Oregon's Public Health Modernization Assessment

Preliminary Findings

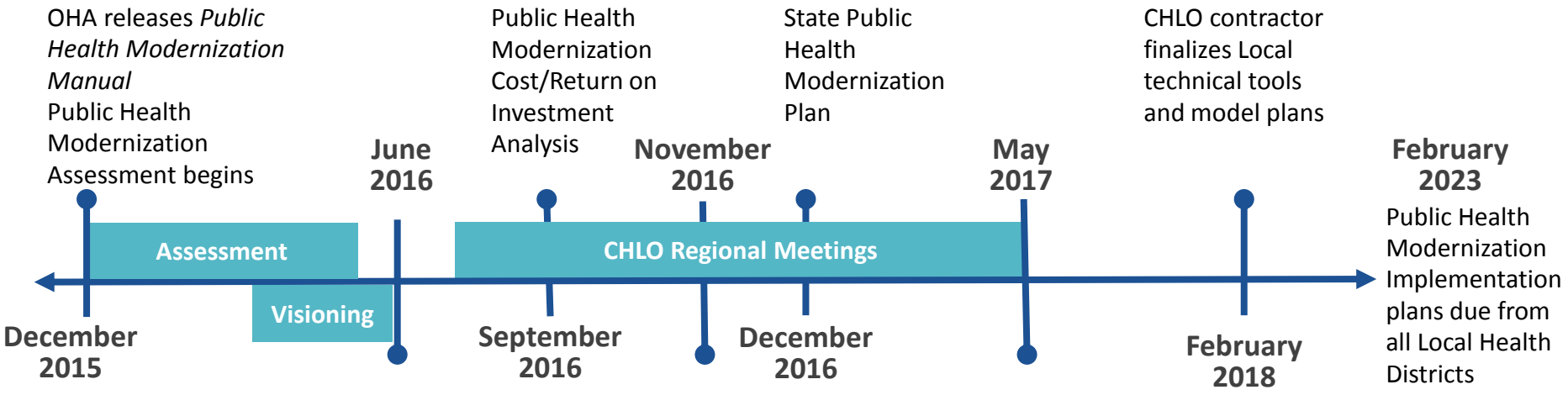
BERK

Discussion Guide

Follow up to April PHAB meeting:

- Discuss expectations for full report
- Review presentation of preliminary key findings
  - Assessment results
  - Cost analysis
  - Policy implications

Public Health Modernization Implementation



PRELIMINARY FINDINGS: May 10, 2016

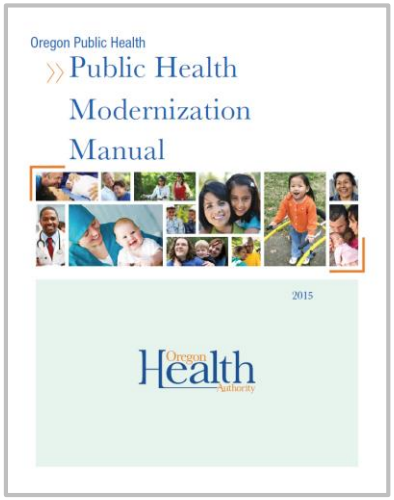
Limitations

- Public Health Modernization is still a fairly new concept for all of the agencies participating in this effort.
  - There is a level of subjectivity in interpreting the Public Health Modernization framework.
  - As much as possible, we developed the Assessment Tool to build a shared understanding of Public Health Modernization within Oregon's public health community.
- Data collected present planning level estimates that provide order of magnitude precision.
- Data are self-reported, which include any inherent respondent biases.
  - We built in checks and balances during the data collection process and as part of validation to identify and, where necessary, correct for these biases at the planning-level.

Analytic Design

Programmatic Framework

- Programmatic framework describes activities State and local governmental public health providers must perform as part of full implementation of Public Health Modernization.
- Organized around 11 Foundational programs and Capabilities.
- Oregon has developed a comprehensive Modernization Manual that outlines mutually supportive roles of state and local public health providers.
- We leveraged this document to inform our programmatic framework.



Analytic Design

Programmatic Framework

	State		Local	
	Roles	Deliverables	Roles	Deliverables
Program				
P-CDC: Communicable Disease Control	26	24	19	16
P-EPH: Environmental Public Health	33	24	25	11
P-PHP: Prevention and Health Promotion	29	13	27	14
P-CPS: Clinical Preventative Services	29	6	24	7
Capability				
C-AEP: Assessment and Epidemiology	11	10	11	9
C-EPR: Emergency Preparedness and Response	26	12	10	11
C-COM: Communications	12	11	6	9
C-PAP: Policy and Planning	16	5	14	5
C-HEC: Health Equity and Cultural Responsiveness	59	7	44	6
C-CPD: Community Partnership Development	11	7	7	7
C-LOC: Leadership and Organizational Competencies	19	8	13	7
TOTAL	**271**	**127**	**200**	**102**

- Number of roles and deliverables can be unmanageable.

