

**Future of Public Health Services Task Force  
3/19/14 – Meeting Summary (Draft)**

Portland State Office Building  
800 NE Oregon Street  
Portland, OR 97232  
9:00 – 1:00 pm

Task Force Members in Attendance:

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

Task Force Members Not in Attendance:

Rep. Jason Conger	Sen. Bill Hansell	
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OHA Executive Sponsor: Lillian Shirley

*Meeting Summary:*

- **Roll was taken; a quorum was present (Liz Baxter).**
  - Vice Chair Baxter called the meeting to order and welcomed Eva Rippeteau to the Task Force.
  - The Agenda was presented and there were no changes; Task Force members were advised to review the Guiding Principles which reflect the changes discussed in the February meeting; the February Meeting Summary was approved.
  
- **Governmental Public Health Financing, Part 1 (Jayne Bailey)**
  - Jayne Bailey, Acting Deputy Director of Oregon Public Health Division, gave a high-level overview of the Public Health Division budget and a breakdown of the approved budget for 2013-15.
  - Total Budget: \$523,079,350
    - Federal Funds \$354.7M: 67.8%
    - Private Grants or Awards \$65M: 12.5%
    - Fees \$47M: 9.0%
    - General Fund \$40M: 7.7%
    - Tobacco Tax \$16M: 3.0%
  - Comments from Task Force Members:
    1. What is our level of understanding of the need, and how does that need then relate back to how we structure our budget? All state and local public health departments are involved with community health assessments; perhaps some can talk about how they did it?

2. Virtually every county uses almost all of their general funds for communicable diseases because it is not a specific category in the funding award but it is a mandated service. But how do we see what those funds are and how much overall funding is there?
3. I would love to understand the reality for local health departments. How are the dollars that are gathered from categorical grants to provide basically profit change to do community health assessments?
4. What are the resources available for local health departments and how does that form the creation of a statewide budget?

- **Governmental Public Health Financing, Part 2**

**Three section managers from the Public Health Division were invited to provide presentations on the funding, scope, activities, and priorities of their programs to give the Task Force a better understanding of how different public health activities in the Public Health system are funded, and how the activities/priorities are identified.**

**Maternal and Child Health Section – Cate Wilcox**

- The scheduled programs and grants come with federally mandated goals, outcomes, and programs defined by the federal agencies or the priorities. The heavy overlay of the federal agenda usually aligns with our state agenda but it doesn't always.
- The vast majority of funding we receive is from the Health Resources and Services Administration (HRSA), CDC, SAMSHA (Substance Abuse and Mental Health Administration), General Funds, NGOs and Department of Justice.
- MCH Funds are distributed this way: 35% to fulfill grant requirements; 52% to local public health; and about 9% to other partners.
- The grants include requirements of how we must use the dollars. We pass a lot of the dollars down to our local partners but we are required to provide infrastructure, oversight, management and support. We are required to report back with our evaluation and data per the grant requirements and any change to those requirements require federal approval. Some are flexible, some are not.
- We have had a challenge to show results and outcomes in a very short period of time; In MCH, results typically are not realized in 3-5 years, it may take several decades to realize results of interventions.
- Follow-up questions:
  1. How do you identify gaps in funding, what kinds of assessments do you do and how do you fund that? Answer: Review grant parameters at the national level and direct our priorities toward the state level gaps.
  2. How much of the MCH funding goes for individually delivered healthcare services? Answer: Very little.
  3. Is it possible to project out what the return on investment is on certain things? What is the law with regard to not doing certain things? Answer: We can look at evidenced-based programs to see the return on investment. Sometimes quantifying the results takes time.

4. Since our group is looking at the future of public health, do you have any advice for us that you would like to see something done differently in the future? Answer: Sometimes we get focused on evidenced-based work at the expense of innovation. We need to take into account not only our physical well being but social and emotional as well. Also taking into account adverse childhood experiences.

