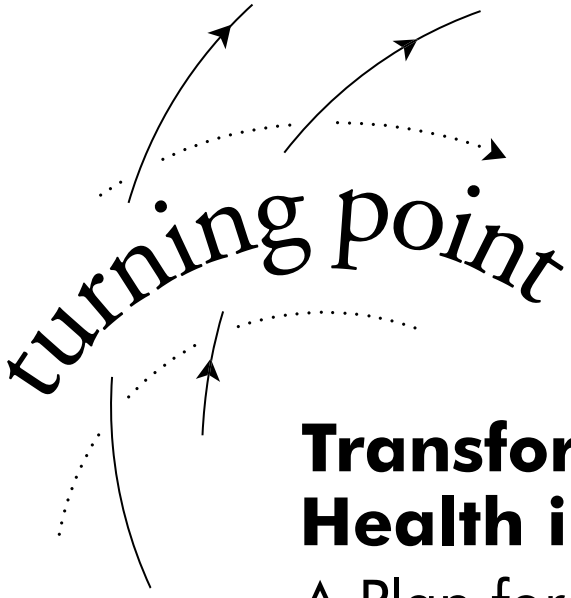

Transforming Public Health in Oregon:

A Plan for a New Century

March 2000

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The complete Public Health Improvement Plan is available on our Web site:
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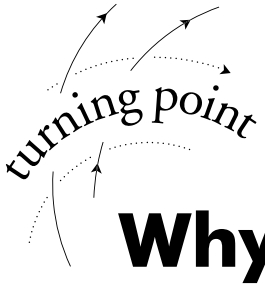


Why Turning Point in Oregon?

In the introduction to *Oregon Shines II* (1997), Governor Kitzhaber writes: "Oregon has a well-earned reputation as a state that believes in planning. Part of any good planning process is re-visiting goals and strategies periodically to assess their relevance and effectiveness." Turning Point is an opportunity for the public health system to re-visit its relevance and effectiveness as we prepare for the 21st Century.

The last decade of the 20th Century has been one of rapid change within the health care system both nationally and in Oregon. Influences on these changes include:

- market-driven forces that impact the delivery system with almost weekly changes
- increased availability of health information creates savvy consumers demanding results
- purchasers of health care are uniting to influence health policies and the quality and cost of care
- increasing dependence on safety net services to fill gaps in health care access
- continued evolution of managed care and the role of individual and population focused services
- widespread acceptance of prevention as a priority

Trends outside of health that influence the public health system include:

- distrust of government by the general public

- interest in accountability and performance measurement
- increased understanding of the interdependence of all community systems
- broader acceptance of needing to address all the determinants of health:
  - socioeconomic conditions
  - the physical environment
  - access to and quality of health care
  - behavioral risk and protective factors
  - genetics

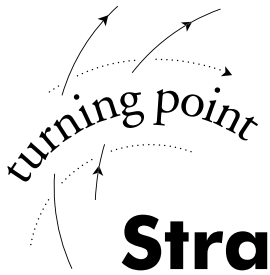
ORS. 431.375 states that *"each citizen of this state is entitled to basic public health services which promote and preserve the health of the people of Oregon. To provide for basic public health services the state, in partnership with county governments, shall maintain and improve the public health services through county or district administered public health programs."* The general powers of the Health Division are described as *"direct supervision of all matters relating to the preservation of life and health of the people of the state."* (ORS 431.110)

State and county governments alone cannot ensure the health of the community. The health of a community is a shared responsibility of many entities, as well as a personal responsibility. Developing policies that acknowledge and put into practice this shared responsibility has challenged decision makers and public health professionals for many years. Addressing the health issues of the 21st Century will require effective solutions to achieving shared responsibility.

Transforming the public health system in Oregon will require a rethinking of existing practices and structures, as well as new

ideas and approaches. It will demand new skills for public health leaders and professionals, as well as other sectors (medicine, health systems, providers, purchasers, consumers). Without a system for key public and private sector players to come together around a common agenda, health care, environmental protection, and the public health system will not meet the needs of the entire community.

The Turning Point planning process provided the opportunity to re-envision public health in Oregon. This process has produced an Action Plan to guide the transformation of the public health system. With this transformation, we will enjoy an Oregon that supports communities taking action to promote and preserve the health of the people of Oregon.



Strategies for Transformation

- *Promote a Vision of a New Role for Public Health.*
- *Increase the Influence of Public Health Leadership.*
- *Assure Basic Public Health Capacity at the Local Level.*
- *Assure Basic Public Health Capacity at the State Level.*
- *Change from a Funding-Driven System to a Needs-Driven System.*
- *Develop a Diverse Work Force to Achieve A New Role for Public Health.*

VISION

We want communities taking action to promote and preserve the health of the people of Oregon.

Creating and supporting the conditions in which people can be healthy is a shared responsibility of many entities, organizations, and interests in the community, both public and private.

Public health fulfills its responsibility in supporting achievement of this vision through the core functions of: assessment, assurance, and policy development. These are achieved through assessing the health of our communities, assuring quality health services, both public and private, are provided to our communities, and developing policies to improve the health of our communities.

To fulfill this vision requires focusing on all the determinants of health: socioeconomic conditions, physical environment, access to

and quality of health care, behavioral risk factors, and genetics.

GOAL

The Goal of Oregon Turning Point is "to create a public health system that has the ability, capacity and competency to address the determinants of health."

