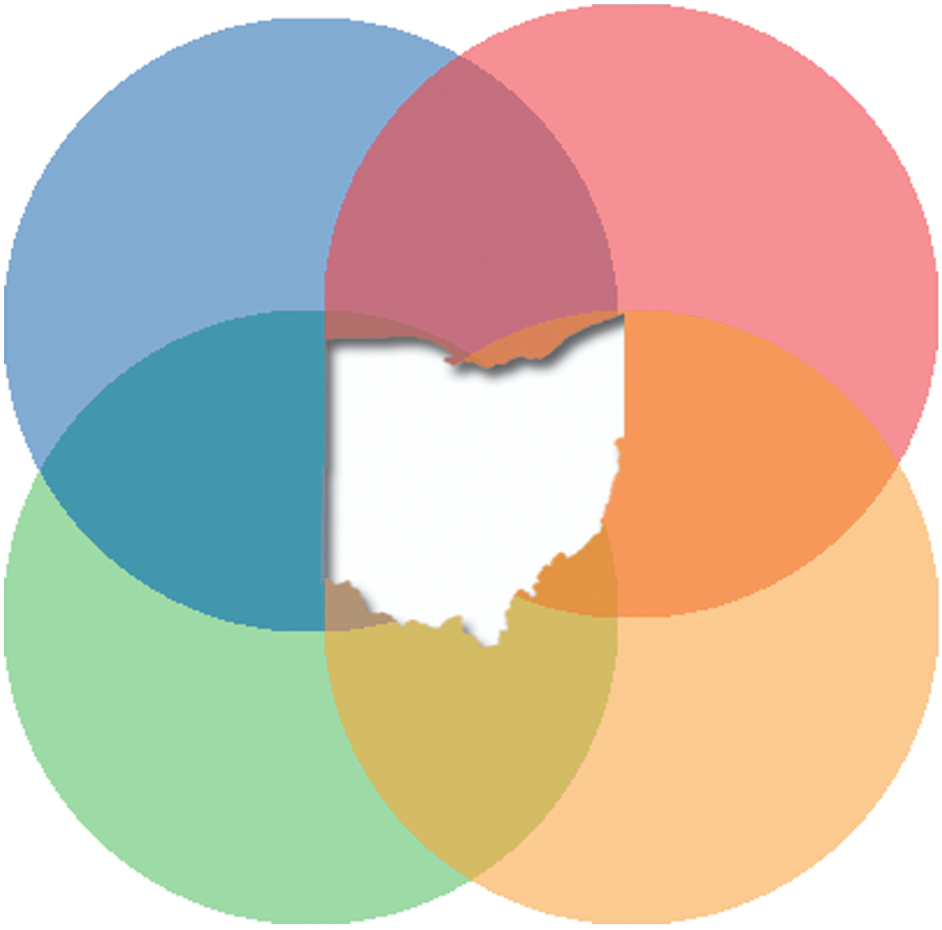
AOHC
Association of Ohio Health Commissioners, Inc.

Public Health Futures

Considerations for a New Framework for Local Public Health in Ohio

Final Report



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Prepared by the Health Policy Institute of Ohio
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Patrick Lanahan, J.D., of Health & Human Services Consulting, LLC and HealthCare Perspectives, LLC, served as a consultant to the Health Policy Institute of Ohio (HPIO) throughout this project. Patrick contributed critical facilitation and consensus-building skills and content expertise, conducted and analyzed the key-informant interviews, and assisted with project management and preparation of the report.

Amy Bush Stevens, MSW, MPH of HPIO served as the Project Manager, assisted with facilitation, and prepared this report.

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The Public Health Futures report is submitted by an ad hoc steering committee appointed by the Board of Directors of the Association of Ohio Health Commissioners. The representative steering committee was established to consider and make recommendations from the perspective of local Ohio health commissioners on the functions, fiscal requirements and organization of local health districts in Ohio. We were supported in this process by a consulting team from the Health Policy Institute of Ohio.

From the onset, the Steering Committee acted to facilitate and guide the collection and interpretation of data, information and opinions on the current status and potential for local health districts in Ohio. This information was gathered through a survey, an all-member meeting and regional dialogues to assure input from all corners of our local health district leadership community. Although the Steering Committee's mark is patently evident in the report, we trust the final product represents the measured consensus of all our membership.

The Report provides a summary of the current state of local public health in Ohio and some recommendations for the future. It documents a remarkable variety of activities local public health agencies perform at the local level with very limited resources. Unfortunately, the Report also illuminates significant disparities in funding and service capacity between health districts in Ohio and in many ways reflects an unsustainable system in decline.

The Report is not a road map nor is it prescriptive. The findings and recommendations should however help steer a continued discourse on strengthening our agencies' capacity to effect and improve the health status of all Ohioans. The discussion will need to be expanded to include the broader public health system including; the Ohio Department of Health and other state agencies, our sister public health associations, hospital and health care systems, elected officials and others. The Report provides a foundation based on sound research for transitioning local public health to an appropriately structured and well financed system positioned to meet core public health responsibilities at the local level.

We wish to thank the Health Policy Institute of Ohio, particularly the project support team of Patrick Lanahan, Amy Bush Stevens and Amy Rohling McGee. They were fast learners of the complex world of local public health, offered keen insight, patient facilitation and exceeded our expectations. Thanks to the AOHC leaderships whose terms this project overlapped: Wally Burden boldly launched the project and Jim Adams continued strong support through its completion; their timely guidance and statesmanship assured the project's success. Our appreciation also is extended to the generous support of the project funders. Thanks also to the Steering Committee members for their commitment and fortitude; it was a true privilege working with you. And finally, thank you to the AOHC membership for their contribution, utmost dedication to their profession and their vision for the future.

Respectfully,

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Executive Summary

Public Health Futures

Considerations for a New Framework for Local Public Health in Ohio

Purpose

Recognizing the need to critically assess the feasibility of sustaining 125 local health departments (LHDs) and to develop proactively new approaches to improving effectiveness and efficiency, the Association of Ohio Health Commissioners (AOHC) established the Public Health Futures Project in 2011 to explore new ways to structure and fund local public health. The project has 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.

This process prompted members to clarify the role of local public health in Ohio by defining a Minimum Package of Local Public Health Services and to assert a vision that upholds the values of community engagement, quality, accountability, efficiency, and public health science. In order to attain this vision, Ohio's local public health infrastructure will need to be strengthened. This report presents a decision framework that will help LHDs to explore the use of cross-jurisdictional sharing and voluntary consolidation as tools to bolster foundational capacities (such as quality improvement, information management, and policy development) and to assure basic public health protections in all Ohio communities. The report also provides a set of recommendations designed to address the complex financial and political challenges facing LHDs in order to better position local public health as a vital leader in improving Ohio's health outcomes.

Objectives

The Public Health Futures Project Steering Committee, made up of 17 AOHC members from a wide variety of LHDs (urban and rural, city and county departments, and all regions of the state), identified the following objectives for the project:

1. Describe the current status of Ohio's LHDs, including structure, governance, funding, and current collaboration.
2. Identify rules, policies, and standards that may impact the future of local public health (including statutory mandates, national public health accreditation standards, and policy changes affecting health care, such as the Affordable Care Act).
3. Identify stakeholder interests and concerns and develop a set of criteria for assessing new models of collaboration or consolidation.
4. Identify and assess potential models of collaboration and consolidation and the factors that would contribute to successful implementation of those models.
5. Foster consensus among LHDs to prioritize a small number of preferred frameworks.
6. Create a decision-making guide for LHDs to use when moving forward with a new framework.

Methods

AOHC contracted with the Health Policy Institute of Ohio (HPIO) to conduct research, facilitate a consensus-building process among members, and prepare this report. HPIO and the Steering Committee used the following methods to meet the project objectives:

Current Status of Ohio's Local Health Departments

- Review of descriptive information about Ohio LHDs
- State-level regulatory scan and review of relevant standards and policies (e.g., Public Health Accreditation Board standards, Affordable Care Act, State Health Improvement Plan)
- Online survey of AOHC members regarding current collaboration

Stakeholder Considerations, Lessons Learned, and Guiding Concepts

- Key-informant interviews with Steering Committee members and state-level policymakers
- Targeted review of research literature related to public health systems, local government reform, and models for collaboration and consolidation

Consensus and Recommendations

- Series of consensus-building meetings: AOHC all-members meeting in March 2012, five regional district meetings in April 2012, and Steering Committee meetings in May and June 2012
- Steering Committee development and approval of recommendations in June 2012

Current status of Ohio's local health departments

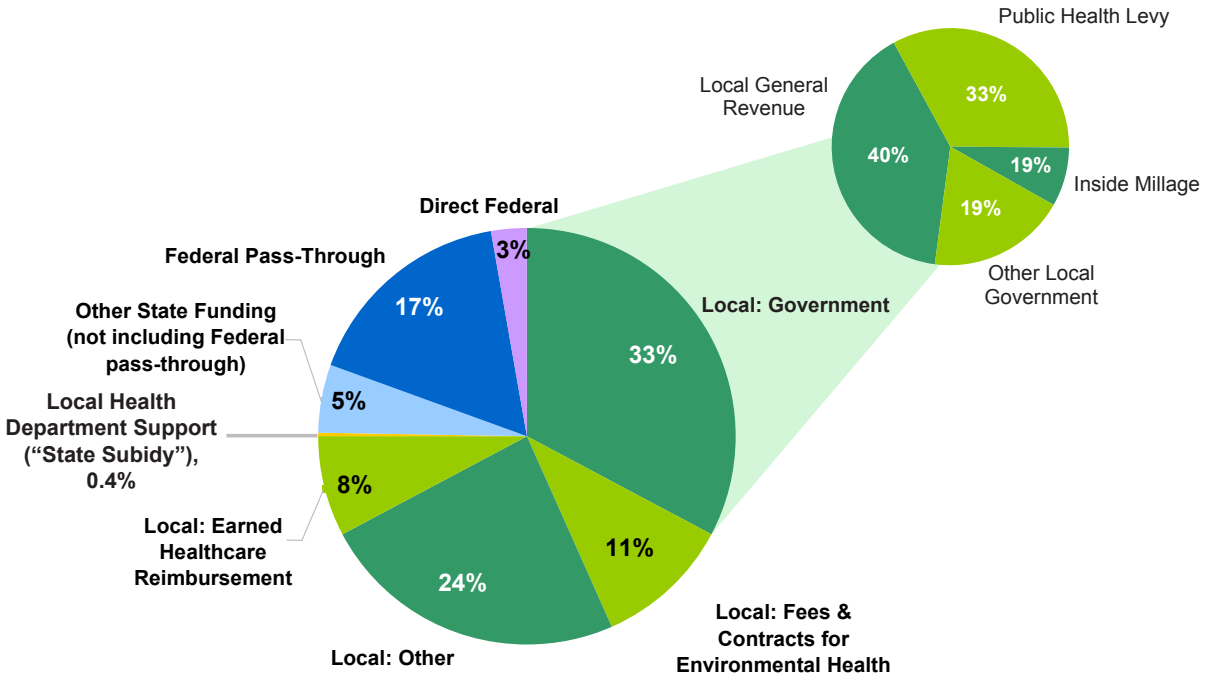
Structure and governance

- Public health is governed and administered at the local level in Ohio. The system is decentralized, resulting in significant variability across LHDs in terms of population size served, per-capita expenditures, and capacity.
- Ohio law allows for three different types of health districts—city, general, and combined. Currently, about three-quarters of Ohio LHDs (71%) are "general" or "combined" districts that encompass all or part of a county. The remaining 29% are comprised of a single city. Ohio does not currently have any LHDs that encompass two or more counties.
- Three-quarters of Ohio counties have only one LHD, while the remaining quarter of counties have up to five LHDs operating within their borders.
- Ohio is home to many LHDs that serve small population sizes. More than half of Ohio LHDs serve fewer than 50,000 residents.

Funding

- LHDs face many resource constraints. Relative to other states, Ohio ranks quite low in terms of median annual per capita LHD expenditures (33rd) and state public health expenditures (41st), and in obtaining federal funding for public health (50th for CDC funding, 39th for HRSA funding).
- Local funding (fees, levy funds, and other local government sources) provides about three-quarters of LHD revenue overall, although these local sources vary widely by jurisdiction. For example, only 39% of LHDs reported local public health levy revenue in 2010. Local funding can also be inconsistent over time because it is vulnerable to local political conditions.
- State-generated funding provides a relatively small portion of LHD revenue. Local Health Department Support ("state subsidy") provided less than 1% of LHD revenue in 2010 and other state sources provided 5%.
- Combining federal pass-through funds, state grants and contracts, and the state subsidy, 22% of LHD revenue flows through the state. However, only

2010 LHD Revenue, by category (total: $564,835,411)



Source: 2010 Annual Financial Report, provided by ODH March 2012

one-quarter of that state-controlled portion is generated from state coffers, while three-quarters of the funds come from federal sources.