**Acute & Communicable Disease Prevention Section – Paul Cieslak**

- 91% of our funding is from federal funds; 9% of it is state funding. The state funding pays for a manager, an epidemiologist and a secretary who can do data entry. We have 2 major grants: the Emerging Infections Program grant with \$2.2 million dollars, and the Epidemiology & Lab Capacity grant, also at \$2.2 million. There are also funds available from other Federal sources.
- We rely on public health nurses and sanitarians at the county level to be primary investigators of communicable diseases. We sense that they are stretched thin.
- We do not have general funds available to do outbreak investigations; such work is performed by epidemiologists and research analysts who are funded by CDC to perform other tasks.
- Program priorities are aligned with Federal grant requirements and needs. For example, Hepatitis C is a huge cause of morbidity and mortality with 60,000 people in Oregon estimated to have the disease, but we have no funding to focus on this infectious disease. As a comparison, we have Federal funds for meningococcal disease epidemiology, yet there were only 13 cases in Oregon last year.
- Cost allocation is challenging; a small amount from each federal grant can be used to support infrastructure; but we cannot charge all necessary costs to the Federal grants, so the remainder ends up coming out of limited general funds.
- Follow-up questions:
  1. Do you have enough staff prepared with additional training to assist with the public health informatics work force? Answer: We use epidemiologists to manage our data systems; they have had to learn computer language and relational database constructions. We care about the data, so we make it happen one way or another.
  2. Can you comment on how on targeted the federal agenda is for Oregon and what is missing? Answer: We are adjusting things that are priorities from CDC. Healthcare-acquired infections cause a lot of morbidity. In the last couple of years the CDC has taken renewed interest in them, and our work in this area has been very successful. I would call out Hepatitis C, infection with antimicrobial-resistant bacteria and other healthcare-acquired infections as being underfunded proportionately to the public health need in the state.
  3. Please give us your candid thoughts. What we should be thinking about in terms of the future of public health? Answer: Whatever structure we choose, we must ensure that data on communicable diseases from across the state flow rapidly and unobstructed into some place where they can be analyzed together. I would be very concerned about our ability to detect and control communicable disease outbreaks if we develop a system that results in pockets of information at different places around the state that don't get aggregated and viewed in a timely fashion. Also, I think public health is fundamentally different from patient

care in that its job is to look more at populations than at individual patients. Public health needs to keep that perspective and not get itself so close to the trees that it can't see the forest.

### **Oregon Public Health Laboratory – Mike Skeels**

- The mission of the lab is to provide and assure quality laboratory testing around the state; each year 450,000 samples are tested and the lab turns out results on 9 million tests.
- The Lab provides services at no charge or at low costs for local health departments, clinics and their clients.
- The Lab is also part of the broader part of the lab surveillance program to help detect diseases. We support the identification investigation and control of outbreaks at the state and local level.
- We also have a role in making sure that some kinds of laboratory testing is available in the state where no other laboratory can provide them.
- A major area of work for us is newborn screening. We test heel stick blood samples from almost every newborn in Oregon, Idaho, Nevada, Alaska, New Mexico, Hawaii and those born on the Navajo Nation for metabolic and other disorders/diseases.
- Another major category of our work is lab compliance. There are about 2400 clinical labs that we regulate in parallel with state and federal laws.
- We also provide training for clinical labs & local health departments and licensing or accrediting for clinical & environmental laboratories throughout Oregon.
- Our total \$31,071,358 lab budget breaks down as follows:
  - 9.6% from State General Funds
  - 26.8% from Federal Funds
  - 63.6% fees (Newborn Screening, testing and licensing fees)
- Compared to other state labs, we have a heavy dependency on federal funding and if that money was to be cut we would have a problem delivering core services.
  
- Follow-up questions:
  1. How is technology going to affect us in the next decade? Answer: There is a shift away from using conventional bacterial culture testing or analyzing for metabolic intermediates to using molecular techniques that analyze DNA. There is no general funding for this but we have the ability to use federal funds to make the technological changes. Also, with the advent of electronic medical records, we can interface the lab information system with client's electronic medical records so we won't have people entering data off of paper forms.
  2. How has your workforce changed? Answer: We are recruiting people who have credentials in biochemistry, microbiology and genetics and in laboratory practice and molecular training. We are actually competing with the private sector to hire people at about 15 to 20 percent lower than they can get in the private sector which diminishes our recruitment pool.
  3. Any other issues? Nevada is going to leave our newborn screening program in July 2014 and start their own program. Nevada represents about ¼ of our revenue.