The term *public health system* is used without a preconceived definition of what the public health system is. Contributors to a public health system include government agencies at the state, federal and local levels, private health care systems and providers, community agencies, and communities. All contributors bring areas of expertise and knowledge that must be shared, supported, and connected to achieve the vision. The public health system must have the capacity to be flexible to address changing conditions and issues not yet identified.

An initial focus of Turning Point has been on the current governmental public health system to determine: Does the governmental public health system have a role in the future? The answer is yes. There is a role for governmental public health, but it will be a changed role.

The new role for governmental public health:

- Shifts from providing services to working with communities to meet their needs
- Enhances the comprehensive assessment of the entire population's health status
- Emphasizes community involvement and community organizing

- Includes regulation and licensing responsibilities
- Focuses on promoting policies that minimize health and social risks throughout the population
- Promotes outreach and linkages among services
- Encourages partnership among service providers

The primary resources governmental public health brings:

- Public health science and methodology (assessment, epidemiology, and analysis)
- Translating data into information (communication, education)
- Relationship building to develop solutions
- Public health values and philosophy
- A direct link to the public policy-making process
- Authority to act on behalf of the public's health

ACTION

To move from the current Public Health system to the vision will require much change and will not be accomplished quickly. The Steering Committee acknowledges the complexity and enormity of the change, including deciding where to start. Rather than focus on finding the best place to start, we recommend simply starting where we are: beginning the dialogue, examining ideas, and creating expectations.

This Action Plan defines six major strategies needed to move the public health system and the governmental public health system toward the vision. Under each strategy are action steps that will become the framework for implementation.

Much of the work ahead of us may be summed up in a quote from Bernard J. Turnock's book, **Public Health: What It Is and How It Works**, pp. 355-6:

> The job description of public health has never been clear. As a result, public health has become quite proficient in delivering specific services, with less attention paid to mobilizing action toward those factors that most seriously affect community health status. ...The public health system, from national to state and local levels, must ...move beyond capably providing services to aggressively advocating and building constituencies for efforts that target the most important of the traditional health risk factors and that promote social policies that both minimize and equalize risks throughout the population. These represent a new job description for public health.

Strategy 1

Promote a Vision of a New Role for Public Health

ACTION STEPS

Clearly define the role of the public health system.

Obtain input from public health professionals:

- Is there agreement from public health professionals on the role and message of public health? Is there agreement on definition of population based services?
- The message needs to focus on public health functions or resources, not on services and programs; focus on addressing community needs.
- Do public health actions support the newly-defined role?

Obtain input from community systems and private providers (health, education, human service, public safety, etc.) to identify:

- an understanding of the interdependence of systems' goals
- role of both individual and population focused actions

Obtain input from the public using a community conversation approach similar to Oregon Health Decisions model.

Support a major communication strategy to make the case for the mission and role of public health.

The questions to be addressed in a communication strategy include:

- What are public health priorities?

- How does public health work?
- What has public health accomplished?
- What happens when there isn't a public health system?
- Who is public health?

Develop a communication strategy that markets the investment value of public health.

Need messages that reflect:

- the link between public health population-based prevention activities and community needs
- the influence social determinants have on health of populations
- the value of prevention
- why public health is a good buy

Strategy 2

Increase the influence of public health leadership

ACTION STEPS

Increase the leadership skills of the public health work force.

Encourage enrollment in CDC's Public Health Leadership Institute.

Working with higher education, explore the possibility of creating an Oregon public health leadership institute.

Assure that current education programs include in the curriculum:

- policy development
- community mobilization
- public health leadership

Increase the visibility of public health leaders at the state and local level.

Increase use of media by public health leaders.

Increase active involvement in Boards, Commissions, etc. beyond traditional public health issues.

Include all the contributors to the public health system (state, local, federal, community, and private sector) in all public health planning efforts.

Develop community leaders for public health.

Strengthen the roles and responsibilities of the Public Health Advisory Board.

Strengthen linkages between statewide boards, such as the Public Health Advisory Board, the Oregon Health Council, the Health Services Commission, and Oregon Health Systems in Collaboration.

Foster and strengthen the statewide public health association by encouraging active involvement of all contributors to the public health system.

Create community Boards of Health:

- to reflect community needs and issues
- to provide advocacy
- to be a forum for discussion among community public health partners to advise on priorities and use of resources

Strategy 3

Assure Basic Public Health Capacity at the Local Level

ACTION STEPS

Establish capacity standards for local governmental public health functions.

Basic capacity needed at local level includes the ability to:

- assure the performance of the statutorily-mandated public health functions, both regulatory and non-regulatory
- analyze data and transform data into information
- educate and inform the public
- understand public policy development and participate effectively in public health policy development
- assess community needs
- participate in local community development
- collaborate with health and human services organizations in the community
- evaluate programs
- manage resources (fiscal, human, physical, and information)

Establish stable state funding for basic local level public health capacity.

Establish minimum expected local level resources to support and enhance basic public health capacity to meet community needs.

Create a meaningful system of accountability to assure achievement of basic capacity at the local level:

- to identify to whom the local entity is accountable and for what
- to define performance expectations for basic capacity standards
- revise the current triennial agency review:
  - to assure basic capacity being met at the local level
  - to provide information for performance improvement and outcomes
  - consider use of self and peer monitoring in addition to state monitoring
- consider state accreditation of local health departments

Strategy 4

Assure Basic Public Health Capacity at the State Level.

ACTION STEPS

Establish capacity standards for state governmental public health functions.