- Funding for local public health is extremely complex and fragmented. There appears to be considerable misalignment between current funding streams and the services that LHDs are mandated and expected to provide.

Current collaboration and future opportunities

- Since 1919 when the current system was established, the number of functioning LHDs has decreased from 180 to 125 through voluntary unions (city-county mergers) and contract arrangements. Contract arrangements have been far more common than full consolidations.
- LHDs have engaged increasingly in a range of collaborative arrangements over the past ten years, including "pooling" funds for shared services and contracts between LHDs to provide services.
- According to a 2012 survey of AOHC members, the vast majority of LHDs are currently sharing some services with other jurisdictions, including "pooled funding" and contracts with other LHDs. The types of services that are shared the most are epidemiology, HIV testing, lead assessment, and STD testing and treatment.
- Administrative functions (information technology, human resources, purchasing) and expertise (subject matter experts, leadership and policy development, and accreditation and quality improvement guidance) appear to be the areas in which health commissioners are most interested in sharing services in the future. Respondents reported little current sharing in these areas, possibly because there have been few grant-funded incentives to collaborate in these areas.

Economic and policy environment

- In the past few years LHDs report experiencing widespread job losses and program cuts. In 2009, 72% of LHDs reported loss of staff and 85% reported cuts to at least one programmatic area.
- Like all local government agencies in Ohio, LHDs are grappling with the challenges of "leaner government." Furthermore, the Ohio Department of Health has experienced a reduction in staff and can no longer provide as many functions for LHDs as it did in the past.
- Accreditation for state and local health departments is a new process launched in 2011. Although accreditation is voluntary, Ohio LHDs are now required to conduct annual "improvement standard" self-assessments using the Public Health Accreditation Board measures. The accreditation standards delineate the essential functions of public health, providing a new tool for assessing LHD capacity and performance. They also present a new opportunity to re-examine the relationship between public health governance structures and financing and contemporary agreed-up standards of essential public health services.
- The Patient Protection and Affordable Care Act of 2010 (ACA) has several potential implications for public health. Most significantly, public health's traditional role in assuring access to care will be affected by decreases in the number of uninsured Ohioans and changes to the health care delivery system. The ACA presents challenges and opportunities for LHDs and will require careful coordination with the broader health care system.

Stakeholder considerations

HPIO conducted 25 key-informant interviews in January and February 2012. The key-informants represented two distinct groups:

- *Local Public Health Group* (n=18): Public Health Futures Steering Committee members and AOHC staff (Executive Director).
- *Statewide Policy Group* (n=7): Senior officials from the Ohio Department of Health and the Governor's Office of Health Transformation; experts on "leaner government" and shared services; and representatives from academic public health.

The following themes emerged as strong messages and areas of consensus across both groups of stakeholders:

- Nearly every key informant believes that the *time is right* for a systematic approach to develop a model for the future. Almost all felt that figuring this out may be difficult, but is necessary.
- There is broad agreement that the new model should define a *minimum standard of health protection*. Most informants believe that the new model needs to address ways of organizing, funding, and providing capacity to support such a standard as a high priority.
- Everyone in the Local Public Health group reported that they are *already doing a great deal of collaborating* within the public health system. All but a few view this positively and most are motivated to do more for reasons other than pure necessity. Only a few were negative or skeptical about collaboration in general; these respondents tended to view resource sharing as a necessity related to factors beyond their control.
- *Motivations are high and interest in new approaches is pervasive* among representatives of nearly all types of

jurisdictions and sizes. Informants pointed to many examples of success in their current collaboration, along with acknowledging that there are probably more efficient ways to organize and do things together.
- Nearly everyone prefers that *next steps taken should be initiated from within the public health system*, rather than being imposed externally.
- *Deciding what are truly local needs* was a common theme, as is figuring out how to address these needs within a new model.
- Most interviewees urged that the future model should *prioritize services and activities that public health can do and others systems cannot or do not do*.
- Most believe that public health should be *more connected with and do more partnering with the broader health care system*.

Lessons learned

Results of an AOHC survey on LHD collaboration and a review of the research literature on shared government services identified the following factors associated with successful collaboration:
- Mutual trust and a history of collaboration
- Strong commitment from top-level leadership
- Partnerships between communities with similar demographics and/or ability to customize to local needs for each community; equity for all partners, while being sensitive to unique local needs
- Success at increasing efficiency and/or cost reductions
- Ability to maintain services that are needed and expected by the community but are no longer feasible for one LHD to provide.
- Achieving clarity of purpose about the reasons for engaging in collaboration
- Weighing the costs of collaboration, including transactional costs, and anticipating systems and business process barriers

Consensus and recommendations

The purpose of the Public Health Futures project is to develop a proposed model for Ohio's local governmental public health system that includes a mechanism for governance and sustainable financing, considers cross jurisdictional sharing and/or regionalization, enhances quality and assures value. While *cross jurisdictional sharing and/or regionalization* were initially the primary focus of the project, it became clear during the consensus-building process that *enhancing quality and assuring value* were equally—if not more—important. Recognizing that mechanisms for governance and financing are means not ends, AOHC members voiced the need to first describe a vision for what local public health should be doing, and then to develop a framework for *how* to fulfill that vision. To that end, the Steering Committee developed the following vision statement.

Vision for the Future of Local Public Health in Ohio

The Association of Ohio Health Commissioners (AOHC) envisions a future where all Ohioans are assured basic public health protections, regardless of where they live, and where local public health continues to be a vital leader in improving Ohio's health outcomes. We envision a network of local health departments that:
- Are rooted in strong engagement with local communities;
- Are supported by adequate resources and capabilities that align with community need and public health science; and
- Deliver high quality services, demonstrate accountability and outcomes, and maximize efficiency.

Rationale for the recommendations

The Steering Committee's recommendations aim to address the following challenges and opportunities related to the *role of public health*:

- Maintain the communicable disease prevention and environmental health protections that have historically been the core function of local public health.
- Respond to increasing recognition that public health has a strong role to play in preventing chronic disease and that the population health approach is critical to improving health outcomes.
- Re-balance public health's role in providing clinical services within the new healthcare landscape, and modernize payment and quality systems when medical services and care coordination are provided.
- Ensure that local public health is positioned to help achieve the outcomes prioritized in the State Health Improvement Plan and Local Community Health Improvement Plans in order to improve the overall health of Ohioans.

These recommendations also aim to address the following *financial and structural* challenges and opportunities:

- Strike a balance between local control and statewide standardization. Support continued local community engagement and preserve the amount of funding generated from local sources, while at the same time improving the consistency of performance, quality, and outcomes for all LHDs. Home rule and the heavy reliance on local funding (76% of all LHD revenue) help LHDs to be strongly rooted in their local communities, although this local structure also presents potential barriers to formal cross-jurisdictional sharing and consolidation (e.g., city/county officials' concerns about resource allocation, lack of parity in fee structures, wide variability in LHD per-capita expenditures and services provided, etc.).
- Use cross-jurisdictional sharing and consolidation as tools for building LHD capacity and improving performance. Transitions to cross-jurisdictional sharing and consolidation must balance local choice with a shift toward more formal and efficient models of collaboration, and must critically assess the feasibility of sustaining 125 LHDs, more than half of which serve fewer than 50,000 residents.
- Build political support for increasing—or at least maintaining—funding for local public health.
- Identify initial steps to address the problems caused by the complex, fragmented, and categorical grant-driven funding environment. These problems include:
  - Lack of dedicated funding sources for the Foundational Capabilities needed to support effective services (e.g., quality assurance, information management, policy development)
  - Lack of dedicated funding sources for cross-jurisdictional sharing and consolidation
  - Inability to make long-term investments to improve efficiency and quality due to revenue instability (e.g., competitive grants, local political conditions, changes in funder priorities, etc.), and
  - Misalignment between current funding streams and the services that LHDs are mandated and expected to provide based on current public health science and local community need.

Recommendations

Local public health capacity, services, and quality

1. All Ohioans, regardless of where they live, should have access to the Core Public Health Services described in the Ohio Minimum Package of Local Public Health Services. (see Minimum Package diagram)

2. All local health departments (LHDs) should have access to the skills and resources that make up the Foundational Capabilities in order to effectively support the core services.

3. The Ohio Minimum Package of Local Public Health Services should be used to guide any future changes in funding, governance, capacity building, and quality improvement. (see Structure Analysis diagram)

4. All LHDs should become eligible for accreditation through the Public Health Accreditation Board (PHAB).

5. LHDs that meet Minimum Public Health Package standards should be prioritized for grant funding in their jurisdiction.

6. The biennial LHD Health Improvement Standards reported to the Ohio Department of Health via the Ohio Profile Performance Database should serve as the platform for assessing LHD provision of the Minimum Package. The Profile Performance Database may need to be updated periodically to capture the Core Public Health Services and Foundational Capabilities.

7. The Association of Ohio Health Commissioners (AOHC) supports a review of current laws and regulations to determine where mandates may need to be revised or eliminated and should advocate for elimination of mandates that do not align with the Minimum Package of Public Health Services.

Jurisdictional structure

8. Decisions about the jurisdictional structure of local public health in Ohio should be based upon LHD ability to efficiently and effectively provide the Minimum Package of Public Health Services. Additional factors that should be considered are:
   a. Number of jurisdictions within a county,
   b. Population size served by the LHD, and
   c. Local geographic, political, and financial conditions. (see Structure Analysis diagram)

9. All LHDs should assess:
   a. Their ability to provide the Minimum Package of Public Health Services,
   b. The potential impact of cross-jurisdictional sharing or consolidation on their ability to provide those services, and,
   c. The feasibility of and local conditions for cross-jurisdictional sharing or consolidation.

10. Most LHDs, regardless of size, may benefit from cross-jurisdictional sharing. However, LHDs serving populations of <100,000 in particular may benefit from pursuing cross-jurisdictional sharing or consolidation to ensure adequate capacity to provide the Minimum Package.

11. LHDs in counties with multiple LHDs should consider the feasibility of voluntary consolidation.

12. Statutory barriers to voluntary multi-jurisdictional consolidation and cross-jurisdictional sharing should be removed, such as allowing for:
    a. Multi-county levy authority, and
    b. Consolidation of non-contiguous cities or counties, and
    c. Addressing other barriers identified in feasibility analyses.

Financing

13. All LHDs should have adequate funding to maintain the Minimum Package of Public Health Services. AOHC should continue the work of the Public Health Futures Financing Workgroup to identify cost estimates for the Minimum Package (Core Services and Foundational Capabilities) by November 2012.

14. The Ohio Department of Health and LHDs should work together to shift the focus from managing fragmented program silos and funding streams toward improving and coordinating state and local organizational capacity to effectively deliver the Minimum Package.

15. AOHC should advocate for block grants or direct contracts when possible so that communities can implement programs based on Community Health Assessment and Improvement Plan priorities.

16. AOHC should work to assure that local health departments are able to obtain fair reimbursement from public and private payers for eligible services (including efforts to streamline insurance credentialing).

17. AOHC should explore new mechanisms for improving the stability and sustainability of federal, state, and local funding, such as:
    a. Dedicated percentage of inside millage in lieu of local levies,
    b. Standardized cost methodology to establish fees for programs where no explicit fee-setting authority currently exists,
    c. Increasing Local Health Department Support ("state subsidy") to LHDs to support Foundational Capabilities,
    d. Excise taxes (e.g., tobacco, sugar-sweetened beverages, medical transactions), and
    e. Integrated health care delivery reimbursement.

Implementation Strategy

18. AOHC should seek funds to support feasibility assessments, transition planning, and incentives necessary for LHDs to implement the new framework (such as submitting a proposal to the RWJF Center for Sharing Public Health Services grant program).

19. AOHC should convene a meeting with state health policy leaders to formally present and discuss the recommendations of the Public Health Futures final report and to collaboratively plan strategies and action steps to advance forward progress toward the vision for the future.

