

## Office of Health Transformation

# Implement Public Health Futures Recommendations

### Background:

Currently in Ohio there are 125 county and city health departments. There is significant variation in the capacity of these local health districts (LHD): from 1 to 435 full-time employees, 6,441 to 854,975 residents served, and \$8 to \$232 in public health spending per capita.<sup>1</sup>

For 50 years, experts have been recommending better ways to organize local health districts. A 1960 report recommended a minimum size for local health districts, and used as examples 100,000 residents for city health departments and 50,000 residents for all other health districts.<sup>2</sup> A 1993 report recommended that local public health jurisdictions be required to have the critical mass necessary to provide core public health functions and that, in most cases, county boundaries would provide the critical mass necessary.<sup>3</sup> And a 2012 Institute of Medicine report recommended providing a “minimum package of public health services” in every community, and greater collaboration between public health and its clinical care counterparts to improve the outcomes of clinical care and the field’s contributions to population health.<sup>4</sup>

In 2011, the Association of Ohio Health Commissioners (AOHC) established a *Public Health Futures* project to explore new ways to structure and fund local public health. The project guided AOHC members through a critical look at the current status of local public health and a careful examination of cross-jurisdictional shared services and consolidation as potential strategies for improving efficiency and quality. Members defined the core public health services that each LHD should provide, and foundational capabilities that can be internal or accessed through cross-jurisdictional sharing (Figure 1). The project culminated in recommendations that linked future decisions about services, jurisdictional structure, and financing to each LHDs capacity to provide core public health services.<sup>5</sup> The report concluded that most LHDs may benefit from cross-jurisdictional sharing, but LHDs serving populations of 100,000 residents or less would particularly benefit from pursuing cross-jurisdictional sharing or consolidation.

### Executive Budget Proposal and Impact:

In October 2012, a Legislative Committee translated the AOHC Public Health Futures recommendations into specific legislative and fiscal policy recommendations for consideration in the 2014-2015 operating budget (Appendix A).<sup>6</sup> The Executive Budget incorporates many of

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<sup>1</sup> Ohio Department of Health, [Local Health Department Expenditures Report](#) (self-reported in 2011).

<sup>2</sup> Ohio Legislative Service Commission, [Organization and Financing of General Health Districts](#) (1960)

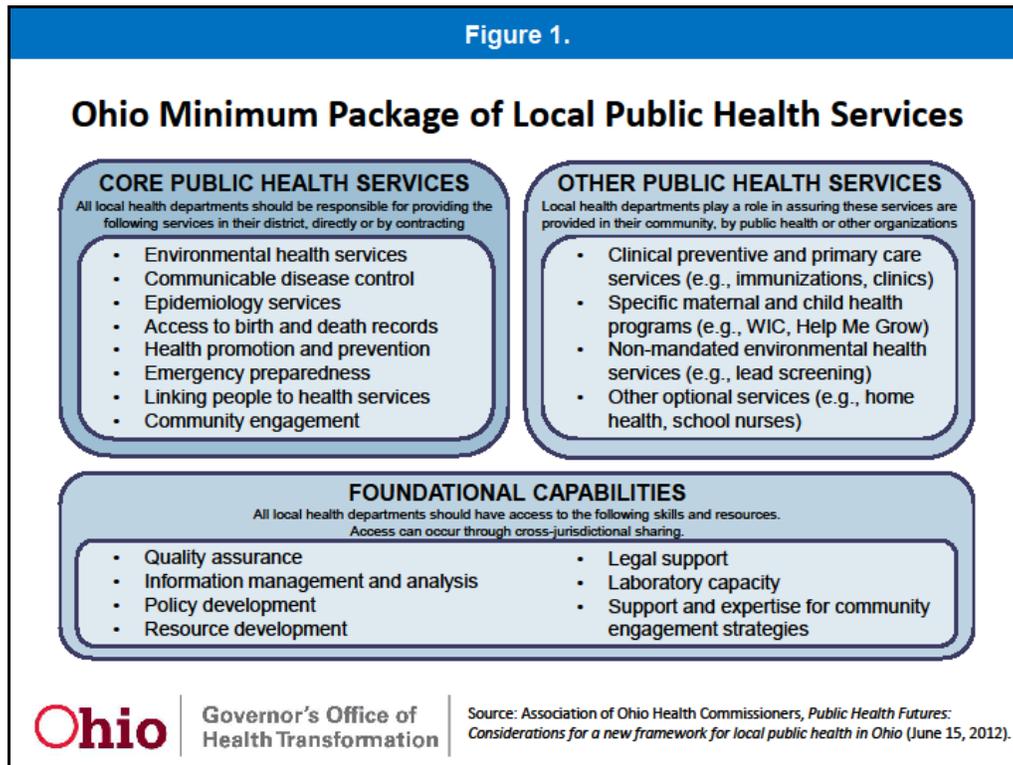
<sup>3</sup> Ohio Public Health Services Study Committee, [Healthy People, Healthy Communities](#) (1993)

