people outside of public health in this process in order to generate more political momentum and funding for public health.

2. Extend public comment period to allow for broader perspective. From a review of meeting minutes, seems there was a very limited number of individuals from PH professionals, CLHO, ACO, and very limited input from rural/frontier providers.

3. Due to economies of scale, "equitable funding" should be more clearly defined. Moreover, with smaller sample sizes, the proposed incentive-based funding structure puts rural communities at disproportionate risk. Measures appropriate to urban communities may not work in rural communities. In order to see substantive improvements in population health, public health needs to work with other sectors to engage in systems change projects. The impact of these projects is difficult to measure in the short term to tie to payment.

4. Much talk about alignment with Health reform goals and collaboration across agencies, from State Public Health, local public Health, CCO's, clinical providers in this plan. Our concern from the RHC perspective is what will be the responsibilities, and potential burden, at the clinic/provider level in this new model? (Not really discussed)

5. Who will provide technical assistance for rural communities to help with creating accountability? Rural communities have unique needs may need assistance in developing benchmarks that are rural appropriate. Few rural communities have internal resources for evaluation and data analysis equivalent to those in urban areas.

6. Specifically, data and measurement comes up often with goal of accountability and improved outcomes/QI. This will require ability to measure. Many of these measures will be dependent on clinics to collect data. Many clinics don't have EMR or expertize to report. Where will the resources come from to enable these clinics to collect and report data?

    a. Gets very confusing for clinics to track and report all the potential CQMs – Meaningful use, HRSA/UDS, CCOs, etc. All agencies requesting CQM/QI data need to communicate and come to agreement on common set of measures/definitions.