- **Facilitated Discussion – Diana Bianco**

- A facilitated discussion was had amongst the task force members, focused on the following prompts:
  - Some of the themes we've heard to date include the overlapping connection with CCOs and public health, the role of local public health, and what is public health focusing on and why? Today highlighted Oregon's leadership despite some of the barriers. However, there is a danger in saying "we did it in spite of having little to no state and local funding." Think of what we could do with a sustainable well-supported system!
  - What resonated with you about what you heard this morning? What do you hear that concerns you?
- Reaction from Task Force members:
  1. The dependence on federal funding and how those funds are distributed- what may or may not be what Oregon needs is concerning. The information provided today discussed funding and the money going to Public Health – is money that should come here going somewhere else?
  2. Something that needs to be part of the discussion is the very large amount of money in WIC that goes to individual health services instead of population health services.
  3. It is worrisome that we don't have enough resources to do what needs to be done at the state and at the local level. And at the same time we have this very fragile net of how we put resources together to do what we do. It almost feels like you could pull one block out of it and the whole thing would collapse.
  4. We still need to learn more about and understand core infrastructure. It makes you wonder about efficiency and best practices. From the community perspective and the philanthropy perspective, it is very concerning when local public health departments delivering some things, and then the state dropping in and doing things. This is a real challenge that we need to put some real thought into.
  5. There was an emphasis on the work that is being done by public health in terms of surveillance, prevention, and activity directed at an entire population of the state or the county, and they are focused on the population and in ensuring the health of that particular population. There is a break between that sort of work and the work that is done that is really focused and delivered in the population. The two are not really the same yet there seems to be some fertile ground for collaboration as we move forward.
  6. It is striking how little state funding is allocated for surveillance when this is a critical need. If we don't measure we won't know and if we don't know we don't have to do anything about it. Sometimes we don't want to measure it because it will cost it more money.
  7. It is interesting that there is a lack of infrastructure and at the same time there are activities happening in different segments and some of them communicate with each other and some do not. The information is not going in both directions, but it should.
  8. The readiness of the workforce and how we prepare public health professionals to do their work is a concern. We need to step back to see if we are teaching the right things.

9. CCOs have a huge new set of requirements for quality reporting outcome reporting and so on. Many CCOs are having to build substantial infrastructure for managing that information flow. Identifying what in that information stream might be best value to the public health and figuring out how we can do that because we have to put the work into collecting the data anyway. If we have the ability to collect information that is needed for public health and if we can find ways to facilitate the work of public health and public health can work with the CCOs to help identify information because it may be easy to share.
10. There is a lack of alignment around the planning, resources and the grants. Part of it is constraints from federal funding.
11. There is a gap of what is fundable without prioritizing what we should be funded. It is impressive that programs that have lasted for many years and there is a need to be mindful that knowledge and expertise so we don't jeopardize what has been built up over many years.
12. How do we identify what is important to us and create a system that provides the right resources to get what is important? We need to think of a system that can work in all our communities: rural and urban. If we become focused on how things work across the entire state, we might not get it right for all communities.
13. For communicable disease, the local entities in the state rely on communicable disease funding and follow-up from the state. There is a need to better understand how this works.
14. Funding is a concern as well as workforce readiness and the staffing. Often there is an inordinate amount of time and staff and overhead in order to be able to write the grant, provide the reporting, and some of those operational pieces just to keep the funds coming in and keeping right with audits, etc.
15. We're trying to make sure that our communities are healthier in order to reduce overall costs. At the same time, there is the environmental health piece of pool inspections and day care centers. How do we align this with the health care transformation world and what are the tenets that need to be there?
16. Communicable disease piece – it is an extraordinary piece as far as costs and as far as needs for a community. It won't matter how much we spend on the medical side if we can't control our communicable diseases. We need to understand how this inner connects to where we are trying to go.
17. The hospitals have labs and they have communicable disease program, could this be a source of communicable disease testing?
18. There are only so many dollars to compete for in so many areas. We need to be better at communicating across programs and how it works together a little bit better so we are not competing with each other for these dollars.
19. Concerning the funding piece, don't forget to look back at the information that was presented here in January. The local public health funding data was presented and is available in the report from CLHO provided to members in January. There is a huge disparity: some counties put in a considerable amount of local general funding while other jurisdictions put in virtually nothing and are completely dependent on this federal and state

pass through. But there is also a considerable amount of local support coming in some counties.

20. There are a lot of things that are working. As a task force do we want to do a MacGyver approach of chewing gum, and using sticks and duct tape to continue because it seems to be working? Or do we take this opportunity to look at a public health system. The danger is that we fail; currently things are working because we have patched them together. We need to get away from that perspective to look at the entire picture and see if there are pieces that we need to restructure completely and maybe start from scratch. From that point, one of the pieces that needs to be brought up is what are the statutory requirements for public health and local public health departments that don't get funded? Can we do a matrix to understand what the ORS is and how do those get funded?
21. Institutions generally and government especially, take the old and layer upon it the new. Most of our energies, money and time go into traditionally based practices which may or may not be effective. How do we as a group put together a suggestion for structure that which includes evidenced based practices, allows for innovation but still includes effective traditional based practices?