Evaluate the State Health Division using CDC's *State Public Health System Performance Assessment Instrument*.

Develop process that includes all state agencies that contribute to achieving public health capacity at the state level.

Create a stable funding method for state level basic public health capacity.

Create a meaningful system of accountability to assure achievement of basic capacity at the state level:

- to identify to whom the state is accountable and for what
- to define performance expectations for basic capacity standards

Strategy 5

Change from a Funding-Driven System to a Needs-Driven System.

ACTION STEPS

Explore ways to use currently received federal categorical funding to achieve new role.

Can the state decategorize current funding when it is passed onto local level?

Increase advocacy and negotiation efforts at the federal level to allow flexible funding to meet community needs.

Advocate for federal funding for basic public health capacity.

Explore use of private non-profit public health foundation to receive and distribute funds.

Explore having health care purchasers pay for basic public health services.

Strategy 6

Develop a Diverse Work Force to Achieve A New Role for Public Health.

ACTION STEPS

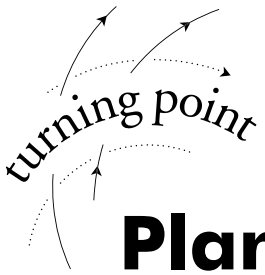
Implement a statewide training effort for the current public health work force focused on skills and education to address changing public health roles.

Encourage agencies to review current job descriptions and revise to reflect competencies and skills needed for the changed roles in public health.

Enhance linkages between the academic and practice settings.

Encourage joint recruitment of students into placements, internships and the public health work force.

Infuse public health principles into basic health profession education curricula.



Planning Change: the Turning Point Process

Turning Point was organized with a Steering Committee to guide the process and a series of Work Groups to address key questions. The Turning Point Coordinator, housed at the Oregon Health Division, was responsible for management of the project.

The Steering Committee met for the first time in July 1998. The Steering Committee adopted working definitions for the project, an organizational structure for itself and the Work groups, and a decision-making process. The Committee developed the charge or expectation for each Work Group based on the following:

- feedback received from presentations about Turning Point
- Steering Committee members' expectations for the project
- background information on identified issues

(See Appendix for Work Group Charges. Note: no written charge was developed for the Roles and Responsibilities Work Group.)

At least one member of the Steering Committee served as liaison to each work group. Reports from the Work Groups were submitted to the Steering Committee for review, discussion, and integration into the proposed plan.

The Turning Point grant identified five key objectives for the project:

- to define the *roles and responsibilities* of the public health system and the private provider system in the provision of individual health care and population-based health services

- to assess how public and private organizations can establish and improve *collaborative relationships* that promote our vision of public health in the 21st Century
- to examine the *organizational structure* of the state and local public health system based on redefined roles and responsibilities, identify strengths and weaknesses, and develop strategies to improve effectiveness
- to determine the *capacity* of the state and local public health system to support defined roles and responsibilities, identify deficiencies, and develop strategies to address those deficiencies
- to identify secure and adequate *funding* to implement and maintain the proposed changes

The following Work Groups were created to address each of the objectives:

Roles and Responsibilities
Partnership
Structure
Capacity
Funding

The Steering Committee identified key organizations or agencies to be invited to participate in each Work Group. The Coordinator was responsible for recruitment of recommended members. Additionally, an open invitation to participate was issued to Health Division employees, local health departments, Oregon Public Health Association members, and users of the Public Health Conference on First Class (the statewide electronic conferencing system). About 100 people participated in Work Groups. Although there was representation from a variety of

health-related agencies and organizations, the majority of participants were from either the Oregon Health Division or a local county health department. *(See Appendix for a list of Work Group participants.)*

Since many of the objectives referenced the defined roles and responsibilities, the Roles and Responsibilities Work Group started first, in December 1998. This group completed their work at the end of March 1999. The other Work Groups had staggered start-ups, from April through May 1999. All Work Groups had a deadline of September 15 1999, for completion of their final reports.

In addition to the Work Groups addressing the five objectives, the Steering Committee created a task group of Steering Committee members to focus on the social determinants of health. The task group was charged to develop a discussion paper for the Steering Committee on how Oregon Turning Point should address social determinants of health within its process.

CHALLENGES

Given the complexity of the issues identified in the charge, the time line was the major challenge for all Work Groups. Each Work Group spent a significant amount of time learning about the current public health system and the specific issues they were to address. This learning process included: understanding current public health funding and budgets; learning the current state organizational structure; and presentations on current information technology efforts and the current system of standards, assurances and annual plan between state and local health departments.

The interrelationships between all the Work Groups presented another challenge. Although the objectives and the charge were designed to separate issues, groups found it difficult to talk only about their issue focus. How can you talk about the structure of the system, without talking about what the system needs to do, and how will it be funded? The participants felt the ideal was to first determine what needs to be done, who should do it, what they need in order to do it, what structure is needed to accomplish it, and how it should be funded. They also knew that it was difficult not to be swayed by the current reality of: "Here's the money we have, what can we do with it?"

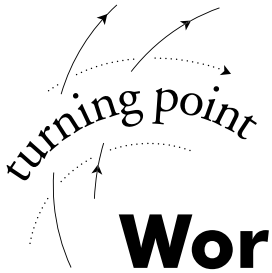
The Work Groups attempted to develop processes that allowed for the free flow of ideas, to "think outside the box." The time line did not allow adequate time for deliberation of all ideas and options before completing final reports.