<sup>4</sup> IOM, [For the Public’s Health: Investing in a Healthier Future](#) (2012)

<sup>5</sup> AOHC, [Public Health Futures Final Report and Recommendations](#) (June 2012)

<sup>6</sup> Ohio General Assembly, [Public Health Futures Recommendations](#) (October 2012)

the Legislative Committee’s recommendations, all of which are designed to give public health more tools to collaborate, integrate programs and services, and improve the assurance of services for all Ohioans. These recommendations do not require consolidation, but they do require that each LHD seriously consider whether or not it has the foundational capabilities to provide core public health services and, if not, to identify how it will gain access to those capabilities, either directly, through cross-jurisdictional sharing, or consolidation.



The Legislative Committee’s recommendations are identified in the headings below, with a description about how the Executive Budget acts to operationalize each recommendation.

## REGIONALIZE GRANTS

- **Block grant funding.** The Committee recommends ODH advocate a “blended funding” approach that integrates all state and federal public health funding using block grants, when possible, to reduce fragmentation and leverage public health funding. ODH will begin a process of consolidating grant awards to LHDs to ensure that the most effective and efficient LHD or consortium of LHDs administers the program for an entire region. Moving all grants that are predominantly operated by local health departments to a regional basis will generate efficiencies and consolidate performance in the highest functioning jurisdictions. The Executive Budget creates a mechanism for ODH to shift authority to the jurisdiction assuming responsibility for the region. Beginning in July 2013, ODH will release a request for proposals to regionalize several targeted grants.

These regional RFPs will be awarded in January 2014 and include dental sealant, creating healthy communities, HIV prevention, STD prevention, immunization action plan, and injury prevention programs. This process will consolidate 180 separate grants into 47 regional awards. Later phases of implementation will involve working with federal partners to “block grant” the separate programs listed above.

## IMPROVE MANDATORY PROGRAMS

- **Boards of Health.** The Committee recommends that local health district board members participate in continuing education requirements related to public health practice, ethics, and governance. The Executive Budget requires each member of a board of health to complete eight continuing education units annually. The Budget also requires each Board of Health to include an executive officer or medical director of a hospital or the largest medical facility in the district, to facilitate community health planning.
- **Performance Standards and Accreditation.** The Committee recommends that all local health districts meet Public Health Accreditation Board eligibility within five years. The Executive Budget authorizes the ODH director to require general or city health districts to be accredited beginning in 2018 as a condition for receiving funding from ODH. Beginning July 2013, accreditation standards will be incorporated into all regional grant deliverables to assist LHDs build capacity and knowledge of the accreditation process and prepare for successful accreditation.

Also, the Budget requires sanitarians of a city or general health district who perform inspections of food service operations or of retail food establishments to obtain and maintain certification from the United States Food and Drug Administration. The benefit to Ohio is a more uniform delivery of services throughout Ohio as well as holding sanitarians to the highest performance standards available. LHDs meeting these requirements will receive less frequent surveys from ODH. Later phases of implementation will include similar standards for other mandated programs.