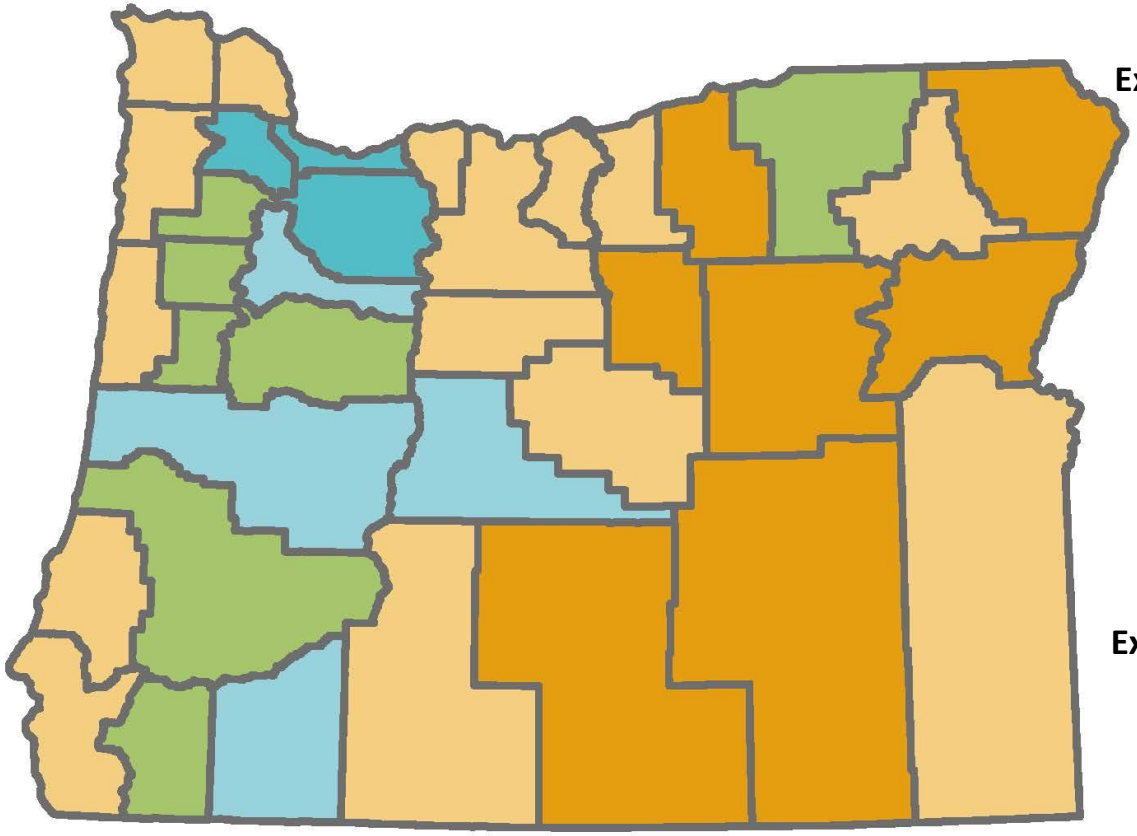
Analytic Design

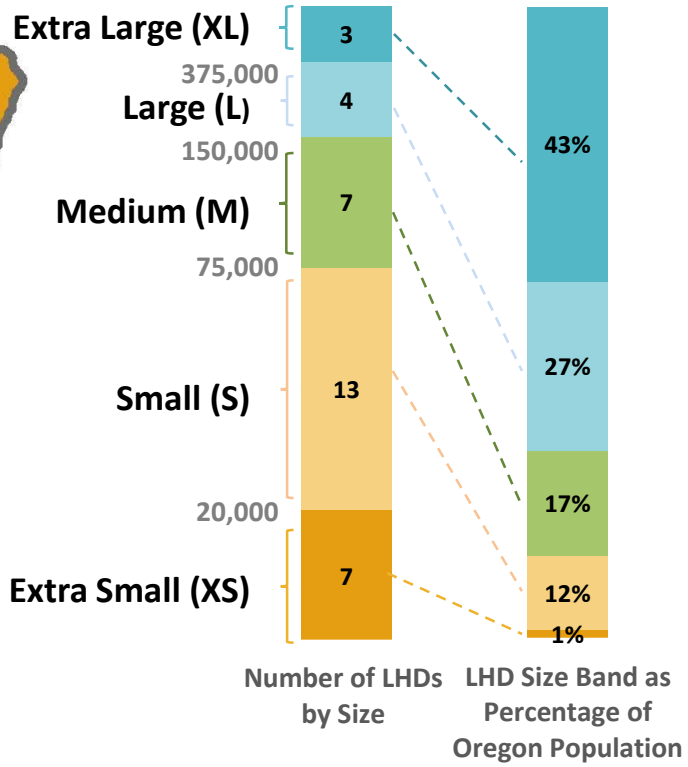
Programmatic Framework

- Defined “functional areas” as an operational construct to help local organizations think about their resource needs based on how they might execute this work.
- Broke our 11 Foundational Capability and Programs into 40 functional areas. Each Foundational Capability and Program had between 2 and 5 functional areas.
- Assigned the roles and deliverables directly to the functional areas to provide a direct one-to-one relationship.