Ohio Minimum Package of Local Public Health Services

Core public health services

All LHDs should be responsible for providing the following services in their district — directly or by contracting with another LHD

- **Environmental health services**,* such as water safety, school inspections, nuisance abatement, and food safety (restaurant and grocery store inspections)
- **Communicable disease control**, vaccination capacity, and quarantine authority*
- **Epidemiology** services for communicable disease outbreaks and trending* and disease prevalence and morbidity/mortality reporting*
- **Access to birth and death records**
- **Health promotion and prevention** (health education* and policy, systems, and environmental change)
  - Chronic disease prevention (including tobacco, physical activity, nutrition)
  - Injury prevention
  - Infant mortality/preterm birth prevention
- **Emergency preparedness**, response, and ensuring safety of an area after a disaster
- **Linking people to health services** to make sure they receive needed medical care*
- **Community engagement**, community health assessment and improvement planning, and partnerships

*Service mandated by state of Ohio (ORC, OAC) (Note: Ohio law mandates several specific services related to environmental health and communicable diseases. Not all are listed here. See Appendix D for complete list.)

Other public health services

(Varies by community need as determined by Community Health Assessments)
LHDs play a role in assuring that these services are provided in their community — either by local public health or other organization(s), including health care providers and other government agencies

Clinical preventive and primary care services
- Immunizations
- Medical and dental clinics (primary care)
- Care coordination and navigation
- Reproductive and sexual health services (including STD testing, contact tracing, diagnosis, and treatment)

Specific maternal and child health programs, such as
- WIC (Women Infants and Children) nutrition program
- Help Me Grow home visiting program (HMG)
- Bureau for Children with Medical Handicaps program (BCMH)

Non-mandated environmental health services, such as
- Lead screening, radon testing, residential plumbing inspections, etc.

Other-optional depending on community need and other available providers
- Home health, hospice care, home visiting programs (other than HMG)
- School nurses; Drug and alcohol use prevention; Behavioral health
- Municipal ordinance enforcement

Foundational Capabilities

All LHDs should have access to the following skills and resources. Access can occur through cross-jurisdictional sharing.

Quality assurance
- Accreditation
- Quality improvement and program evaluation
- Identification of evidence-based practices

Information management and analysis
- Data analysis expertise for surveillance, epidemiology, community health assessment, performance management, and research
- Information technology infrastructure
- Interface with health information technology

Policy development
- Policy analysis and planning
- Expertise for policy, systems, and environmental change strategies

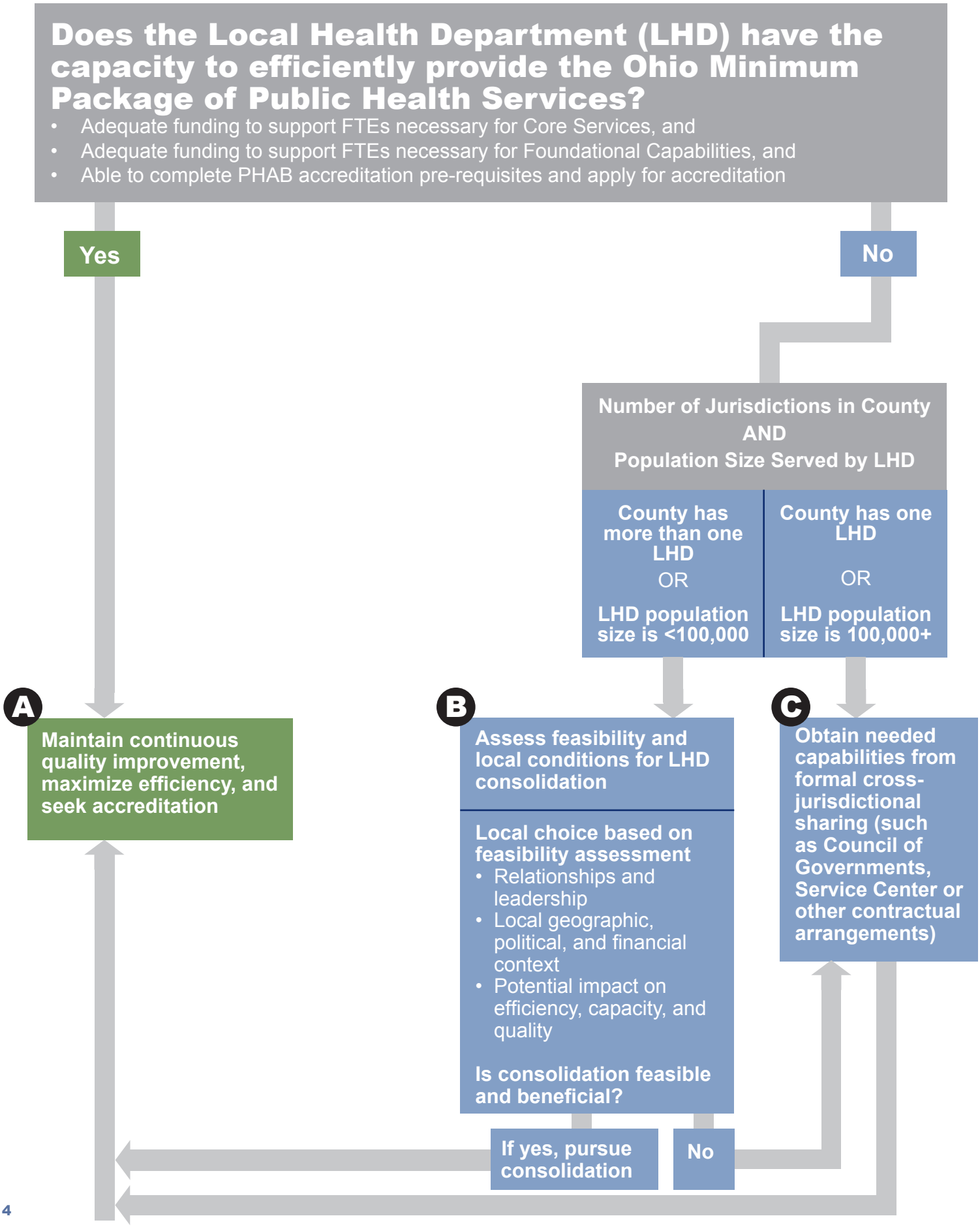
Resource development
- Grant writing expertise and grant seeking support
- Workforce development (training, certification, recruitment)
- Service reimbursement, contracting, and fee collection infrastructure (interface with third party payers)

Legal support
- Specialized consultation and analysis on public health law

Laboratory capacity
- Environmental health lab
- Clinical lab services (as appropriate)

Support and expertise for LHD community engagement strategies
- Community and governing entity engagement, convening and planning
- Public information, marketing, and communications
- Community health assessment and improvement planning
- Partnerships to address socio-economic factors and health equity

Local Public Health Structure Analysis



Overview

The Association of Ohio Health Commissioners (AOHC) established and led an effort called Public Health Futures started in late 2011 to explore approaches to cross-jurisdictional shared services, consolidation, and/or regionalization in order to develop a new model or a set of preferred models for Ohio's local governmental public health system that enhances quality, assures value, and attains sustainable financing.

History. Ohio's current local public health system was established in 1919 by the Hughes-Griswold Act. Partly in response to a global influenza pandemic, the Act required Ohio's 2,158 city, village, and township health units to combine into 88 county ("general") and 92 city health districts in order to strengthen the system's ability to protect the health of all Ohioans (Healthy People- Healthy Communities, 1993). Successful public health efforts and scientific advances have greatly extended life expectancies since then, and the primary threats to health have transitioned from communicable diseases such as influenza and tuberculosis, to chronic conditions such as heart disease, diabetes, and cancer.

The science of public health has continued to advance in recent decades. Evidence-based approaches that focus on population-based health and the social and environmental context of individual behavior, rather than individual clinical care and education, have been identified as the most effective ways to improve health, particularly related to preventable chronic conditions and injuries (Frieden, 2010). Technology has improved the capacity to collect, analyze, and share health data. Yet the basic organizational, jurisdictional, and financial underpinnings of Ohio's local public health system continue to reflect century-old mechanisms that focus on infectious-disease-related environmental health (sanitation, quarantine measures, water purification, pest control, food safety) and direct services for specific vulnerable populations (Bureau of Children with Medical Handicaps, Help Me Grow, WIC).

Recent changes within the system have been driven largely by local-level decisions and by reactions to major national events. Despite a 1993 recommendation from a legislatively-mandated study committee that the boundaries of local health jurisdictions should be "coincident with county boundaries," the basic structure of local health jurisdictions established in 1919 has not undergone any significant restructuring. Some local districts have chosen to combine and many others have elected to contract with another department for services. Along the way, reactions to a number of events have also shaped the current system. Recent examples include the nation's focus on emergency preparedness following the September 11, 2001 terror attacks and subsequent anthrax scares, and the need for coordinated action to protect Ohio's citizens from the H1N1 virus. The result of this history is a patchwork of programs, mandates, and funding streams that include vestiges of public health's original environmental health functions, "last resort" safety net services, new emphasis on disaster preparedness, and more proactive approaches to health promotion.

Current challenges and opportunities. Presently, a series of additional unprecedented factors are converging that pose fundamental challenges and bring

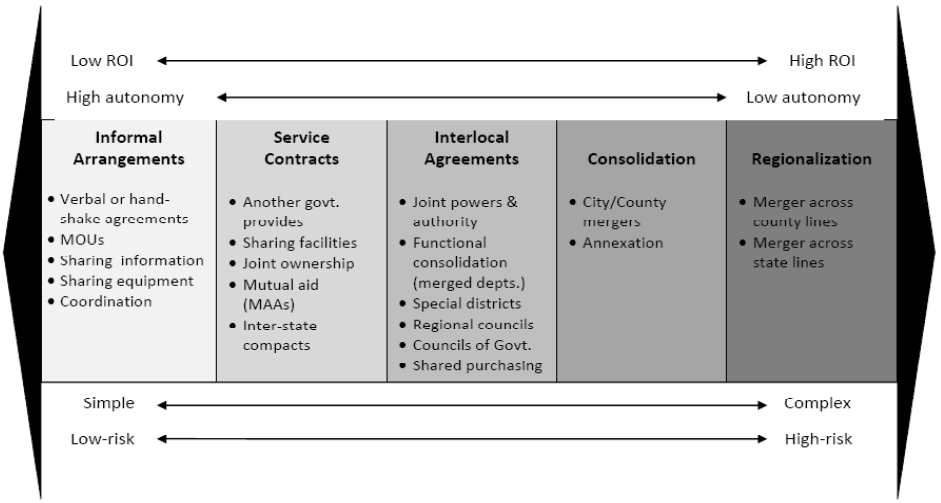
significant opportunities to the relevance, capacity, and sustainability of Ohio's local public health agencies. First, changes are occurring in the broader health care delivery system (in part due to the Affordable Care Act), including greater emphasis on prevention and care coordination, expanded coverage for those who were uninsured previously and served by public health safety net services, and new opportunities to improve quality through data integration and electronic health records. Second, national accreditation standards for state and local public health were introduced in 2011, providing new opportunities for performance assessment and quality improvement. Added to this milieu, Ohio's public agencies are coping with reductions in available state and local government funding and the need to produce better value by optimizing shrinking resources.

The potential impact of the scope and pace of these changes is profound. Many of Ohio's local public agencies, including local health departments, are struggling with the increasingly desperate task of merely trying to "survive." Some agencies within public health and throughout all levels and areas of government are re-shaping themselves, adopting new tools, building on longstanding and newly formed relationships, and re-examining their purpose, role and capacity to bring maximum value for Ohio's residents.

Determining what to do next in public health through a fragmented series of localized or funding-driven reactions is not a viable option. Such a course would very likely imperil the system's overall ability to meet rising and changing expectations, and many local health departments likely would not survive. Ohio's residents deserve better—and Ohio's local public health agencies can do better.

Possibilities being considered. The AOHC Public Health Futures project began without any preconceived notions about the type of model that will work best for local public health in the future. Recognizing the complexity of the current environment and the need to obtain stakeholder feedback before defining a new framework, the project is exploring the full range of collaborative approaches. As shown in Figure 1, the project recognizes that there is a continuum of shared services, from informal and contract arrangements that retain current jurisdictional autonomy to consolidation and regionalization of jurisdictions. (The glossary in the appendix provides definitions of the terms used in this continuum model.)

Figure 1. Government Shared Services Continuum



Source: Kauffmann, N.J, *Regionalization of Government Services: Lessons Learned & Application for Public Health Delivery*, July 2010. Prepared for the Robert Wood Johnson Foundation.