OPPORTUNITIES

Although time for full deliberation on options was limited, the process did create opportunity for new ideas and learning to emerge. A frequent comment from participants was: "I had never thought of that" or " I had never known how that system worked." Many of the Work Group participants commented that they had joined a Work Group because they wanted to learn about the public health system in Oregon.

Work Groups were an opportunity for participants to meet public health colleagues from various program areas and communities. The relationship building that occurred in groups may be one of the most important outcomes of the process.

One of the major accomplishments of this planning phase has been the review and analysis of a variety of information related to issues defined in the objectives. Local data, national reports, journal articles and presentations were gathered and shared among Work Group members. The analysis sometimes generated more questions than answers, but it has helped to define key policy issues needing further discussion and decision.



Work Group Reports

This section presents results from each Work Group. The reports are reflective of each group, the complexity of their charge, the group process, and the membership. For some reports, the recommendations were very specific; in others, they were more general. Some of the assumptions made by Work Groups imply major changes from the current system and will require actions. The synthesis of these reports by the Steering Committee was the basis for the recommendations in the Action Plan.

The following outline was used for each Work Group report:

Charge to the Work Group
Process
Assumptions *(if any identified)*
Limitations *(if any identified)*
Recommendations

Roles and Responsibilities Work Group

CHARGE TO THE WORK GROUP

Objective from the grant:

To define the roles and responsibilities of the public health system and the private provider system in the provision of individual health care and population-based health services.

PROCESS

Using the public health goals identified in the *Public Health in America* (1994) statement, the group defined the system goal as: To create a public health system that has the ability, capacity, and competency to achieve the following goals:

- prevent epidemics and the spread of disease
- protect against environmental hazards
- prevent injuries
- promote and encourage healthy behaviors
- respond to disasters and assist communities in recovery
- assure the quality and accessibility of health services

For each of the six goals, the group identified elements and practices that were essential to achieving the goal. These were then categorized as:

- those elements and practices government public health must do
- those elements and practices where government shares responsibilities with others

- those elements and practices government public health should not do

Analysis of this categorization was used to develop recommendations.

ASSUMPTIONS

The health of a community is a shared responsibility of many entities, organizations, and interests, including: health service delivery organizations, public health agencies, other public and private entities, and the people. Within this context of shared responsibility, specific entities should identify and be held accountable for the actions they take to contribute toward the community's health.

The public health system should support the ability of communities to identify their priorities related to any of the public health goals and to create and implement community-specific strategies.

LIMITATIONS

Recommendations were based on input from a limited number of individuals, primarily from within government public health, although collectively they represented a wide range of experience both in and out of government.

Given the group time line and membership, the focus was on the public sector role. The group did not differentiate responsibilities between the different levels of public sector: federal, state, and local.

Although the Work Group did identify practices government

public health should not provide, these were not explored enough to make any conclusions.

There was difficulty in clearly defining, in commonly understood language, the functions for which the public sector has both shared responsibility and final authority. For example, in regulatory standard setting, government public health has final authority to set standards. There is agreement that this is not done in isolation and the development of standards is a shared responsibility involving a variety of perspectives. However, the final authority to set the standard rests with the public sector. Similarly, the activity of identifying gaps in services is a shared responsibility. However, in the absence of other entities carrying out their responsibility, the public sector takes a lead role to assure this activity is done.

RECOMMENDATIONS

Although some readers may want more specific recommendations, the Work Group concluded that roles and responsibilities for services or programs change over time as needs and resources change. Because the group's goal was to create recommendations that would last over time, they focused on a framework or set of principles that policy makers can use for decision making.

1. A role and responsibility that is solely government public health is assessment, surveillance and monitoring of the entire population.

2. Within shared responsibility, government public health must have the authority, responsibility, and accountability for certain practices. However, that should in no way relieve

non-government partners from carrying out their respective responsibilities in this shared arena.

3. Government public health has authority:
    - to set standards
    - to determine acceptable level of risk
    - to establish guidelines
    - to regulate (assure compliance with standards, guidelines)
    - to advocate and stimulate action to comply with standards (other than through enforcement)

4. Government public health has the responsibility:
    - to apply scientific and technical knowledge to public health problems
    - to define scope of health problems and identify needed response
    - to identify need for and create public policy
    - to set standards
    - to assure accurate, reliable, valid educational information to the public
    - to review research for accuracy, reliability, and validity
    - to develop education/information messages
    - to integrate new knowledge and practices
    - to define the economic impact of health problems and solutions

5. Government public health is accountable to assure the public health system:
    - stimulates partnerships to create and adopt appropriate public policy
    - identifies gaps in services, information, and research

- sets priorities based on science, economic impact, and social justice
- directs resources to community needs
- serves under-served communities
- stimulates the alignment of cultural and community norms, business practices, and political will

Capacity Work Group

CHARGE TO THE WORK GROUP

Objective from the grant:

To determine the capacity of the state and local public health system to support defined roles and responsibilities; identify deficiencies; and develop strategies to address those deficiencies.

Key issues to be considered:

- standards/accountability
- information/communication/technology
- work force
- infrastructure

PROCESS

Key questions that framed Capacity Work Group discussions:

- Can capacity be defined without having a clear vision/ mission of public health?
- Can standards be defined without defining the capacity needed?
- Should standards and/or capacity be defined first or is education needed, to be sure there is a vision of public health?
- Is it necessary to define capacity at all levels: national, state, local?
- Is the same capacity needed throughout Oregon?