Analytic Design

Operational Sizing

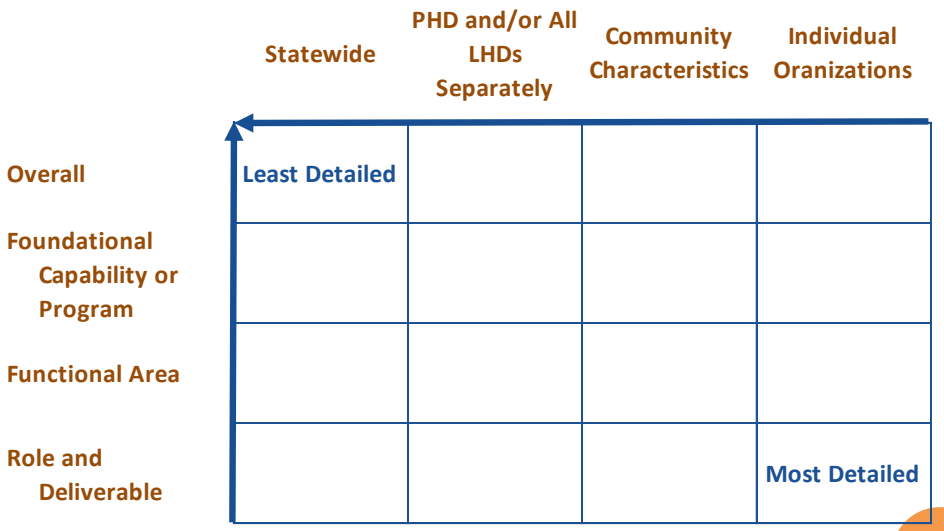




Analytic Design

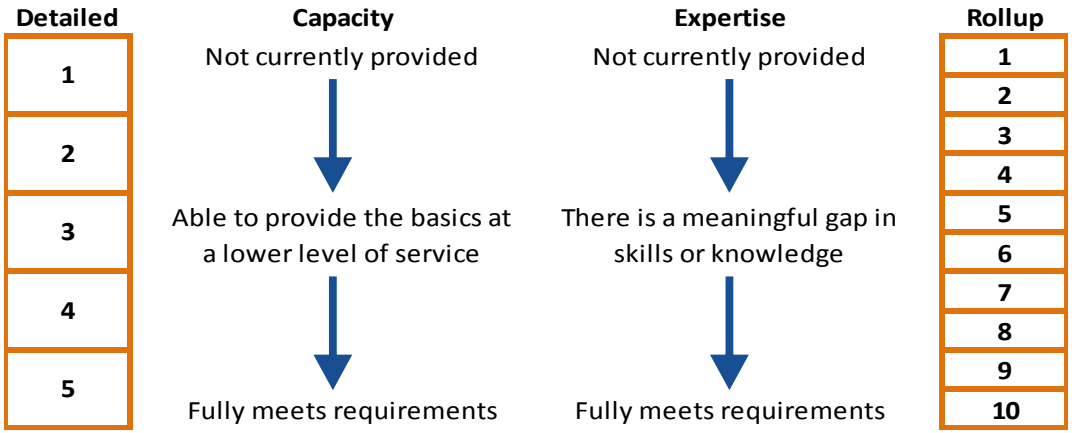
Level of Detail

- Provide level of detail that balances meaning and analytic value with function.
- Provide data in a way is digestible and easy to consume for legislative and other audiences.
- Also want to minimize risks possible from providing provider-level detail.
  - Honor concerns of LHDs
  - Avoid pitting LHDs against one another



Self-Assessment Scoring

- Programmatic Self-Assessment helped organizations determine their current implementation of Public Health Modernization:
  1. A Detailed Assessment (1-5) for roles and deliverables; and,
  2. A more generalized Rollup Assessment (1-10) for key functional areas and an overall assessment for the Foundational Capability or Program.

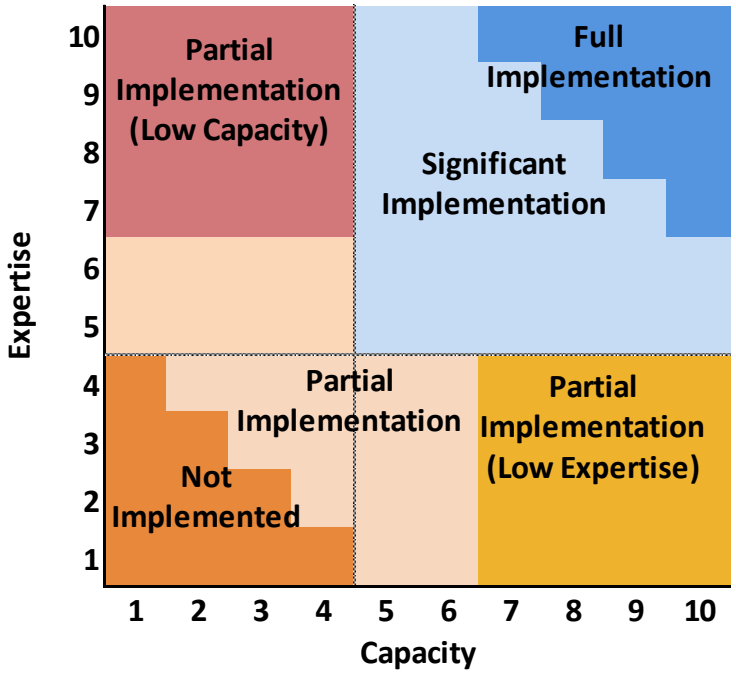


Self-Assessment Scoring

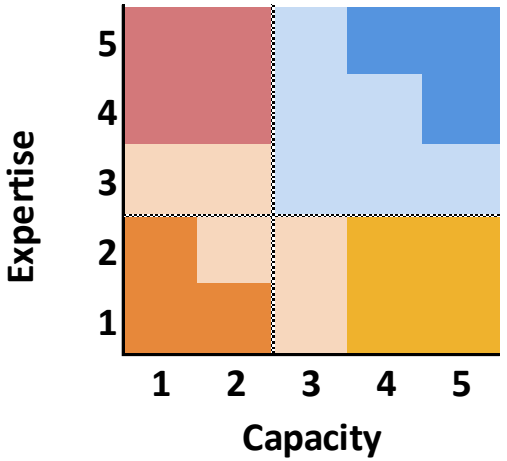
- **We will review Self-Assessment scoring across two dimensions:**
  - **Provider Level of Implementation.** We will review providers' scores as they relate to those providers' level of implementation.
  - **Population Service.** We will also review providers' scores as they relate to level of service that residents in those providers' service areas.
- **Both dimensions offer important insights.**

Self-Assessment Scoring

Self-Assessment Scoring Relationship to Provider Level of Implementation for Foundational Capabilities and Programs and Functional Areas