Purpose and objectives

Recognizing the need to respond to current challenges and proactively propose new approaches to improving the effectiveness and efficiency of local public health, AOHC determined that a comprehensive analysis of the factors and feasible options was needed. AOHC established and led Public Health Futures, guided by a Steering Committee of 17 AOHC members from a wide variety of LHDs (urban and rural, city and county departments, all regions of the state). AOHC contracted with the Health Policy Institute of Ohio (HPIO) to conduct research, facilitate a consensus-building process among members, and prepare a document that summarizes the findings. The Steering Committee identified the following objectives for the project:

1. Describe the current status of Ohio's local public health departments (LHDs), including structure, governance, funding, and current collaboration.
2. Identify rules, policies, and standards that may impact the future of local public health (including statutory mandates, national public health accreditation standards, and policy changes affecting health care, such as the Affordable Care Act).
3. Identify stakeholder interests and concerns and develop a set of criteria for assessing new models of collaboration or consolidation.
4. Identify and assess potential models of collaboration and consolidation and the factors that would contribute to successful implementation of those models.
5. Foster consensus among LHDs to prioritize a small number of preferred frameworks.
6. Create a decision-making guide for LHDs to use when moving forward with a new framework.

The Steering Committee also identified the following questions to be explored by the project:

Role and functions of public health

- What should the minimum capacity of public health look like in the future? What do Ohio residents need and deserve from the public health system?
- What are the potential impacts of various models of shared services and consolidation on LHDs' ability to deliver the essential functions of public health?

Addressing concerns about the current system

- Is the current system sustainable?
- How should the local public health system address longstanding (but now more intense) and fundamental funding shortfalls and fragmentation?
- How can local public health become more proactive and driven by evidence about what works and what is most needed, rather than re-active and driven by chasing after available funding streams?

Considerations for new approaches

- Are there changes in policy or law that are necessary and ought to be considered?
- What models or business practices are available that will help LHDs to go beyond "talk and relationship-based" collaboration to more efficient and standardized collaboration?
- What models or business practices are available that will help LHDs to improve quality and outcomes?

Methods

This report will includes three sections, reflecting the descriptive, exploratory, and consensus-building phases of the project. HPIO and the Steering Committee used the following methods to meet the objectives of the project:

Part 1.The Current Status of Ohio's Local Health Departments

- Review of descriptive information about Ohio LHDs
- State-level regulatory scan and review of relevant standards and policies (e.g., Public Health Accreditation Board standards, Affordable Care Act, State Health Improvement Plan)
- Online survey of AOHC members regarding current collaboration

Part 2. Stakeholder Considerations, Lessons Learned, and Guiding Concepts

- Key-informant interviews with Steering Committee members and state-level policymakers
- Targeted review of research literature related to public health systems, local government reform, and models for collaboration and consolidation

Part 3. Consensus and Recommendations

- Series of consensus-building meetings: AOHC all-members meeting in March 2012, five regional district meetings in April 2012, and Steering Committee meetings in May and June 2012
- Steering Committee development and approval of recommendations in June 2012

HPIO presented Parts 1 and 2 of this report at an AOHC all-member meeting in March 2012. Input from members gathered through discussions at the all-member meeting, the regional district meetings, and Steering Committee meetings guided the development of Part 3 of the report.

PART ONE: THE CURRENT STATUS OF OHIO'S LOCAL HEALTH DEPARTMENTS

Objectives

Describe the current status of Ohio's local health departments (LHDs) with respect to:

- Jurisdiction type, size, and governance
- Funding (revenue sources, mechanisms and expenditures)
- Current collaborative arrangements
- National standards for public health functions and capacity
- Regulatory and policy environment factors (federal, state, and local) that may impact cross-jurisdictional sharing and/or regionalism

Summary of key findings

Structure and governance

- Public health is governed and administered at the local level in Ohio. The system is decentralized, resulting in significant variability across LHDs in terms of population size served, per-capita expenditures, and capacity.
- Ohio law allows for three different types of health districts—city, general, and combined. Currently, about three-quarters of Ohio LHDs (71%) are "general" or "combined" districts that encompass all or part of a county. The remaining 29% are comprised of a single city. Ohio does not currently have any LHDs that encompass two or more counties.
- Three-quarters of Ohio counties have only one LHD, while the remaining quarter of counties have up to five LHDs operating within their borders.
- Ohio is home to many LHDs that serve small population sizes. More than half of Ohio LHDs serve fewer than 50,000 residents.

Funding

- LHDs face many resource constraints. Relative to other states, Ohio ranks quite low in terms of median annual per capita LHD expenditures (33rd) and state public health expenditures (41st), and in obtaining federal funding for public health (50th for CDC funding, 39th for HRSA funding).
- Local funding (fees, levy funds, and other local government sources) provides about three-quarters of LHD revenue overall, although these local sources vary widely by jurisdiction. For example, only 39% of LHDs reported local public health levy revenue in 2010. Local funding can also be inconsistent over time because it is vulnerable to local political conditions.
- State-generated funding provides a relatively small portion of LHD revenue. The state subsidy provided less than 1% of LHD revenue in 2010 and other state sources provided 5%.
- Combining federal pass-through funds, state grants and contracts, and the state subsidy, 22% of LHD revenue flows through the state. However, only one-quarter of that state-controlled portion is generated from state coffers, while three-quarters of the funds come from federal sources.

- Funding for local public health is extremely complex and fragmented. There appears to be considerable misalignment between current funding streams and the services that LHDs are mandated and expected to provide.

Current collaboration and future opportunities

- Since 1919 when the current system was established, the number of functioning LHDs has decreased from 180 to 125 through voluntary unions (city-county mergers) and contract arrangements. Contract arrangements have been far more common than full consolidations.
- LHDs have engaged increasingly in a range of collaborative arrangements over the past ten years, including "pooling" funds for shared services and contracts between LHDs to provide services.
- According to a 2012 survey of AOHC members, the vast majority of LHDs are currently sharing some services with other jurisdictions, including "pooled funding" and contracts with other LHDs. The types of services that are shared the most are epidemiology, HIV testing, lead assessment, and STD testing and treatment.
- Administrative functions (information technology, human resources, purchasing) and expertise (subject matter experts, leadership and policy development, and accreditation and quality improvement guidance) appear to be the areas in which health commissioners are most interested in sharing services in the future. They reported little current sharing in these areas, possibly because there have been few grant-funded incentives to collaborate in these areas.

Economic and policy environment

- In the past few years, LHDs report experiencing widespread job losses and program cuts. In 2009, 72% of LHDs reported loss of staff and 85% reported cuts to at least one programmatic area.
- Like all local government agencies in Ohio, LHDs are grappling with the challenges of "leaner government." Furthermore, the Ohio Department of Health has experienced a reduction in staff and can no longer provide as many functions for LHDs as it did in the past.
- Accreditation for state and local health departments is a new process launched in 2011. Although accreditation is voluntary, Ohio LHDs are now required to conduct annual "improvement standard" self-assessments using the Public Health Accreditation Board measures. The accreditation standards delineate the essential functions of public health, providing a new tool for assessing LHD capacity and performance. They also present a new opportunity to re-examine the relationship between public health governance structures and financing and contemporary agreed-upon standards of essential public health services.
- The Patient Protection and Affordable Care Act of 2010 (ACA) has several potential implications for public health. Most significantly, public health's traditional role in assuring access to care will be affected by decreases in the number of uninsured Ohioans and changes to the health care delivery system. The ACA presents challenges and opportunities for LHDs and will require careful coordination with the broader health care system.

1.1 Current Landscape

Current structure, governance, and jurisdictions

Public health is governed and administered at the local level in Ohio. Ohio is one of 27 states with local health department governance; state control or shared local-state authority models are used in other states (NACCHO, 2010). Ohio's 88 counties are home to a total of 125 local health departments (LHD). Sixty-five Ohio counties have one LHD (74%), while the remaining 23 counties have two or more LHDs (see Table 1). Ohio law allows for three different types of health districts—city, general, and combined (ORC 3709.01). General districts encompass one county and include all townships and villages in the county. A combined district is the union of a general health district and one or more city districts.

Table 1. Number of LHDs per county

	Number of Counties	Percent of Counties (n=88)
County has 1 LHD	65	74%
County has 2 LHDs	13	15%
County has 3-5 LHDs	10	11%

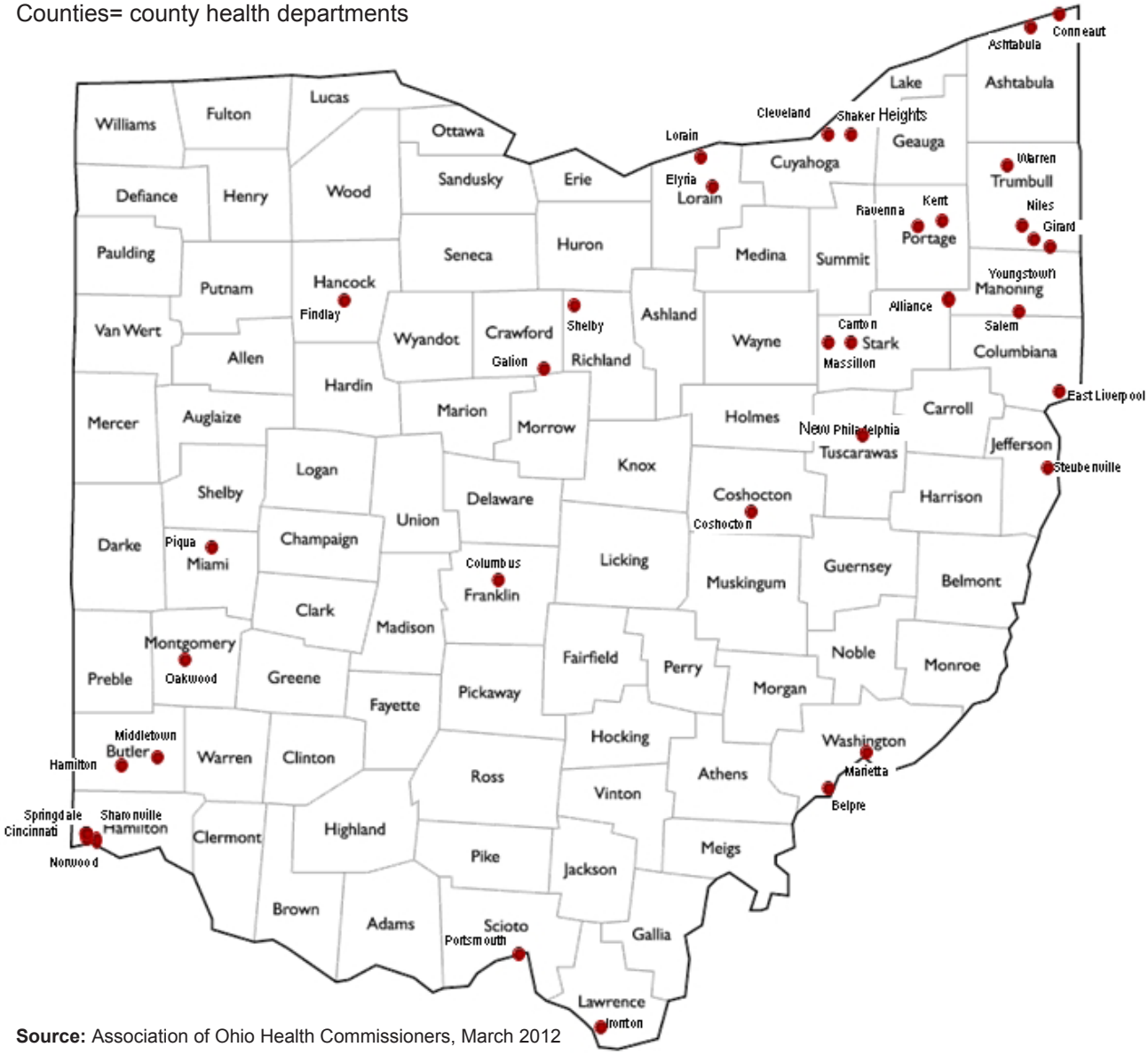
Source: Ohio Local Health Department Census 2010, Ohio Department of Health, 2011.

Note: Two city health departments have geographic areas that cover two counties (Sharonville in Hamilton and Butler Counties, and Alliance in Stark and Mahoning Counties). For the purposes of this calculation, these city departments were assigned to one county each.