ASSUMPTIONS

The definitions of capacity and infrastructure used by the Work Group assumed:

- *infrastructure* is the organization, the structure
- *capacity* is what the organization has the ability to do

Critical to the group's recommendation is the need to simultaneously create and implement standards for capacity and a system of accountability to assure standards are met. To do one without the other will set up the system for failure.

The concept of local public health is used without a preconceived notion of what is meant by local. "Local" may be a county, a region, a group of counties, etc. Local entities should define what is meant by "local."

A basic public health capacity needs to be in place at the local level. Specific programs and services are built upon that capacity.

There should be a minimum level of public health functions to which every Oregonian has access. There should be a minimum amount of funding that both state and county provide for public health services.

The Work Group affirms the assurance role, meaning public health does not have to provide all services and functions, but public health needs to assure that they happen.

LIMITATIONS

Given the timeline for the Work Group and the breadth of their charge, the group's focus was the development of capacity and standards at the local level. Analysis and recommendations specific to state-level capacity, information technology, and work force still need to be done.

More discussion is needed on: the role of a state advisory board, the relationship of a state board to community advisory boards, and a method of translating advice from Advisory Boards into action and policy.

RECOMMENDATIONS

1. The minimum basic capacity to be available at state level and at the local level throughout the state needs to be defined. Capacity needs to be based on a clear mission for public health in Oregon. The initial focus should be on defining capacity at the local level.

2. Basic capacity needed at the local level is:
    - ability to assure the performance of the statutorily-mandated public health functions, both regulatory and non-regulatory
    - functional knowledge of public health principles
    - ability to analyze data and transform data into information
    - ability to educate and inform the public
    - ability to understand public policy development and to participate effectively in public health policy development

- ability to conduct environmental scanning (monitoring the environment and cross-sectoral interactions to know what else is going on in your area)
- ability to participate in local community development
- ability to manage resources (fiscal, human, physical, information)
- administrative and managerial skills

3. Basic capacity needs to be funded through a stable source of both state and local funding, not through program specific administrative funding.

4. The local entity needs to be held accountable to achieve basic capacity.

   A system of accountability needs:

   - to answer the question: To whom is the local entity accountable and for what?
   - to understand system motivators and use negative motivators sparingly
   - to link performance measurement with performance improvement
   - to define performance expectations for basic capacity standards

5. Systems need to be in place to help local entities build the capacity necessary to achieve standards, e.g., the state provides technical assistance to the local level.

6. Whoever is providing the local level function or service should be accountable by the same standards as the public health entity.

7. Each local entity should have a Community Advisory Board:
    - to reflect community needs and issues
    - to provide advocacy
    - to be a forum for discussion among community public health partners
    - to advise on priorities and use of resources

Structure Work Group

CHARGE TO THE WORK GROUP

Objective from the grant:

To examine the organizational structure of the state and local public health system based on redefined roles and responsibilities; identify strengths and weaknesses; and develop strategies to improve effectiveness.

Specific questions identified by the Steering Committee:

- How should state-level, health-related agencies be organized to be most effective?
- Should there be a designated local public health authority? Who should be the local public health authority? Should there be a single option for the state? Can there be regional services, health districts, state-based services?
- What should be the relationship between state agencies, local government agencies, and community-based organizations for service delivery, planning, policy development, funding?

PROCESS

To better understand the current system, the Work Group used the six public health goals from the *Public Health in America* (1994) statement and created a matrix of current state and local organizations that have responsibility to address the goals. The matrix identified responsibilities for: service delivery, planning and

policy, or regulation by type of population (general population, focused population, client population).

Based on analysis of the matrix, the Roles and Responsibilities report, and group discussion, the following were identified as being critical to consideration of the public health system of the future:

- should be community- and population-based
- should use minimum standards modified to meet local needs, based on population, risk, geography, etc.
- increase ability to do assessment and epidemiology
- allows the public health leader the power and authority to take risks necessary to present the public health messages that people don't want to hear; to have the ability to get the Governor's or County Commissioner's attention on an issue
- services and functions that can be done at the local level should be done locally
- flexibility to move funding at state and local level to identified public health issues

ASSUMPTIONS

Policy makers need to be clear on what is the essence of public health before they can determine what the structure is.

The key to any structure is adequate funding. There needs to be a mix of funding (local, state, and federal) that is reflective of what is necessary to meet needs.

There is a need to include consumer/customer input in determining where they want to receive services. Consumer/customer is used broadly to reflect all customers of public health and includes members of the public, licensees, private health providers, etc. Consumer input is especially critical in the decision making process to determine what is state and what is local responsibility.

The ability to improve the health of a community or the state will be dependent upon the strength of all community systems. Public health cannot accomplish the goals alone and continually has to look at ways to strengthen other systems in the community.

Recommendations may require statute or administrative rule change for implementation.

LIMITATIONS

The majority of the discussion related to the first question, "How should state-level health-related agencies be organized to be most effective?", and focused on the issue of: Should there be a governor's cabinet-level department of health at the state. The Work Group did not come to agreement but did define criteria to consider and the benefits and disadvantages.

The group did not directly discuss the issue of local public health authority or what should be the relationship between state agencies, local government agencies, and community-based organizations.