- **Approaches to delivering governmental public health services – Pat Libbey**

**Pat Libbey is the co-director for Sharing Public Health Services. Previously, Pat served as the Executive Director of the National Association of County and City Health Officials (NACCHO) from September 2002 through 2008. Before that, he served as the Director of the Thurston County Public Health and Social Services Department in Olympia, Washington. Pat has been invited to present on varying approaches to delivering governmental public health services and provide his expertise on governmental public health structures.**

- There is not a prototype, or an archetype or a model structure or set of structures for public health delivery at a local or state level. We will look at the governance and who manages the finance, what role the state plays, what role the local unit plays. But the “categories” assigned to these states were defined retroactively. None of the public health systems was designed with the intent of being Type A, B or C, but rather these definitions were developed of different types of governmental public and states were fit into them based upon some commonalities of the systems.
- The **decentralized category** covers the largest number of states. In this category the local health units are primarily led by employees of the local government and the local government retains authority over most of the fiscal discussions. State law determines how the local public health authority is organized and structured. In some cases it puts together a listing of required services. The required services tend to be a service focused rather than functionality. Disputes relative to the health code are typically settled at the local level, and they have the authority to develop public health codes as long as it is not in conflict with state code. The local policy board has the responsibility to establish fees for the services performed. At the local level we are

seeing some consolidation of the local health department with the social services function, sometimes by legislation at a state level and sometimes by local action.

- The authority to oversee the budget is vested in the **centralized** states with local governance structure and that varies in some places. Some centralized states have a Board of Health that may be appointed by a county commission. In a number of cases the county board of commissioners may also serve as the Board of Health under separate statutory responsibilities. Characteristics in centralized states are that ¾ of the state's population are served by local health departments that are units of state government.
- Local health departments in some states are led by local folks but over 50% of their budget comes from the state; they are more of a **shared model**. When you look at Florida, Georgia and Kentucky their statutes require a health department serving every county and a local board of health but the counties are very small. The state has created districts and regions and the local level are those regions to which those counties belong. The same in Wyoming where there are two or three local health departments and the rest are served by the state. In those cases it is a state employee that is the local health officer but he answers to the county commission as well as to the state.
- And then we have **mixed states**.
- Regardless of the typology -- whether it is a state centralized system or decentralized system, the jurisdictional basis for local health departments across the country is predominately county-based. Slightly more than 2/3 of the health departments operate at a single county level regardless of how they are governed.
- We have created a sense of a public health system that isn't necessarily shared by those who are responsible for carrying it out. In some cases they have a different systems perspective; we are thinking of an integrated public health system and many times elected officials think in terms of an integrated system of public services of which public health is one. It makes it a challenge to how you bring those two together.
- Over half of the state health departments function as a state health department – that is their function. The remaining states are part of a larger organization, could be health and human services, or a super agency or umbrella agency, so that function that has the responsibility to exercise public health authority is oftentimes the division or however they choose to name their organizational structure within a larger agency. The larger agency oftentimes has the responsibility for broader issues of health and they behavioral health and Medicaid. Oregon would fall into the latter category.
- Questions to leave you with: Organization and structure in public health generally talk about the way you organize the structures you have created to match efficiency and effectiveness, provide for public engagement and public accountability. Are the ways in which we are now organized in public health in line with that? Or has that fallen out a bit? The second question: do the forms that we use follow the functions that we believe public health needs to be doing? Can the approaches that I have talked about and drilled down deeper, the structural options that you have in Oregon currently, are they going to be sufficient? Can they be manipulated within the law to advance the end that you are coming to with your goal and vision? Structure is not an end. Our goal is to be able to do something that we are not able to do well now and is

regionalization a means in which you can do that? You need to keep sight of what the goal is. The statutory regulations: in looking at those, do those align in a way to what you are looking at moving forward with the CCOs, or with the notion of foundational capabilities? Are those the things you want to look at? In your budgeting how far can you manipulate categorical funding, manipulate within the law, provide for the kinds of foundational needs and capacity? How do you use the resources? Does that chart of accounts that you are obligated to use in your state's accounting system help or hinder? Or is it broken down pretty tight at a service level, and you never really have an ongoing and consistent means to describe those foundational capabilities in a public health sense. I would suggest you look to see whether the forms and functions that are in place now are based on necessary functions that are different then when they were created. If so, can they work to this end now?