Throughout this report we will refer to "general" and "combined" districts as "county" districts. About three-quarters of Ohio LHDs (71%) encompass county districts. The remaining 29% comprise of a single city. Ohio does not currently have any LHDs that combine two or more counties (Ohio Department of Health, 2011). Nationwide, 68% of LHDs have jurisdictions based on county boundaries, while 21% are city jurisdictions and 12% are multi-county or other (Ohio Department of Health, 2011). Table 2 displays the statutes most relevant to LHD governance and cross-jurisdictional sharing.

Figure 1 displays the locations of Ohio LHDs. The red dots indicate city health departments. Counties with more than one LHD tend to be clustered in the northeast and southwest areas of the state.

Figure 1. Map of Ohio LHDs, 2012
Red dots= city health departments
Counties= county health departments



Source: Association of Ohio Health Commissioners, March 2012

Table 2. Key statutes relevant to LHD governance and cross-jurisdictional sharing

Ohio Revised Code (ORC)	Governance
2744.01	Political subdivisions defined; powers of political subdivisions
2744.02	Governmental and proprietary functions of political subdivisions
3709.01	Establishes type of health districts (city, general, combined) – boundary and population relationship to number of districts
3709.03-.04	For general health districts, establishes District Advisory Council, provides for appointment of its members; Council appoints Board of Health (BOH) members;
3709.05-06	City health district legislative authority of each city constituting a city health district shall establish a BOH. BOH shall have four members appointed by the mayor and confirmed by the legislative authority and one member appointed by the health district licensing council.
	Union/Merger and Contract arrangements
3709.07	Union: combined health district is a union of a general and one or more city health districts. Two or more contiguous city district may unite to form single cite district; two or more contiguous general health districts, but not more than 5, may unite to form a single health district (subject to majority vote of the district advisory council)
307.15	Board of County Commissioners may contract with legislative authority of a health district or with the Board of Health
307.153	City Board of Health or General Health District may contract with Board of County Commissioners within same county in which the Board is totally or partially located
167.01	Provides for formation of Council of Governments
167.08	May contract with Council of Governments
3709.29	Special levy for general health districts: local revenue uses affect union/merger/contracting arrangement
OAC 3701-36-10	Formula for payment of health district subsidies; local revenue raising requirements affect union/merger/contracting arrangements
305.23	County Commissioner may establish and require centralized services
9.482	New, very broad “universal service agreements” Political subdivisions may enter into agreements with any subdivision agreeing to perform any power, perform any function, or render any service for another contracting recipient subdivision
	Other
Ohio Constitution Section 7 of Article XVIII	“Home Rule” Charter Cities

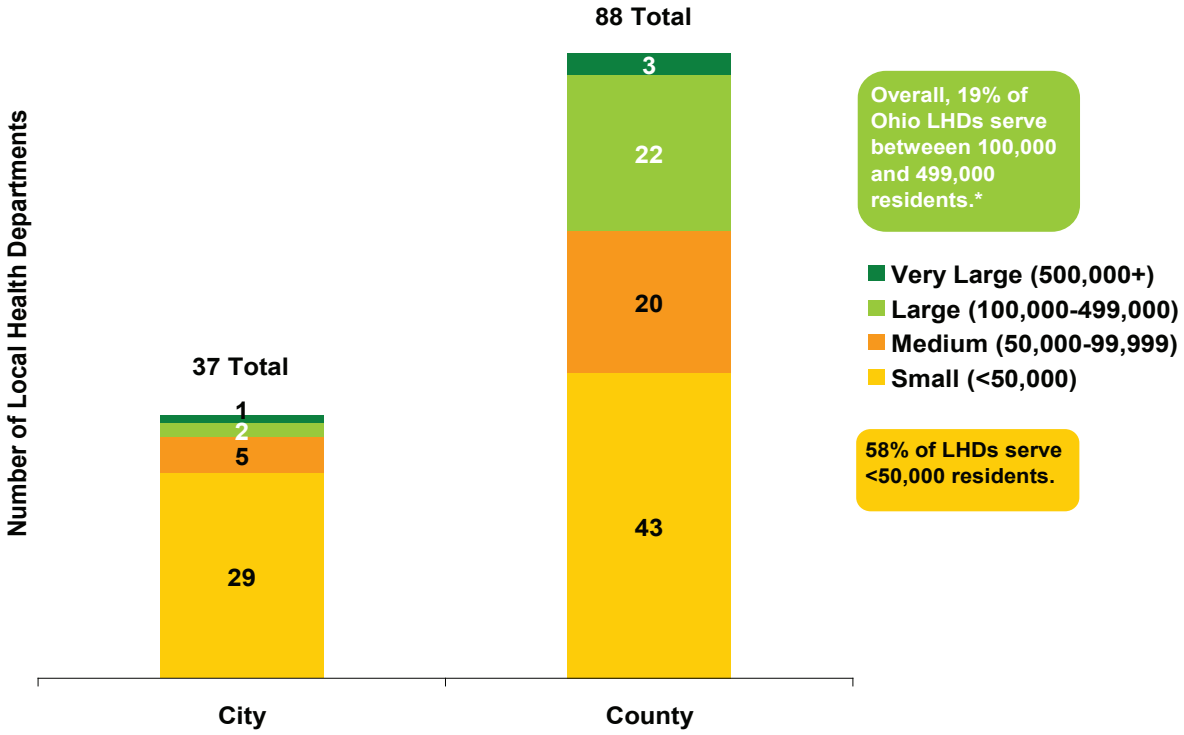
Population size

Ohio LHDs serve a wide range of population sizes, from 854,975 residents in the Cuyahoga County Board of Health's jurisdiction to less than 12,000 for several small city departments. Overall, 58% of LHDs in Ohio serve small population sizes (<50,000), 39% serve medium or large population sizes (50,000-499,999), and 3% serve very large population sizes (500,000+) (see Figure 2).

Throughout this report, the population size served by LHDs will be referred to in the following categories:

- Small (2010 population <50,000)
- Medium (50,000-99,999)
- Large (100,000-499,000)
- Very Large (500,000 +)

Figure 2. Number of city and county LHDs, by population size, 2011 (n=125)



Source: Ohio Local Health Department Census 2010, Ohio Department of Health, 2011.
*See Appendix for list of all districts sorted by pop size/type.

AOHC members are organized into five regions. The northeast region serves the largest total population, while the southeast serves the smallest total population. Table 3 displays the number of LHDs in each region and the population sizes served in those regions.

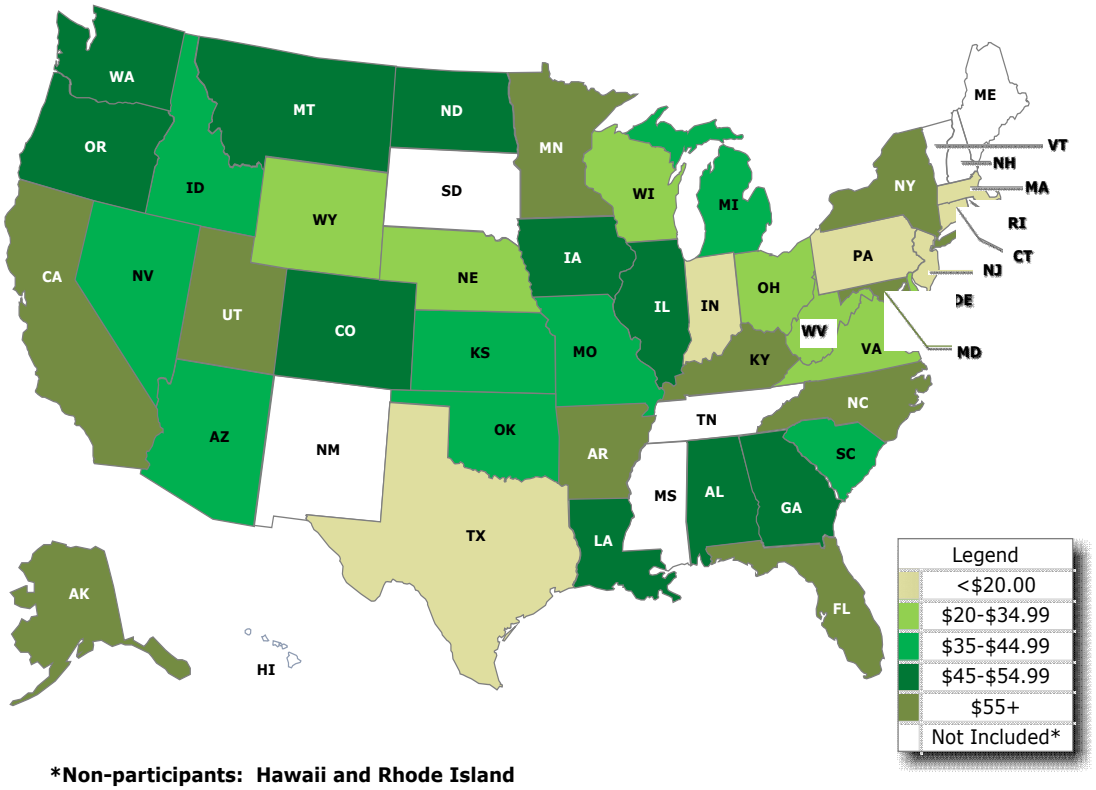
Table 3. Population Sizes Served by the Five LHD Districts (2012)

	All		Larger Population Size	Smaller Population Size	
	Number of LHDs	Total Population in District	Number of LHDs Serving >100,000	Number of LHDs Serving 5,000 to 99,999	Total Population of all <100,000 Pop. Districts Combined
Central	16	2,150,880	6	10	382,085
Northeast	39	4,209,835	11	28	1,063,781
Northwest	24	1,531,555	3	21	
Southeast	22	782,409	0	22	855,733
Southwest	24	2,861,825	8	16	
All	125		28 (22%)	97 (78%)	782,409

LHD expenditures per capita

Among the 44 states for which data were available, Ohio ranks 33rd in median annual per capita LHD expenditures. For the US overall, the median per capita expenditure for LHDs was $41 in 2010, twenty percent higher than the Ohio median of $33 per person (see Figure 3).

Figure 3. 2010 median annual per capita LHD expenditures, by state



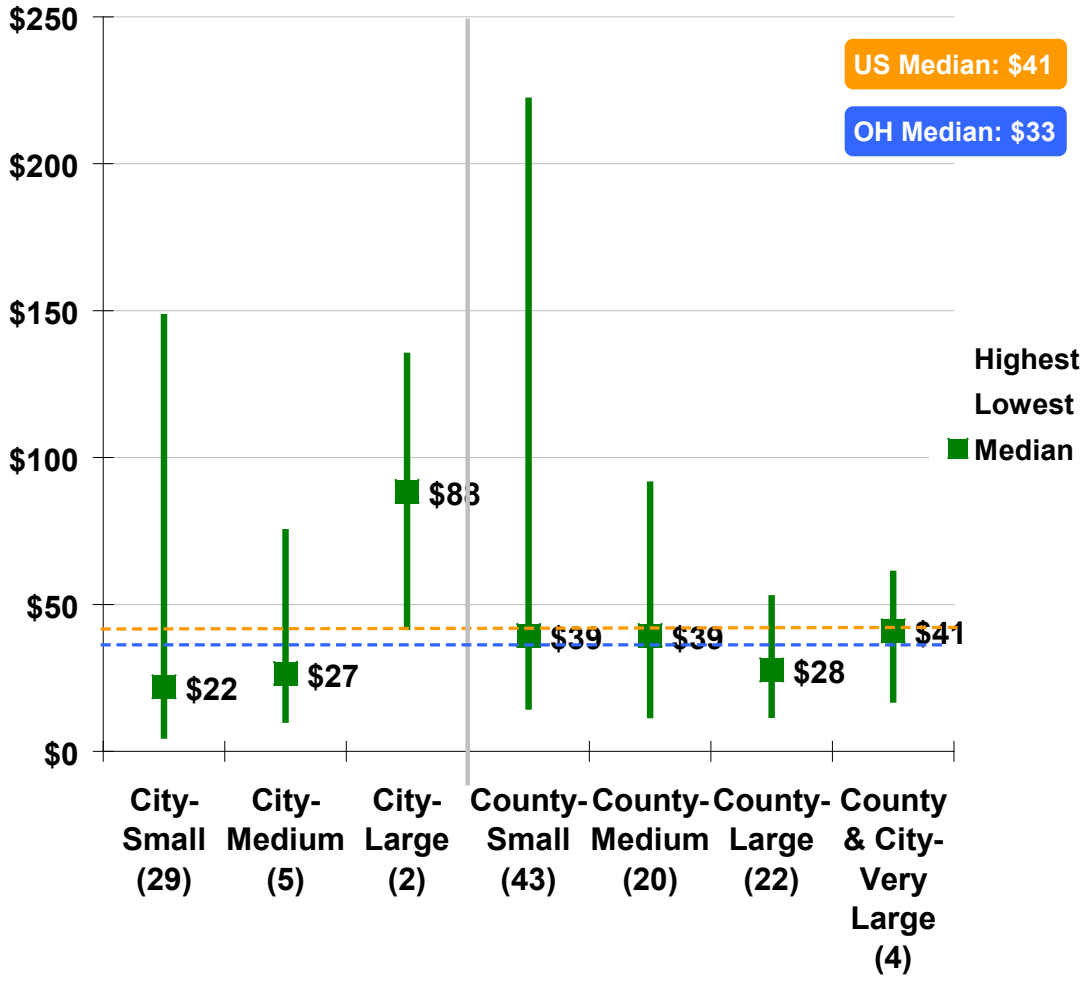
***Non-participants: Hawaii and Rhode Island**
None or insufficient data for Maine, Mississippi, Nevada, New Hampshire, New Mexico, South Dakota, Tennessee, and Vermont