A key question underlying the discussions about state and local structure is deciding what should be a state function and what should be a local function. The group did not attempt to determine

this, but did outline questions to consider when deciding whether an activity should be a state or local responsibility:

- Is there need for uniformity of activity across the state?
- Are low-incidence events involved, so that maintaining capacity at the local level is not cost effective?
- Is there an issue of economies of scale that would create more efficiency at a centralized level?
- To be effective, is the activity dependent upon having local control?
- How tolerant can we be of local diversity?
- How does the funding need to occur? If there are some areas that want to do more, but do not have local funds, does the state assure the funds?
- What if a local entity lacks the ability financially or politically to accomplish the task? Is the fall back to have the state do it, or do you give resources so it can be done on the local level if you feel strongly that it should be done at that level?
- Is there value in having visibility or a presence at the local level? At the state level?

The Work Group did not come to a conclusion on how to fund a standard of public health services. Options ranged from requiring the standard funded by state funds, to having a mix of county and state funds, to having a mix of whatever resources could be found. The group did agree that a method of equitable funding needs to be found.

RECOMMENDATIONS

1. There should be a standard of public health services that every citizen in Oregon has the right to expect, no matter where they live.

2. The primary need is to increase the influence of public health at both the state and local level. Any consideration of structure needs to be a means of increasing influence. The initial emphasis should be at the state level. Two means to accomplish this include:

   - creating a cabinet-level department of health
   - having an active board of health with broad-sector representation.

   Analysis and discussion on these options should continue. Critical to the decision is the need for a public health system that "allows the public health leader the authority to take actions necessary to address critical public health issues."

3. Local public health authority should not assume county-level jurisdiction as the only level for being local. The definition of local jurisdiction can be based on geography, population, common needs, etc. A variety of options should be allowed and regionalization should be encouraged.

4. Any structure developed needs to be mindful of and develop approaches to address issues of equity for under-served populations.

Funding Work Group

CHARGE TO THE WORK GROUP

Objective from the grant:

To identify secure and adequate funding to implement and maintain the proposed changes.

Specific questions identified by the Steering Committee:

- How do we prioritize and create incentives for providing prevention services?
- How do we create incentives for practicing healthy behaviors?
- How should we finance prevention at the individual service level?
- How should we finance prevention at the population or community level?
- How do we use incentives to support desired health policy outcomes?

PROCESS

The Work Group reviewed a number of budget- and funding-related documents, as well as several reports on public health funding. From this review, four key questions and issues were identified:

- *What are public health priorities?*

  The general image of public health seems to be: Anything related to health, public health should be doing. It is a negative

image. If you say everything is important, the implication is that nothing is really important. Priorities seem to be decided by what there is money for, meaning, priorities are set by the funder.

Is current public health spending truly a reflection of the priorities and needs of Oregonians?

- *Is public health funding intended for functions, roles, or programs?*

  Part of the problem in not being able to easily define public health is the difficulty in making the distinction between public health functions, like surveillance or monitoring and individual programs. Is public health family planning clinics or monitoring and assessment? How can the system have the capacity to address issues when there are population shifts and different health problems not covered in one of the categorical funding streams?

- *The message*

  Public health is issuing different messages at different times, depending upon different grants and programs. There is no overarching leadership giving a consistent message of: "This is really important, so it should be a priority at the national level, at the state level, etc."

- *Source of funds*

  If funding sources are an indication of who is in charge, public health in Oregon is a federal program. This suggests that the federal level sets the priorities for what programs are funded in Oregon. Is this acceptable? Is there congruence between federal and state priorities?

  Should there be a principle about minimum county support? About minimum state support?

RECOMMENDATIONS

After defining the issues, the group determined that trying "to identify secure and adequate funding" was not an objective they could meet, nor could they answer the specific questions posed by the Steering Committee. The group agreed the focus needs to be on how to make the case for public health funding, keeping in mind economic impacts, the political arena, and the populations served by public health.

1. A major emphasis needs to be put on developing strategies to "make the case for public health funding."

   A major communication strategy should address:

   - What are public health priorities?
   - How does public health work?
   - What has public health accomplished?
   - What happens when there isn't a public health system?

2. Fundamental to any communication strategy is the need for the primary message to be consistent and sustained over time at all levels. For public health, this means the state and local level need to be committed to one another and to obtaining the resources for one another to do their jobs. For public health to be effective, there needs to be effective leadership at both the state and local level.

3. A diverse group of persons making the case for public health is needed, not just public health professionals. Public health needs to build relationships and use them to help make the case for public health. Having people make the case for public health from a variety of perspectives enhances credibility.

Partnership Work Group

CHARGE TO THE WORK GROUP

Objective from the grant:

To assess how public and private organizations can establish and improve collaborative relationships that promote our vision of public health in the 21st Century.

Specific questions identified by the Steering Committee:

- Can recommendations from the Roles and Responsibilities Work Group for achieving shared responsibility and shared accountability be implemented?
- What are incentives for partnerships and how are they enhanced?
- What are barriers to partnerships and how are they minimized?

PROCESS

The Work Group chose to reword the objective to become: "To assess how public and private organizations can establish and improve relationships that promote public health in the 21st Century."

Reasons for the proposed wording change include:

- The word "collaborative" has various meanings and connotations that are not commonly shared.

- There is a range of organizational relationships that may be effective, and collaboration is not always the end point.
- Using the possessive phrase "our vision" implies there is one vision of public health. It is not inclusive of diverse perspectives and the evolving direction of public health created through relationships.

The Work Group chose to use the word "relationship" in place of "partnership" or "collaboration" throughout their report.