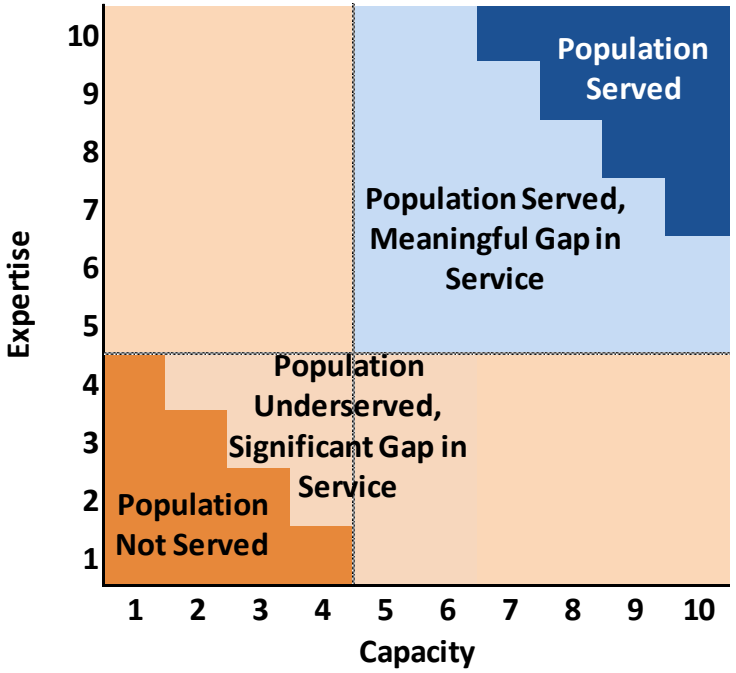


Self-Assessment Scoring Relationship to Provider Level of Implementation for Roles and Deliverables

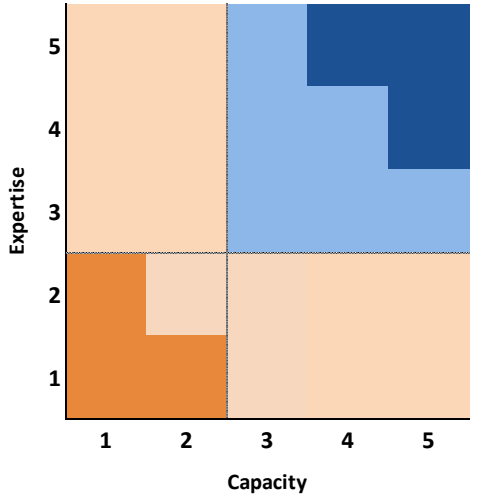


Self-Assessment Scoring

Self-Assessment Scoring Relationship to Population Service for Foundational Capabilities and Programs and Functional Areas



Self-Assessment Scoring Relationship to Population Service for Roles and Deliverables



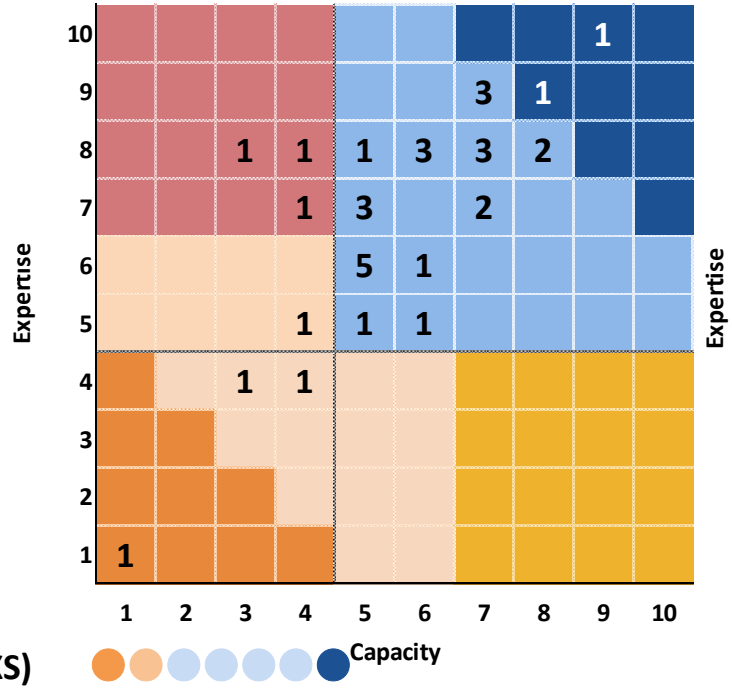
Applying the Scoring Framework

- We'll use Environmental Public Health as a case example of how the scoring framework provides analytic value.
- We'll review:
  - State and Local Foundational Program level of implementation and population service scoring by providers and provider size.
  - State role and deliverable level of implementation
  - Functional Area level of implementation scoring by providers and provider size.
  - Functional Area level of implementation and population scoring.

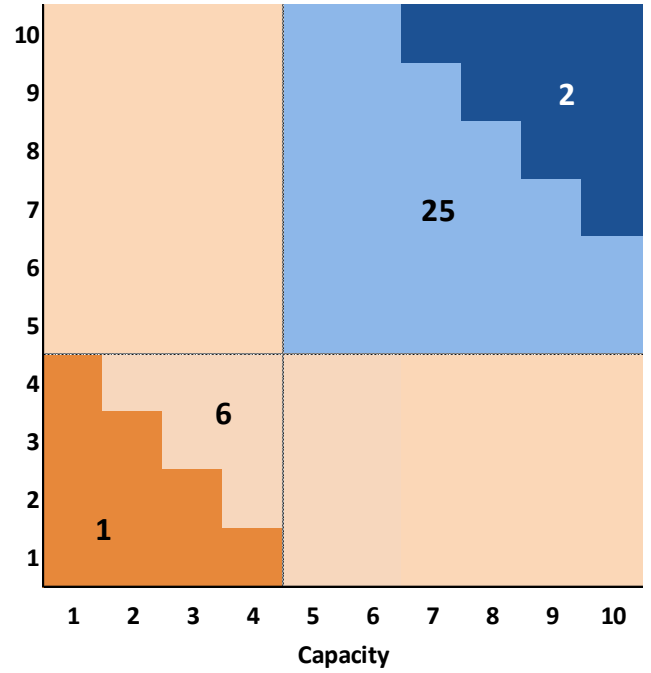
Key Findings: Example – Environmental Public Health