Source: 2010 National Profile of Local Health Departments, NACCHO, 2011
Note: Although there are considerable differences in how LHDs are funded in different states, the NACCHO survey methodology attempts to collect the most consistent data possible for all states from a standard set of funding source categories: city/township/town, county, state direct, federal pass-through, federal direct, Public Health Emergency Response (PHER), American Reinvestment and Recovery Act (ARRA), Medicaid, Medicare, private foundations, private health insurance, patient personal fees, non-clinical fees and fines, tribal, and other.

Within Ohio, per capita expenditures vary widely by district, from a low of $5 per person per year to a high of $221 (see Figure 4). Small cities and small counties experienced the greatest variation in per capita funding; the lowest and highest per capita amounts were both for small departments. Small city departments and large and very large county departments had the lowest median per capita amounts.

Much of the variation in per capita expenditures is likely explained by differences in the number and type of services provided. For example, some LHDs run primary care clinics or offer home health, while others do not provide clinical services.

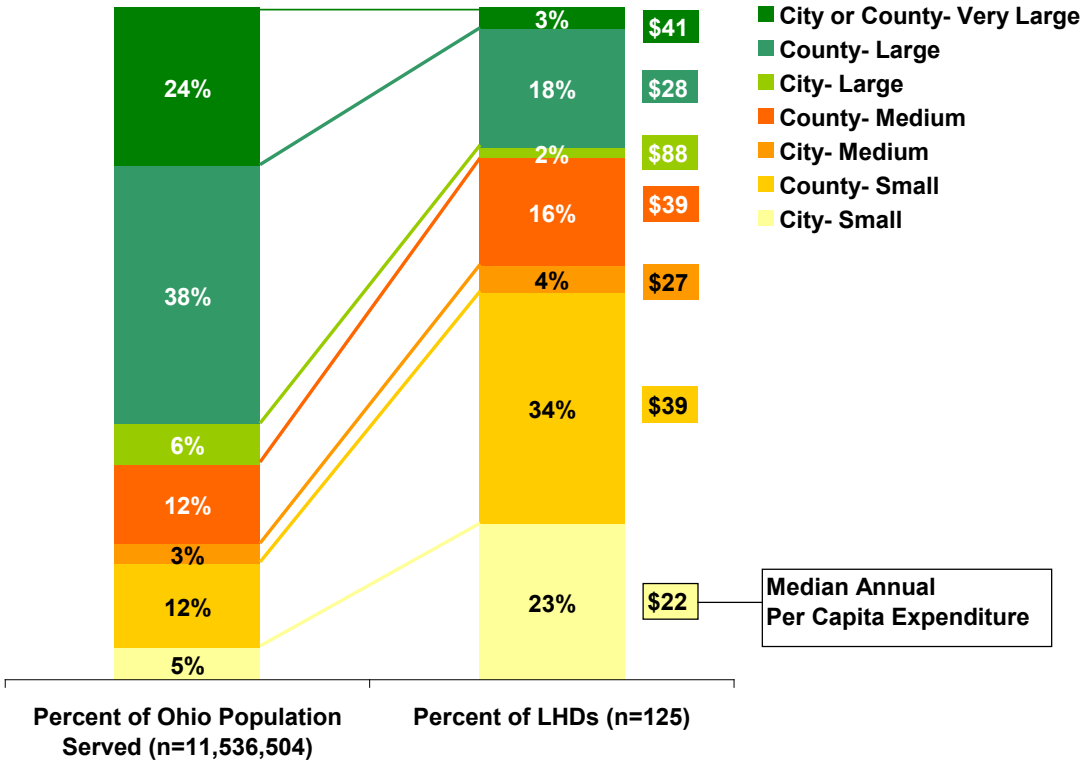
Figure 4. 2010 annual per capita LHD expenditures, by jurisdiction type and population size (median amount and highest/lowest amount within population size category)



Source: 2010 National Profile of Local Health Departments, NACCHO, 2011; and author's calculations of Annual Financial Report (ODHAFR008 Expenditure by Region, District Type and Population, 2010) provided by Ohio Department of Health
Note revised: Data for the category "City- Very Large" is not shown because there is only one department in that category (annual per capita expenditure of $56).

Figure 5 combines the information presented above regarding jurisdiction type, population size, and median annual per capita expenditures. The colors indicate the jurisdiction type/population size category. The bar on the left displays the percent of Ohio's population served by each LHD category. For example, 5% of Ohioans are served by a small city LHD. The bar on the right shows the percent of LHDs within each category. For example, 23% of LHDs are small city departments. The boxes along the right side display the median annual per capita expenditure for each LHD category.

Figure 5. Percent of Ohio Population Served by Different Types of LHDs (2010)



Source: Ohio Local Health Department Census 2010, Ohio Department of Health, 2011; and author's calculations of Annual Financial Report (ODHAFR008 Expenditure by Region, District Type and Population, 2010) provided by Ohio Department of Health

LHD expenditures by service type

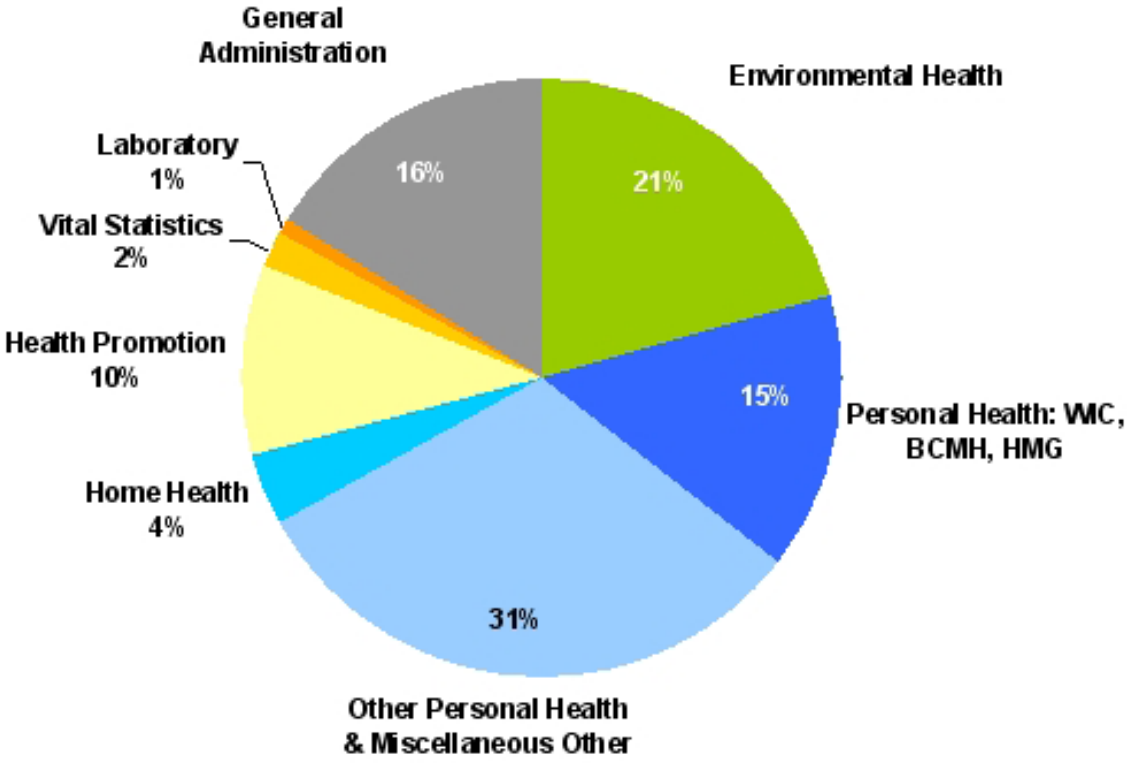
The Ohio Department of Health requires LHDs to report annual expenditures in eight service categories. Table 4 lists each category and indicates the percent of LHDs that reported any expenditure of funds in each category. Environmental Health and General Administration and Services were the two areas in which nearly every LHD reported some activity. Roughly three-quarters of departments reported expenditures in the areas of Vital Statistics, Laboratory, and Personal Health. Only 15% of departments reported Home Health activity and 64% had Health Promotion expenditures. Environmental Health and Personal Health were by far the largest expenses in 2010 (overall, personal health encompasses the WIC/BCMH/HMG, Other Personal Health, and Home Health categories). General Administration and Services represented 16% and Health Promotion was 10%, while Vital Statistics and Laboratory Services consumed <2%.

Table 4. 2010 Ohio LHD Expenditures by program type

		LHDs reporting this type of expenditure for 2010 (>$0)		Total amount	Percent of total expenditures generated by this source
		Number	Percent		
	Environmental health Activities such as food service, vending, water, sewage, nuisance, consumer protection and sanitation, air quality, noise pollution control, radiation control, and waste management	127	100%	$90,289,850	21%
	Vital statistics Operation of local registrar	99	78%	$8,624,275	2%
	Laboratory Medical and environmental, provided on-site or contracted out	54	73%	$4,007,190	1%
	Health promotion Prevention and education (e.g., tobacco, obesity, or injury prevention; child car seat programs)	81	64%	$45,604,188	10%
	Personal health: WIC, BCMH, and HMG Health services delivered to individuals by a nurse, physician, or other health professional (i.e., OT, PT, SW) in any setting (i.e., clinic, school, industry, nursing home, or institution)	91	72%	$65,403,366	15%
	Other personal health and miscellaneous other Personal health expenditures other than WIC, BCMH, and HMG, such as health clinics, school health, immunizations, dental care, general nursing, women's health, reproductive health, and screening; Other services such as preparedness, tobacco prevention, drug-free communities, etc.*	93	73%	$137,758,721	31%
	Home health Health services delivered to individuals by a nurse, physician, home health aide, or other professional or paraprofessional (i.e., OT, PT, SW) in the home (licensed providers)	19	15%	$16,389,159	4%
	General administration and services General agency management not allocated specific program areas	126	99%	$70,063,694	16%
	Total	127	100%	$438,140,442	100%

Source: 2010 LHD Annual Financial Report (AFR)
* Unfortunately, we are not able to split out this category further.