Answers to questions from the Steering Committee:

- *Can recommendations from the Roles and Responsibilities Work Group for achieving shared responsibility and shared accountability be implemented? Before shared responsibility or accountability can be achieved, numerous other steps are necessary.*

  A critical first step is to address the question: "Has public health made a compelling case for public and private organizations to work together?" The public and private organizations that public health needs "to make the case for"will vary by community and concern. Historically, public health has not made good linkages with the business community, private sector, or environmental advocacy groups. To make a compelling case for anyone, the self interests of the group or individual need to considered. The case needs to be put into the language and context of the people with whom you're trying to be in relationship. A primary task for any relationship is the development of shared language and concepts which will lead to a shared vision.

- *What are incentives for relationships and how are they enhanced?*
  - crisis or urgent issue
  - belief that working together can achieve benefits that are important to the players, and which none can achieve alone
  - money and/or funding
- *What are barriers to relationships and how are they minimized?*

Barriers

- categorical funding focused on single issues
- An organization's history of relationships for example, public health is perceived as working independently both internally and externally and not being collaborative, not "walking the talk."
- using language that is not commonly understood by all
- Organizations can have multiple types of relationships with the same organization; for example, local health departments have a contractual relationship with the Health Division for some programs, but for other programs they may be in a collaborative relationship. These have different responsibilities and expectations, and individuals need to be clear what type of relationship it is.

Ways to minimize

- need time to develop trust and effective relationships
- acknowledgment that relationship building is a primary task and role; and relationship building is complex, takes time to develop and requires skills

RECOMMENDATIONS

1. Create an ongoing statewide Oregon Health Alliance focused on population health.

   Alliance members, of broad demographic and geographic representation, should be either persons with personal influence or should represent groups with the widest influence possible in the state. Members should be at the CEO or agency administrator level. The size of the Alliance should be 11-13 members, knowing there will be task groups for specific issues that will involve a broader scope of people.

   Goals for the Alliance:

   - to create ongoing relationships on which to build for future issues
   - to set a vision based on analysis and research of population health issues in Oregon
   - to advocate for solutions

   Primary issue emphasis should be on underlying conditions that impact the health of Oregonians.

   The State Health Division should take the lead in convening the Alliance and in supporting it. Additional resources and staff should be shared among the members of the Alliance. The Alliance would not be a Governor-appointed advisory body, but would be self-appointed and self-governed, charged to chart its own mission to improve the public's health.

Social Determinants of Health Task Group

CHARGE TO THE TASK GROUP

Develop a discussion paper for the Steering Committee on how Oregon Turning Point should address social determinants of health within its process.

PROCESS

The Work Group defined social determinants as those sociologic, economic and political factors that directly influence ill health, morbidity, and premature mortality within and across populations. These factors include poverty, institutional racism and unequal access to quality education, adequate housing, and jobs that provide a living wage. The social determinants' perspective highlights the role of social and political choices independent of personal behavior.

The group started with a literature review, including a summary of work published on the social determinants of health as well as historical review of definitions of public health viewed through both medical and social science perspectives. The group then reviewed the *Turning Point: Collaborating for a New Century in Public Health Premise Paper*.

RECOMMENDATIONS

From the reviews the group developed recommendations based on the link between their understanding of the influence social

determinants have on health of populations with the opportunity presented in the Turning Point initiative to reinvigorate and refocus the mission of and responsibility for public health. The group concluded that the strategies of the public health improvement plan must include the following roles for a renewed and refocused public health system:

- public health as advocacy agent
- public health as voice of the community
- public health as convener
- public health as assessor and assurer of community health

Questions the Steering Committee should ask as Turning Point moves into the implementation phase:

1. Has the Steering Committee proposed an inclusive approach to engage those historically excluded from participating in planning and decision making?

2. What are the new partnerships being proposed? Do they engage different and non-traditional public health sectors and institutional players? Do the action steps include the active involvement of non-governmental institutions?

3. Has the Steering Committee provided tangible examples of how new, non-traditional collaborations can be made real?

4. Has the Steering Committee cited or otherwise made reference to the social determinants of health as targets of action?

5. Does the Public Health Improvement Plan include concrete recommendations for achieving community participation in developing policies for the new public health agenda?

6. Has the Steering Committee suggested a new model for community participation? Have they offered up innovative ways to fund public health partnerships and locally identified community projects?

7. Have the Work Groups included social justice indicators in the list of core public health functions?

Appendix

Steering Committee Charges to the Work Groups

CHARGE TO CAPACITY WORK GROUP

Objective and key considerations from the grant:

To determine the capacity of state and local public health system to support defined roles and responsibilities, identify deficiencies and develop strategies to address those deficiencies.

Key considerations: workforce needs, education and training needs, the role of academic partners, the ability to track key community health indicators and coordination of data resources between public and private systems.

Key issues to be considered:

Standards/Accountability:

- What is minimum capacity needed to do core functions at local level? State level?
- How to assure minimum capacity?
- How to assure quality?
- Who assesses effectiveness?
- Is there use of public health performance measures?
- Should there be a certification process for local health departments?

Information/communication/technology

- What data needs to be collected, who should collect, who should analyze?

- Is there the ability to share data that is usable and timely?
- Is there a system for sharing and collecting data across private and public agencies?
- Are there information systems (for community, for agencies)?
- Is data available at community level?

Work force

- needed skills of current and future public health work force
- diversity of the public health work force
- diversity of students entering public health education, undergraduate and graduate
- distribution of skilled public health work force throughout state rural and urban
- salary differences across state
- availability of public health leadership throughout state
- role of academic partners in preparing/assuring adequate public health work force

"Infrastructure"

- What are the minimum operational supports needed; what support services need to be in place?
- What capital support (such as space, facilities) is necessary; are there minimum standards?