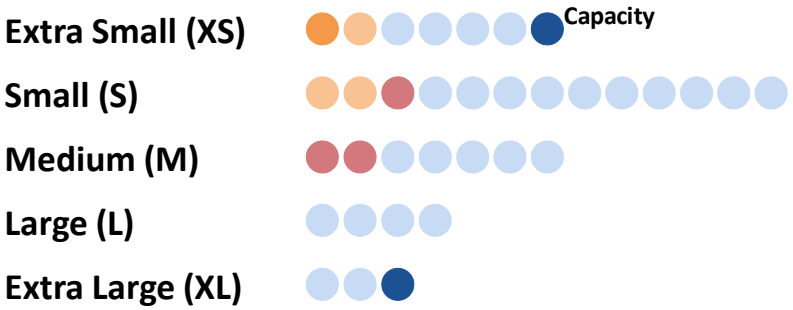
Foundational Program

Provider Level of Implementation



Population Service

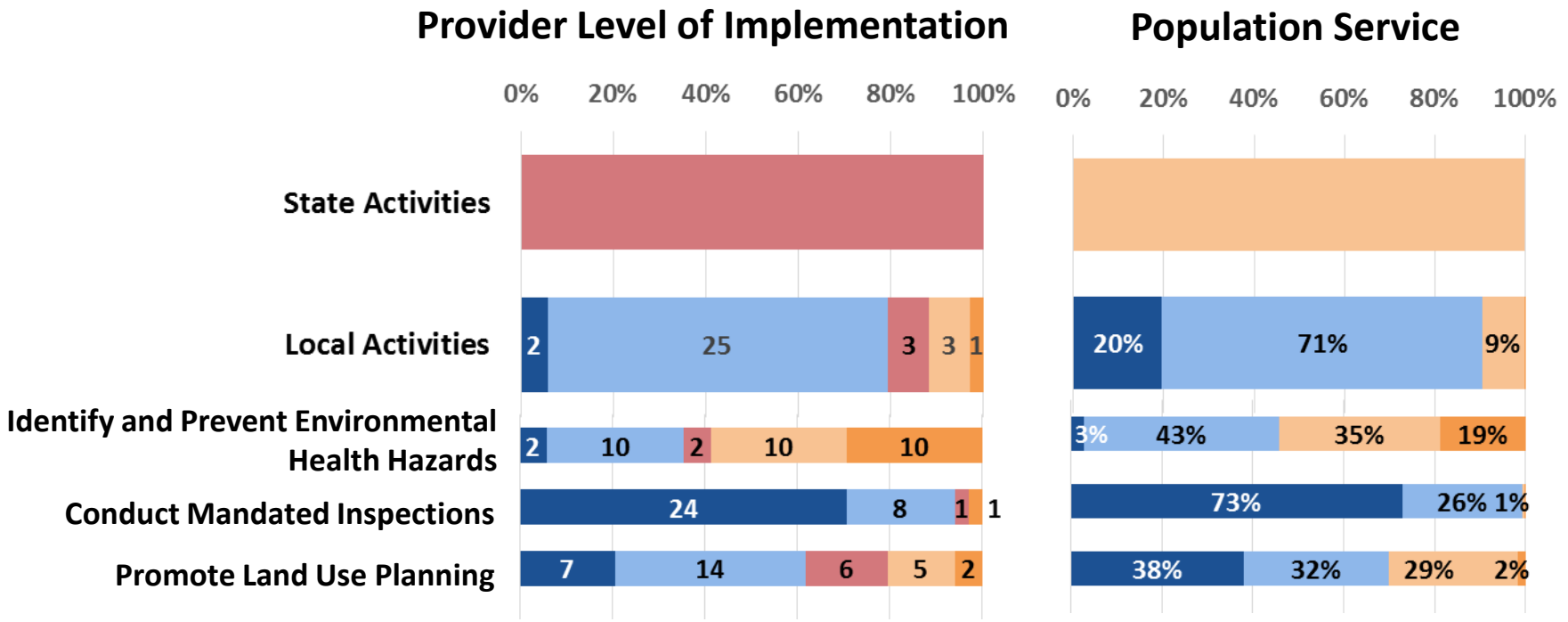




PRELIMINARY FINDINGS: May 10, 2016

Key Findings: Example – Environmental Public Health

Foundational Program and Functional Area



State Roles and Deliverables

- If desired, use understanding to generate lists of roles and deliverables by PHD's level of implementation.

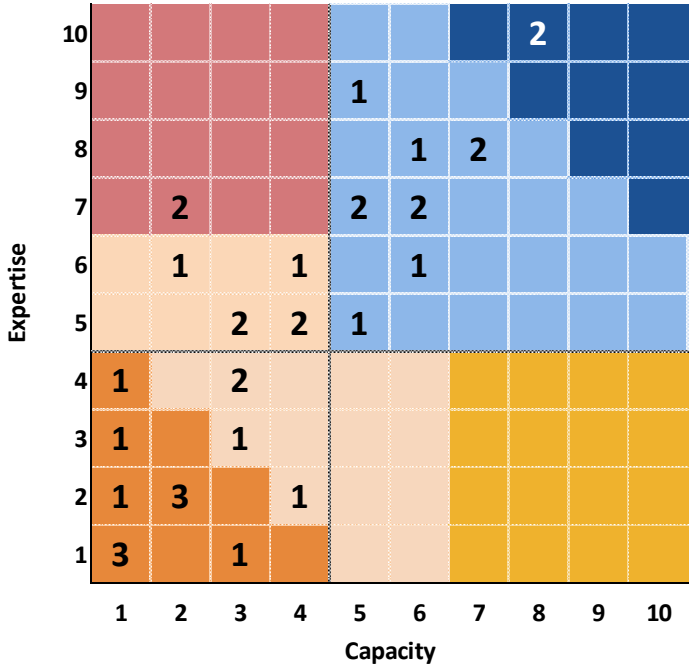
(Fully Implemented roles and deliverables provided to right)