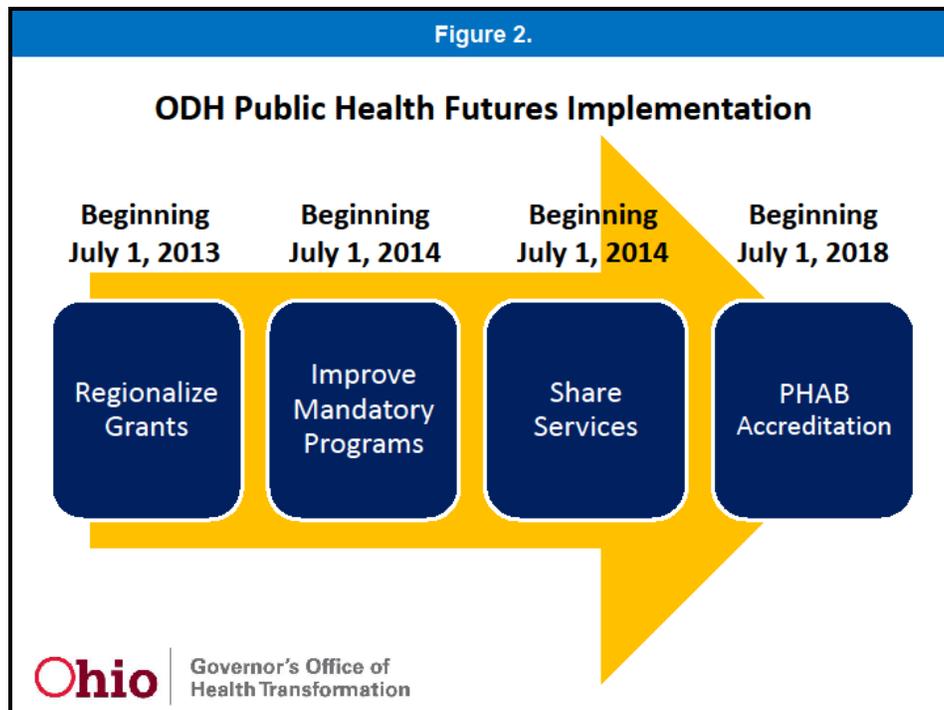
## SHARE SERVICES

- **Shared services resources.** The Committee recommends that ODH encourage and enhance shared services by local health districts. Beginning in July 2014, ODH will expect LHDs to demonstrate movement toward regional shared service hubs for foundational capabilities such as human resources, payroll processing, information technology, and financial management. This item will be included in the fiscal monitoring activities included in LHD regional grants, and grant applications that fail to demonstrate movement or contractual relationships with the regional hubs will result in points off in scoring. The Executive Budget authorizes ODH to reassign authority for mandatory programs from an LHD that cannot demonstrate it has the foundational capability to provide core public health services to another LHD that has that capability. This does

NOT entail ODH taking over any non-compliant jurisdiction, but rather a shifting authority from a non-compliant jurisdiction to a compliant jurisdiction.

- **Sharing across contiguous and non-contiguous cities or counties.** Current law limits certain cross-jurisdictional sharing opportunities to “two or more contiguous” health districts “not to exceed five.” The Committee recommends and the Executive Budget includes provisions to remove these restrictions, thus allowing cross-jurisdictional sharing among an unrestricted number of contiguous and non-contiguous counties. Also, the Committee recommends and the Executive Budget authorizes permissive multi-county levy authority for public health services.
- **Outcomes and data.** The Committee recommends that ODH create a standardized process of specific data collection and identification of common public health indicators. The Executive Budget requires the health commissioner of a general health district to develop a comprehensive community assessment for the county, in collaboration with city health districts, private health care providers, hospitals, other medical facilities or medical services, behavioral health providers, and members of the general public.

In combination, these strategies create new incentives to improve public health system performance and increase efficiency by sharing foundational capabilities across local health districts. These changes do not occur all at once, but over time, and tie services, jurisdictional structure, funding, and accreditation to providing core public health services (Figure 2).



**Appendix A.**  
**Legislative Committee on Public Health Futures**  
**Approved Recommendations and Concepts**

**Performance Standards and Accreditation.** All local health districts shall meet PHAB eligibility within five years. Such documentation shall be independently verified.

**Outcomes and Data.** The Ohio Department of Health and local health districts shall create a standardized process of specific data collection and identification of common public health indicators to include quality, quantity, comparables and efficiency. The sharing of de-identified health related data among payers, providers and public health is encouraged.

**Boards of Health.** Local health district board members shall participate in continuing education requirements related to public health practice, ethics, and governance.

**Multiple Agency Program Administration.** Identify and refer programs currently administered by two agencies (Ohio Department of Agriculture and Ohio Department of Health) such as food safety and waterpark / swimming pools to the Common Sense Initiative (CSI) for further review and recommendations related to the program efficiency.

**Multi-District Public Health Levy.** Revise Ohio Revised Code 3709.29 to allow for permissive multi-county levy authority for public health services.

**Shared Services Resources.** The Ohio Department of Health shall encourage and enhance shared services by local health districts such as, but not limited to, the sharing of model contracts, memorandums of understanding, financial, and other technical assistance, that are easily adaptable by local boards.

**Contract/Consolidate/Merger of Contiguous and Non-Contiguous Cities or Counties.** Revise Ohio Revised Code sections 3709.051 and 3709.10 to allow contiguous and non-contiguous city and county health districts to contract/consolidate/merge together within a “reasonable” geographic distance (consider AOHC regions).

**Reimbursable Services.** The Ohio Department of Insurance should work to enhance the ability of local health districts to contract and credential with private payers and Medicaid for services such as immunizations and other public health and clinical services, integrated health management and other care models. This recommendation is not to be interpreted as supporting new legislative mandates or the placing of mandates upon local health districts.

**Chronic Disease Block Grant Funding.** The Ohio Department of Health shall initiate review and advocate federal, state and regional authorities for a “blended funding” approach that integrates all state/federal public health funding using block grants (when/where possible) to reduce fragmentation in an effort to increase public health funding.

**Sustainable Funding.** Ohio should explore sustainable funding to achieve Ohio’s public health mission and responsibilities. This work should include steps to: implement standard measures of outcomes, examine the link between funding disparities at the health district level and health outcomes, identify any additional opportunities for operational efficiencies, review incentives to drive outcomes at the local level and pursue federal funding opportunities.

**Reconvene Committee.** The Director of Health shall reconvene a similar committee no later than three years after report submission of October 31, 2012 to review its purpose and implementation of recommendations.