Figure 6. 2010 LHD Expenditures, by category (total: $438,140,442)

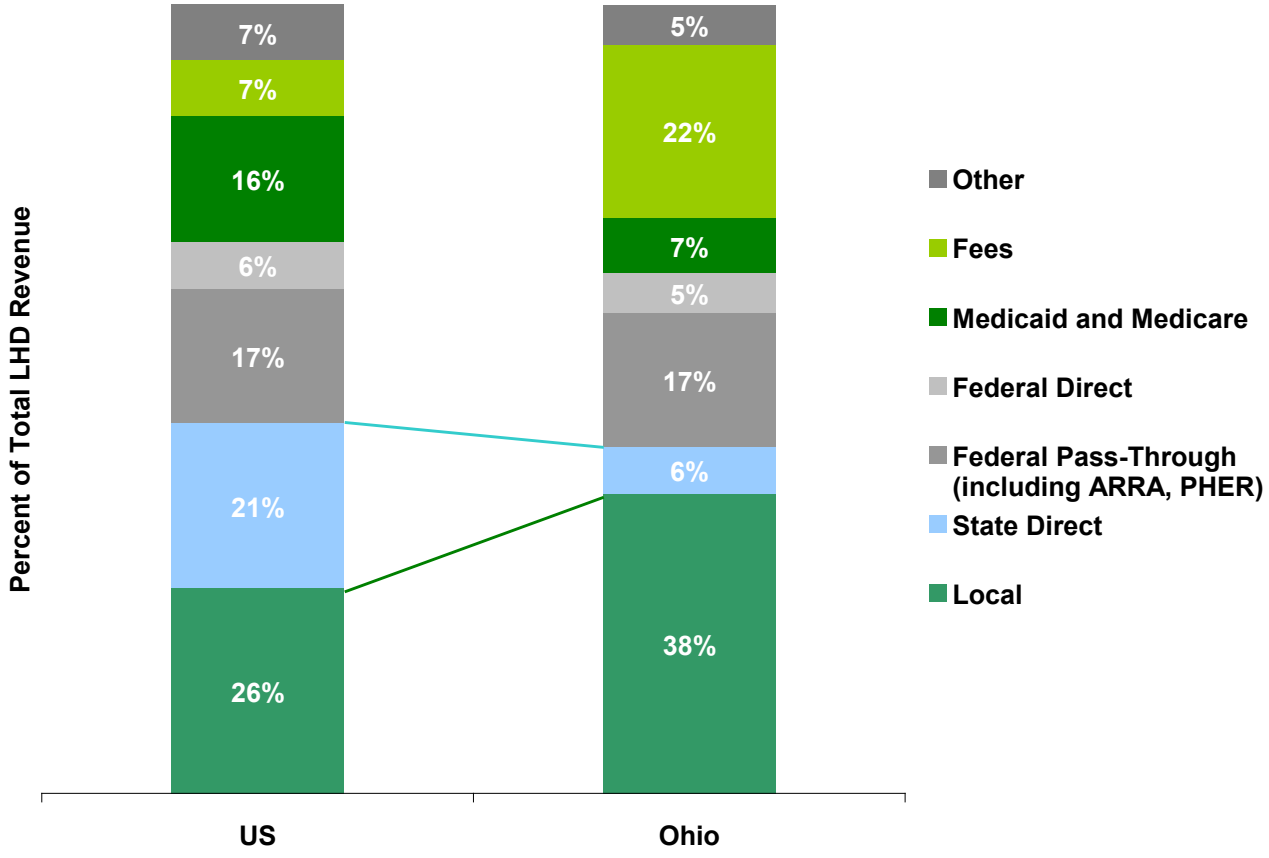


Source: 2010 LHD Annual Financial Report (AFR)

Revenue source overview

LHDs receive funding from a complex array of funding streams. The NACCHO 2010 National Profile of Local Health Departments provides for a comparison of how LHDs are funded in Ohio compared to other states. (Note that NACCHO's definition of "local" is narrower than that used in the Ohio LHD Annual Financial Reports [AFR], placing fees and direct reimbursement for health care services in separate non-local categories.) According to NACCHO, Ohio LHDs are much more dependent on local revenue sources and fees than are LHDs nationally, and rely upon direct state funding for a much smaller portion of their overall support (see Figure 7). In Ohio, local sources (38%), service fees (22%), and federal sources (direct and indirect: 22%) are the largest revenue sources. State direct funding accounts for only 6% of LHD revenue (as categorized in the NACCHO analysis).

Figure 7. Percent of total annual LHD revenue, US and Ohio, by revenue source (2010)



Source: 2010 National Profile of Local Health Departments, NACCHO, 2011

A 2011 report by the Trust for America's Health (TFAH) finds that Ohio ranks quite low among states when it comes to state public health budgets and federal public health grant revenue (*Investing in America's Health: A State-By-State Look at Public Health Funding and Key Health Facts*). This funding is not specific to LHDs, although some of it is allocated to LHDs in Ohio.

Table 5. Per Capita State and Federal Funding for Public Health: How Ohio Compares to Other States

	National Median/ Average* Per Capita Amount	Ohio Per Capita Amount	Ohio Per Capita State Ranking
State public health budget (FY09-10)	$30.61	$15.13	41
Centers for Disease Control and Prevention (CDC) (FY2010)	$20.25	$13.96	50
Health Resources and Services Administration (HRSA) (FY10)	$22.32	$17.27	39

Source: Investing in America's Health, Trust for America's Health (TFAH), 2011
*The TFAH report provides a national median for state public health budgets and a national average for CDC and HRSA funding.

A recent report from The Center for Community Solutions explores the reasons for Ohio's disproportionately lower share of federal funding for public health and describes funding categories in which Ohio has been successful and not successful in obtaining federal grants (*Federal Funding for Public Health and Health Services: Is Ohio Getting its Share?*, March 2012). No single reason for Ohio's disproportionate share emerges from this analysis, although lower disease incidence, population characteristics that make Ohio ineligible for some grants, and the lack of a state requirement for all Medicaid providers to enroll in a children's vaccine program, are among the most significant factors.

Revenue mix for LHDs

LHDs must report their annual revenue to ODH in 54 different program/service categories. These categories are condensed into eight revenue streams in Table 6. Three-quarters of all LHD revenue is generated at the local level in the form of local government revenue (33%), earned healthcare reimbursements (8%), fees and contracts for environmental health services (11%), and other local sources, including vital statistics fees (24%). The state allocates funding to LHDs in three different ways: the state subsidy (0.4%), state grants and contracts generated from state sources (5%), and federal "pass-through" funds from federal sources (17%). The state therefore controls 22% of overall LHD revenue, although only one-quarter of that state-controlled portion is generated from state sources (three-quarters of the funds that flow through the state come from federal sources).

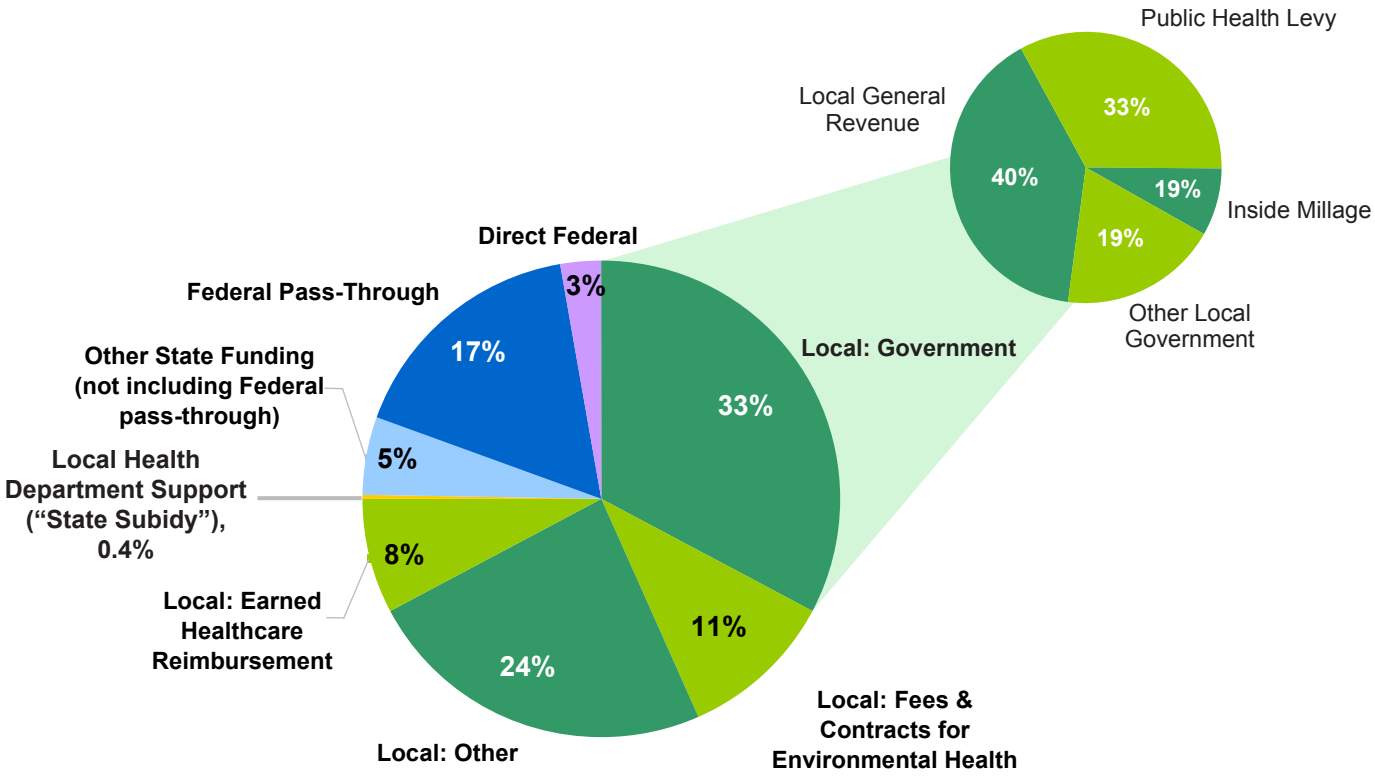
Most departments receive funds from all of these local and state funding sources, although about 20% of LHDs do not receive any federal pass-through dollars. Direct federal funding is only received by 18% of departments and makes up only 3% of the total. Although large and very large city and county LHDs were overrepresented in the group of departments that received direct federal funding in 2010 (40% of the LHDs that got direct federal grants were large or very large), small (30%) and medium (30%) LHDs also received direct federal funds.

Table 6. 2010 LHD Revenue Sources and Amounts

		LHDs reporting this type of local revenue for 2010 (>$0)		Total amount generated by this revenue source	Percent of total LHD revenue generated by this source
		Number of LHDs	Percent of LHDs (n=127*)		
	Local: Government Inside millage, PH levy, local general revenue, local city/county contract, local county TB contract, local pass-through, local government entity, FCFC (see Table 6 for detail)	125	98%	$184,364,981	33%
	Local: Earned Healthcare Reimbursement Personal Health, Health Promotion, and Home Health (Medicaid, Medicare, private insurance, and fees)	120	95%	$43,905,295	8%
	Local: Fees & Contracts for Environmental Health Campground, food, parks, marina, private water, sewage, waste, pools, plumbing inspections, etc.	127	100%	$59,727,132	11%
	Local: Other Vital statistics fees; clinical and environmental laboratory; special contracts for health promotion, preparedness, school health, and other; donations; miscellaneous; local carryover	115	91%	$135,204,225	24%
	State Subsidy	127	100%	$1,988,160	0.4%
	Other State Funds (not including Federal pass-through) Grants from ODH and other agencies, state carryover	111	87%	$29,951,829	5%
	Federal Pass-through ODH grants and grants from federal sources	100	79%	$93,988,745	17%
	Federal Direct Grants and contracts directly from federal government, federal carry-over	23	18%	$15,705,044	3%
	Total	127	100%	$564,835,411	100%

*This table includes data for St. Bernard and East Palestine health departments, which were transitioned to village status in 2011.
Source for state subsidy: 2010 State Subsidy Report, provided by OHD, March 2012
Source for all other categories: 2010 Annual Financial Report data provided by ODH, March 2012

Figure 8.
2010 LHD Revenue, by category (total: $564,835,411)



Source: 2010 Annual Financial Report, provided by ODH March 2012

Local funding detail. In order to receive their annual state subsidy, LHDs must spend a minimum of three dollars per capita in local funds for public health services per year (OAC 3701-36-03). This local funding comes from a variety of sources, as shown in Table 7. In 2010, 40% of departments had funds generated by a public health levy and 31% received inside millage. These local sources vary widely by jurisdiction and health commissioners report that they can be inconsistent over time because they are vulnerable to sometimes volatile local political conditions.

Table 7. Local government funding sources and amounts for Ohio LHDs, 2010

	LHDs reporting this type of local revenue for 2010 (>$0)		Total amount generated by this revenue source	Percent of total local government revenue generated by this source
	Number of LHDs	Percent of LHDs (n=127*)		
Local general revenue	73	57%	$73,303,947	40%
Public health levy	50	39%	$61,334,813	33%
Local pass-through	46	36%	$6,517,076	4%
Other local government entity	45	35%	$11,510,351	6%
Local city county contract	41	32%	$8,038,866	4%
Inside millage	39	31%	$14,653,982	8%
Local government FCFC	31	24%	$6,539,833	4%
Local county TB contract	22	17%	$2,466,115	1%
Total: Local government funding	**125**	**98%****	**$184,364,981**	**100%**

Source: Annual Financial Reports, Ohio Department of Health, March 2012
*This table includes data for St. Bernard and East Palestine health departments, which were transitioned to village status in 2011.
**St. Bernard City and Belpre City reported $0 total local government revenue for 2010.