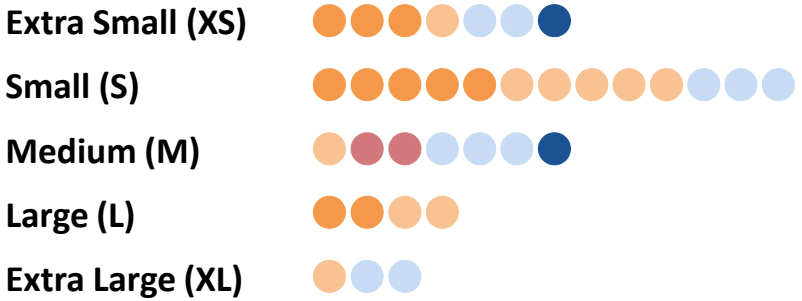
P-EPH: Environmental Public Health
Ensure consistent application of health regulations and policies including those related to:
Adopt drinking water quality standards.
Maintain a trained and equipped radiation emergency response team for radiological emergency.
Implement a food borne illness-prevention program which includes developing an annual program plan after consultation with local public health officials and industry associations and assures communities across the state have access to safe retail food through the consistent application of rules and standards.
Collect, analyze, interpret, maintain, and provide access to environmental data that other agencies or stakeholders produce, including data pertaining to natural and built environment
Provide decision support on environmental health issues of statewide or cross-jurisdictional importance including guidance on utilizing environmental health expertise to address accident and disease prevention and environmental exposure reduction at the local level.
Report using environmental data that other agencies or stakeholders produce, including data pertaining to natural and built environment (i.e. air quality, water quality, pesticide use).
Produce annual foodborne illness program plan.
Write guidance on mitigating environmental health risks and maximizing health benefits (radon, lead, air quality, mold, other environmental hazards).
Produce public communications about environmental health risks (public health advisories).
Consult on the assessment and mitigation of environmental health hazards to local public health authority staff, the food service industry and the general public.
Recommend to other organizations approaches to ensure healthy and sustainable built and natural environments.
Produce environmental health data reports pertaining to natural and built environment (i.e. air quality, water quality, pesticide use).

Functional Area

Functional Area 1:

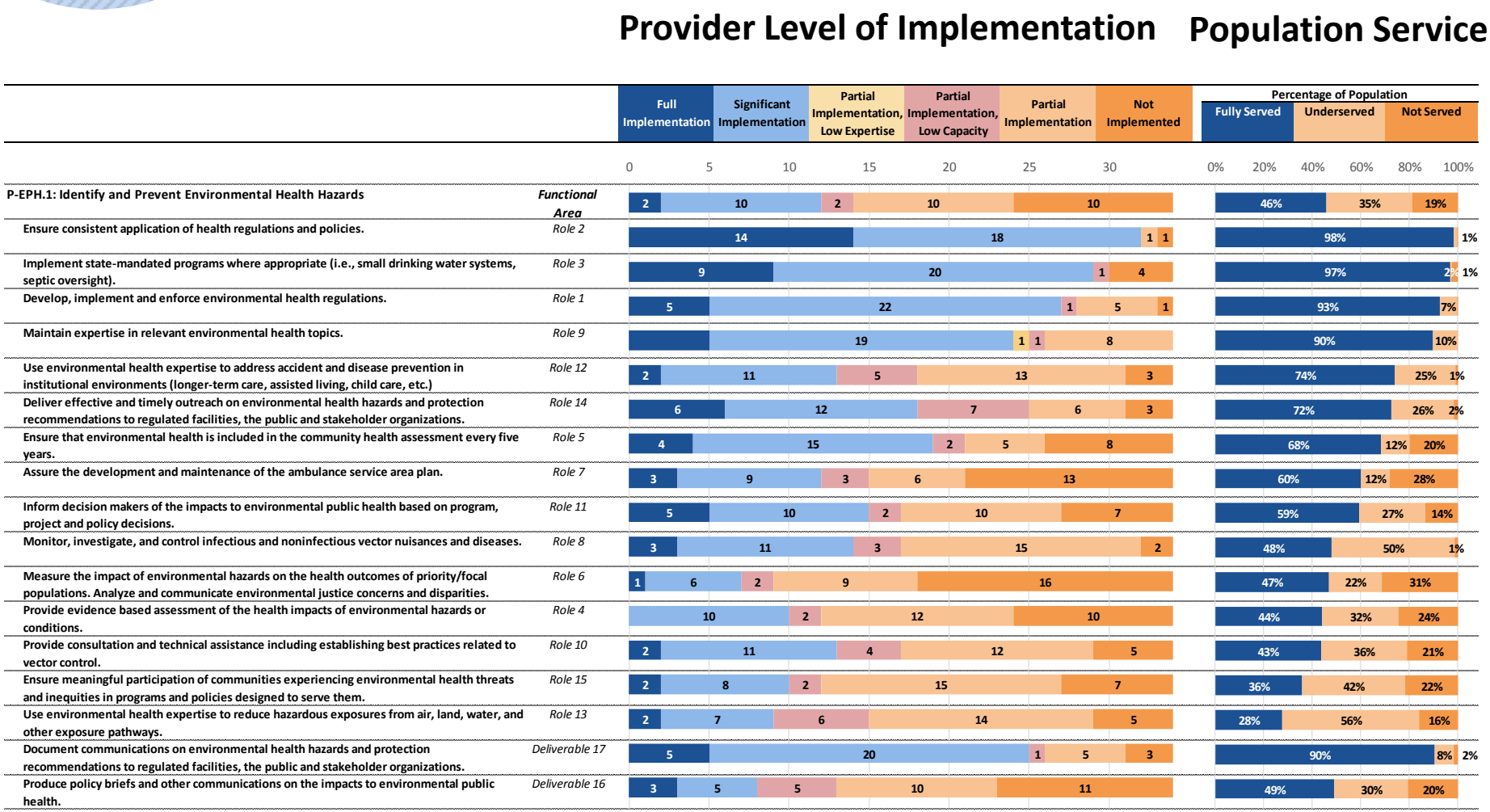
Identify and Prevent Environmental Health Hazards