- There are different drivers and different reasons to look at some of these things. Where do you find the intersection between the health officials and the policy makers of the involved jurisdictions? In some cases it is cost savings, in some cases there are concerns of autonomy and some cases you have culture and history. In one case the local health officials were very much protective of their turf and they were nervous about disrupting the system that they had invested in. The commissioners were much more interested in how this would affect the tax situation, how do we support, what do we do with the need to provide medical services for those who lacked insurance. It went down to them thinking of themselves as the health authority (the board of commissioners) and they were much more interested in thinking is there a different way of doing this. They didn't want the state to come in and tell them what to do.
- What happens in your environment, in the fiscal environment and culturally and what is going on in other service vectors influences what happens in public health. I think we have spent a lot of time in public health developing a public health system; the movement through core functions, 10 essential services and what we are now calling foundational capacities, one of the characteristics is that we have done that among ourselves and did not as deeply involve the policy makers who have a responsibility of the conduct of the public health system. We are finding ourselves at odds and when we roll these things out we are finding ourselves surprised that it is not immediately embraced. We have not taken the time to get that input and to think through the contextual and environmental implications. We have created a sense of a public health system that is not necessarily shared by those responsible for its conduct. For carrying it out. In some cases, they have a different systems perspective; we think in terms of integrated public health system but many times elected officials think of an integrated system of public services of which public health is one, particularly at a local level. It makes it a challenge to how do you bring those together.

- **Public Comment**

Kate O'Leary, Washington County Public Health.

Thank you for your work on this task force. These are exciting times for public health and shared opportunities to improve the public's health. You need to look at comparable information from the local

level. It looks different at the local level. What are individual services and population based services, and how do we meet the needs at the local level? The significant investment of county general fund makes a huge difference. How at the local level do we work with our coordinated care organizations, our hospital partners and other community organizations make a huge difference in terms of funding and resources and shared cost. At the local level, in addition to the county general fund, there are federal national, state, and regional opportunities that we seek out, leveraging with our local partners as well as private. There are a variety of issues to take a look at funding at the local level. I hope you get the opportunity for comparable information at the local level. (Co-Chair Baxter: we did have that in our January meeting.)

The state MCH budget overview talked about some state general fund that state public health gets for nurse home visiting. At Washington County we get \$58,000 for that particular program. We use county general funds to increase the services to at risk children and families, including non-Medicaid eligible children. The local county reality looks very different than the state perspective. It is that kind of map that I hope you will be able to get across all of the counties so that you compare apples to apples to understand what is the landscape. I hope you do apply what are individual services and what are populations and policy kinds of work that happens with those investment because that is important to have. Then you will have the landscape of public health funding not just one part of the system.

#### Rebecca Austin, Lincoln County Public Health

I am here also representing my public health advisory council and they want to bring the message to this committee that they are thrilled that there is a statewide conversation going on about public health. They are also watching what is going on in this committee and hoping that at some point they can give some input to the process. Also, they are very interested with meeting with the public health advisory council from neighboring counties, Linn and Benton County, and they have had a couple of meetings already and want to continue to do that because they feel it is important that we insert the public health discussion into health care transformation, or as we like to think of as health transformation going on in Oregon. I am very excited about that because I think that one of the functions that public health does is convene partners and collaborate across many different areas as well as different jurisdictions. I cannot tell you how thrilled I am being a resident of Lincoln County to have my partners in Linn and Benton County who are awesome. Keep your eye on this region of partners who are working fearlessly to engage their whole communities and improving the health of their populations.

One example of that partnership is our tobacco programs. Smoking is by far our biggest problem in Lincoln County and we can see that in the rate of chronic disease in the community. We are working together with Benton and Linn to build a program so we can do the policy work that is going to have to happen in all of our communities to move this forward. In Benton, they have an epidemiologist which Linn or Lincoln will never have, so they lend that epi to us. In our little region we want to work together because we see how we can move forward to helping the community to be healthier.

I am a public health nurse and one of our biggest challenges in workforce development is when we have to recruit for nurses. It is extremely difficult to recruit for your run of the mill nurse. And if you want to have the nurse have a specialty care in public health nursing which requires a bachelor or masters, it ups the difficulty. And if you want a public health nurse and a leader, it is almost impossible in the rural areas. I hope the workforce development person can take that message back to the universities and tell them we really need more public health nurses.

Joselyn Warren, Oregon State University

As the vice chair of Linn County's public health advisory committee I salute your comments about inclusion of the advisory committee at the local level. We would love to be able to comment. I am reporting back to my committee in a few weeks. We don't have a school of nursing but workforce development is a mission of our college. We have the future policy analyst, the epi, the community health planners in this state and at this time we are also re-envisioning public health education at the university level so this might be a really great time to also think about what else we can do to prepare our students for a future in public health. That approach could be case based rather than experiential learning.

I also want to say as far workforce development that OSU has a number of extension offices around the state and that could be a resource for providing continuing education. We can think about that also in terms of doing continuing education for our public health practitioners at the local level.

### **Closing Comments**

A task force specific email will be set up to take public comments.

The next meeting is April 16 in Portland starting at 10:00