Steering Committee liaisons:

Marina Stansell, *Clackamas County Health Department*
Pamela Hanes, *Oregon Health Policy Institute*

CHARGE TO FUNDING WORK GROUP

Objective and key considerations from the grant:

To identify secure and adequate funding to implement and maintain the proposed changes.

Key considerations: Identify full range of funding options, considering their strengths & weaknesses.

Key issues to be considered:

Funding of system questions/issues to consider:

- What should be responsibility of federal, state, local governments?
- What should be responsibility of health care provider, business, individuals?
- What is impact of categorical/programmatic funds on funding a system'
- Who funds for population services' or community oriented services?
- Use of funding focused on individual services (Medicaid, Medicare, private insurance)
  - for prevention services
  - for population services
- How can funding be synergistic' or pooled; frequently all systems trying to address issue from their perspective

Funding as policy questions/issues to consider:

- Consider the variety of entities that impact health care/ health system funding (Medicaid, Medicare, liability insurance,

worker's compensation, employers, purchasers, employees, unions).

- How can/should public health influence the payers of health care and how can payers influence public health?
- How can/should the system use funding to influence health policy, to influence health status outcomes?
- Who determines what to fund, cost effectiveness, accountability?
- How are priorities determined?

Specific questions to be answered:

- How do we prioritize and create incentives for providing prevention services?
- How do we create incentives for practicing healthy behaviors?
- How should we finance prevention at individual service level?
- How should we finance prevention at population or community level?
- How do we use incentives to support desired health policy outcomes?

Steering Committee liaison:

Joel Young

CHARGE TO THE PARTNERSHIP WORK GROUP

Objective and key considerations from the grant:

To assess how public and private organizations can establish and improve collaborative relationships that promote our vision of public health in the 21st Century.

Key issues to be considered:

Focus on how to facilitate partnerships to improve the public's health:

- framework needed to support partnerships

Who are the partners and why would they want to be involved?

- What process will bring and retain stakeholders?
- Who is welcome?
- Are all participants coequal?

Expectations/outcomes of partnerships need to be defined:

- What are expected outcomes?
- Are partnerships the key to addressing social determinants of health?

Specific questions to be answered:

- Can recommendations from Roles and Responsibilities Work Group for achieving shared responsibility and shared accountability be implemented?
- What are incentives for partnerships and how to enhance them?
- What are barriers to partnerships and how to minimize them?

Steering Committee Liaisons:

Ederlinda Ortiz, *Oregon Council for Hispanic Advancement*
Paige Sipes-Metzler, *Regence BlueCross BlueShield*

CHARGE TO STRUCTURE WORK GROUP

Objective and key considerations from the grant:

To examine the organizational structure of the state and local public health system based on redefined roles and responsibilities, identify strengths and weaknesses and develop strategies to improve effectiveness.

Key considerations: roles and responsibilities of local, state, and federal governments in supporting the public health system; the relationship between public health and mental health, substance abuse, and environmental programs; the shared responsibilities of public health agencies and the private and private non-profit community.

Key issues to be considered:

Relationships among state agencies:

- in planning and service delivery (Oregon Health Division, Mental Health, Office of Alcohol and Drug Services)
- in providing environmental health services (Oregon Health Division, Department of Environmental Quality and Department of Agriculture)
- in health policy, planning, and regulation (Oregon Health Division, Office of Medical Assistance Programs, Office of Health Plan Policy and Research, Health Insurance Commissioner Office, OR- OSHA, DEQ)

Organization of services at local level:

- Diversity of local configuration of health agencies, how does this relate to state organizational structure.

- Is county wide system the best way to organize? Is state/ local (county) way to be organized? What about regional structures? Health districts?
- Should public health be organized at smaller units-neighborhood level?
- Can there be different organizational structures of public health-urban and rural

Other issues:

- What is relationship/coordination among state and local level health related Advisory Boards, Commissions, Advisory Committees, etc. Who appoints, what responsibility do they have, who do they report to, level of support, etc.
- What is local public health authority'? How do you become a local public health authority? Could a tribe become local public health authority? Who gets access to funding, does requiring public health funds to go to county government/local health department meet community needs? How do community based organizations fit into funding? What if local public health authority refuses funding?
- What should be relationship between state system and local system? Who determines standards, accountability, performance measures?
- How to balance desire/need for level of standardization and accountability across state and system with the importance of local decision making?

- Who is accountable to meet community needs? When funding or program requirements do not meet community needs who takes responsibility to make changes to meet community needs?

Specific questions to be answered:

- How should state level health related agencies be organized to be most effective?
- Should there be a designated local public health authority? Who should be the local public health authority? Should there be a single option for the state? Can there be regional services, health districts, state based services?
- What should be the relationship between state agencies, local government agencies and community based organizations-for service delivery, planning, policy development, funding?

Steering Committee liaisons:

Bob DiPrete, *Office of Health Plan Policy and Research*
Rick Gates, *DEQ*
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Social Determinants of Health

Thomas Aschenbrener
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Vision:

Healthy People in Healthy Communities

Mission:

Promote Physical and Mental Health
and Prevent Disease, Injury, and Disability

Public Health

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

Essential Public Health Services

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems

Adopted: *Fall 1994, Source:*
Public Health Functions Steering Committee, Members (July 1995)

http:/web.health.gov/phfunctions/public.htm