Key Findings: Programmatic Self-Assessment

Local Roles and Deliverables



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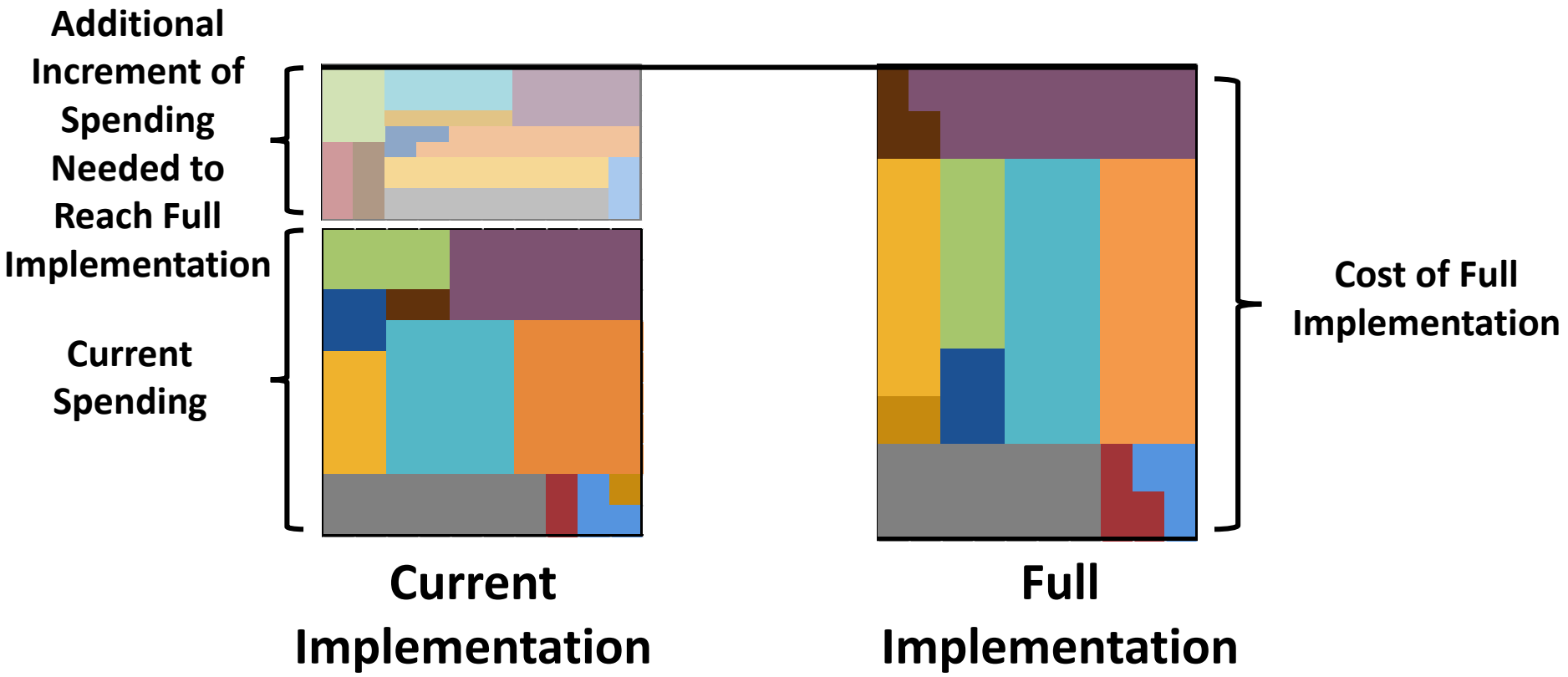
Local Non-Financial Barriers to Implementation

- LHDs identified several barriers to implementation of Environmental Public Health; for example:
  - Capacity is dedicated to fee-for-service environmental inspection programs.
  - Limited staff expertise related to like chemical, radiation, and brownfield and other specific hazards.
  - Need for additional cross training opportunities.
  - Existing regulations at State and Local levels are insufficient to ensure timely enforcement.
  - Vector control programs in some counties are under the jurisdiction of each city/town and are not countywide. In those places, public health is not involved in vector control programs locally.
  - Inability to hire appropriate expertise at existing pay scale.

Non-Financial Barriers to Implementation

- LHDs also identified a few unique barriers specific to a particular role or deliverable:
  - For Role 2, “ensure consistent application of health regulations and policies,” at least one LHD identified that lack of standardization of sanitarians makes this a challenge.
  - For Role 3, “implement state-mandated programs where appropriate (i.e., small drinking water systems, septic oversight)” at least one LHD noted that non-EPA regulated public water systems have not been surveyed as required by state law.
- We’ll provide this level of detail to help support future phasing decisions.

Cost of Full Implementation



Cost of Full Implementation

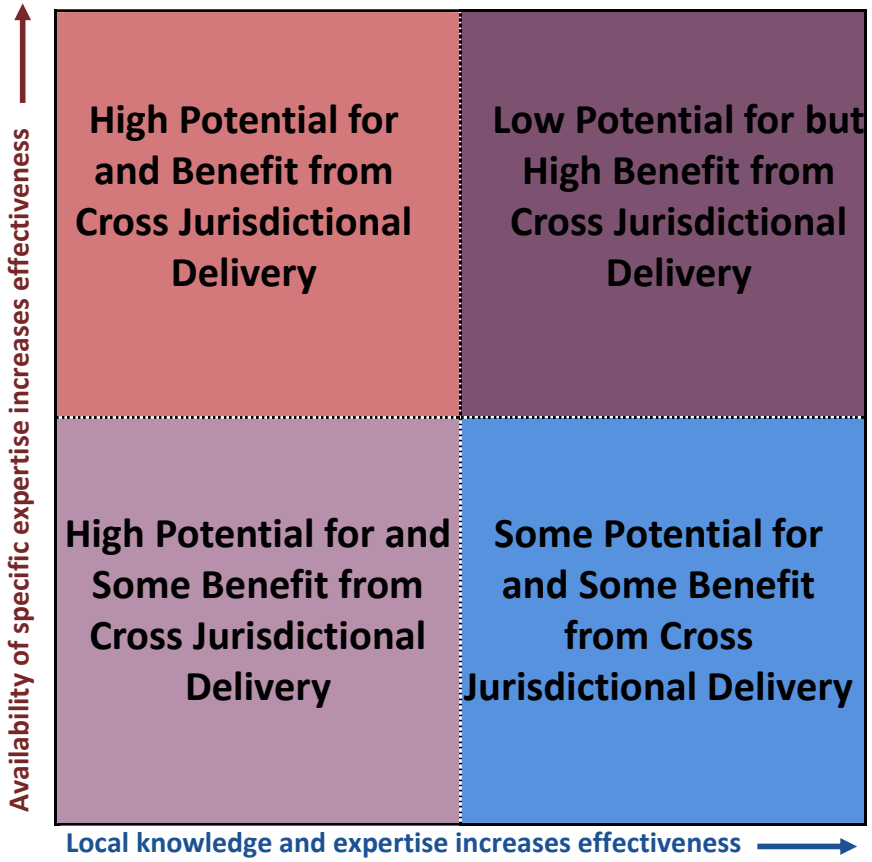
- Additional Increment of Spending Needed to Reach Full Implementation is the difference between the cost of full implementation and current spending.
  - This is not necessarily the same as “funding need.”

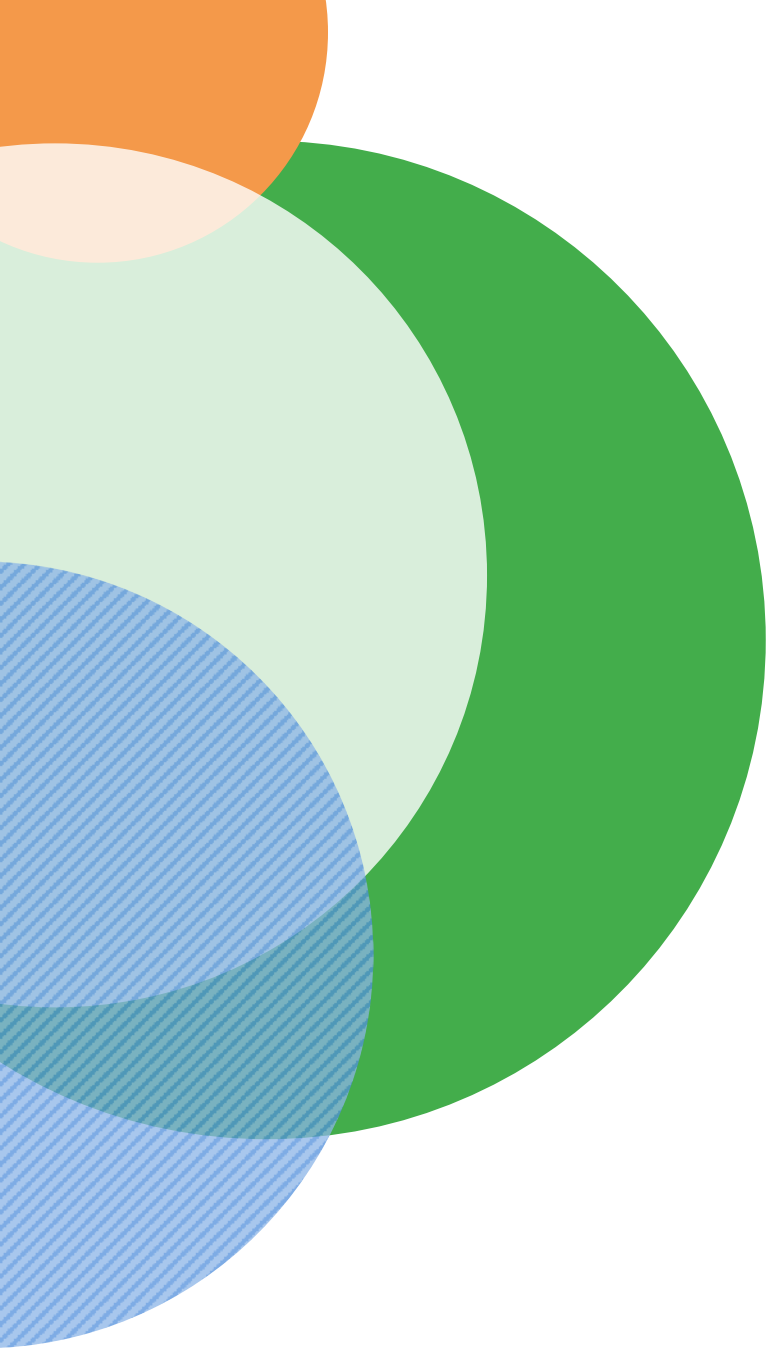
Cross Jurisdictional Sharing

- Some counties area already significantly sharing resources (with each other and with nonprofits and other local agencies).
- The Public Health Modernization Assessment process catalyzed conversations between LHDs.
- There is need for additional time and resources to support further conversations.

Cross Jurisdictional Delivery

- Some roles and deliverables may be appropriate for cross jurisdictional delivery.
- Local providers should be involved in determining what roles and deliverables are delivered cross-jurisdictionally.





Questions?

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