Workforce trends

Local workforce. National studies of job loss and program cuts in 2009 through 2011 found widespread reductions among Ohio LHDs and found that Ohio experienced more severe reductions compared to other states (see Table 8). For example, 72% of Ohio LHD representatives surveyed reported loss of staff through layoffs or attrition during 2009, compared to 46% among LHDs nationwide.

Table 8. Percent of LHDs with cuts in staffing or programs, 2009-2911

	July to December 2009*		July 2010 to June 2011**	
	US (n=704-718 LHDs)	Ohio (n=34 LHDs)	US (n=637-662 LHDs)	Ohio (n=30 LHDs)
Loss of staff (layoffs and attrition)	46%	72%	44%	48%
Reduced staff time (hours cut and furlough)	23%	43%	22%	19%
Cuts to at least one programmatic area	50%	85%	55%	69%
Cuts to three or more programmatic areas	28%	47%	27%	39%

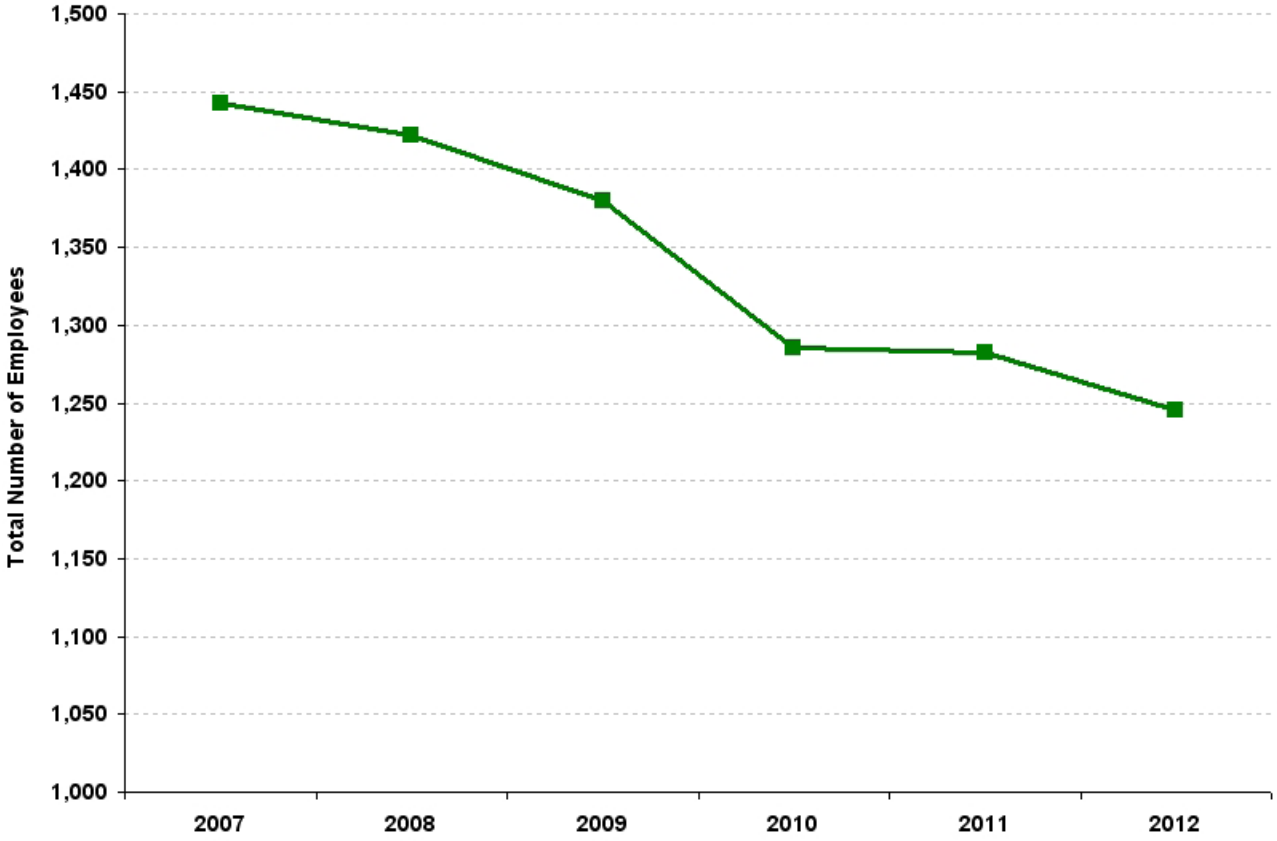
Sources: Local Health Department Job Losses and Program Cuts: State-Level Tables from January/February 2010 Survey, NACCHO, March 2010, and Local Health Department Job Losses and Program Cuts: State-Level Tables from July/August 2011 Survey, NACCHO, November 2011.
*The 2009 study drew a random sample and had an overall response rate of 72%. Ohio response rate not reported.
**The 2011 study drew a random sample and had an overall response rate of 70%. Ohio response rate not reported.
Note: In March 2012, NACCHO released results of a similar survey conducted in January 2012, although state-level data has not yet been released.

State-level workforce and impacts on LHDs. In addition to workforce reductions for LHDs, the Ohio Department of Health (ODH) has also scaled back some of the workforce capacity it has traditionally provided to LHDs. Overall, the number of ODH employees dropped from 1,442 in 2007 to 1,245 in 2012 (see Figure 9).

The reduction in the number of ODH Epidemiologists is one example of how the shrinking ODH workforce impacts local departments. State Epidemiologists assist LHDs with disease event investigations, particularly for unusual events such as large food-borne disease outbreaks that require advanced epidemiological support. This is particularly important when the local epidemiology capacity is lacking or significantly diminished due to lack of qualified and trained individuals.

ODH reports that from 2007 to 2012 the number of Epidemiologists fell from 47 to 39 employees. This reduction in the ODH epidemiology workforce may greatly reduce local department's ability to thoroughly or adequately investigate, interpret and/or report on disease events in Ohio.

Figure 9. Total Number of Ohio Department of Health Employees, 2007 to 2012



Note: Includes full-time, part-time, and temporary employees.
Source: Ohio Department of Health, March 2012

1.2 Current Collaboration

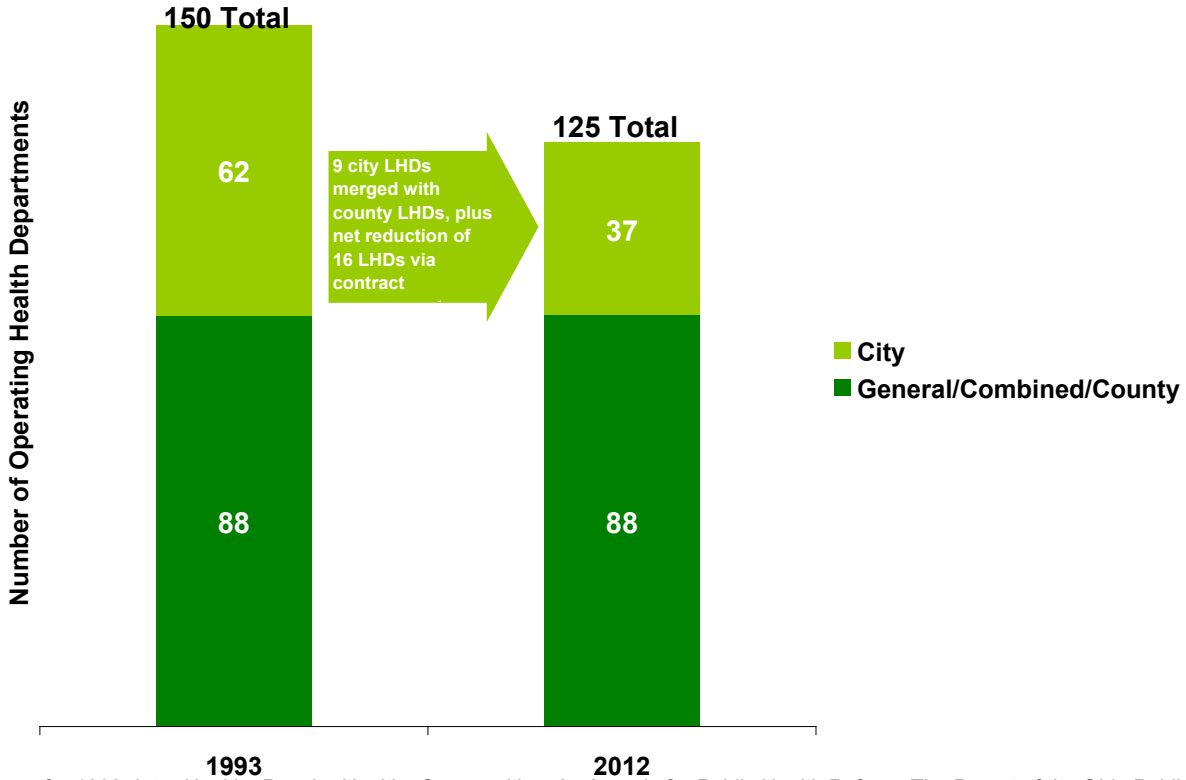
Recent mergers and cross-jurisdictional sharing

The Hughes Griswold Act of 1919 established 180 health districts in Ohio (88 county and 62 city). In 2012 there are 125 LHDs in Ohio, down from 150 in 1993 (see Figure 10). During that time period, nine departments combined. This is defined as a "union" in statute, but is commonly referred to as a "merger" or "consolidation." All of these mergers involved city health departments combining with county health departments.

Additionally, there was a net reduction of 16 LHDs via contract arrangements (including several "back-and-forth" changes in which a LHD changed contract providers more than one time, and cities transitioning to village status and therefore losing their ability to function as an independent health department). Contracts involve an agreement between two autonomous jurisdictions (for example, when a city retains health district status and contracts with a county department to provide public health services in their district, or a city transitions to village status and contracts or combines with a county department).

During the 1993 to 2012 time period there was one "re-constitution" in which the Salem City Health Department re-established itself as a separate entity from Columbiana County in 2009.

Figure 10. Number of local health departments operating in Ohio, 1993 and 2012



Source for 1993 data: *Healthy People- Healthy Communities: An Agenda for Public Health Reform*, *The Report of the Ohio Public Health Services Study Committee*, Ohio Department of Health, 1993.

Source for 2012 data: Ohio Local Health Department Census 2010, Ohio Department of Health, 2011.

Table 9. Changes in Local Health Department jurisdictions, 1994-2012

Year	LHDs	Union*	Contract**
1994	Upper Arlington and Grandview Heights contract with Franklin Co. HD		
1994	Salem City contracts with Columbiana Co HD		
1995	Gallipolis City contracts with Gallia Co. HD		
1995	Cleveland Heights City contracts with Cuyahoga Co. HD		
1996	Springfield City combined with Clark County		
2000	Toledo City combined with Lucas County		
2000	Bellaire City transitioned to village status, to Belmont Co HD		
2001	Barberton contracts with Norton City		
2001	Martins Ferry contracts with Belmont Co HD		
2002	Bucyrus City combined with Crawford Co. HD		
2002	Lancaster City and Pickerington City combine with Fairfield Co. HD		
2003	Campbell City contracts with Mahoning Co. HD		
2003	Reading City contracts with Hamilton Co. HD		
2005	New Carlisle contracts with Clark County		
2006	Indian Hill City contracts with Hamilton Co. HD		
2006	Bellevue contracts with Huron Co. HD		
2007	Bexley contracts with Franklin Co. HD		
2007	Toronto contracts with Jefferson Co. HD		
2008	Lakewood contracts with Cuyahoga Co. HD		
2008	Newark City combines with Licking Co. HD		
2010	Marion City combines with Marion Co. HD		
2004	Crestline City contracts with Galion City		
2009	Salem City re-constituted (no longer part of Columbiana County HD)	NA	NA
2009	Barberton contracts with Summit Co HD		
2009	Struthers contracts with Mahoning Co. HD		
2009	Norton City combines with Summit Co HD (from Barberton)		
2010	Barberton combines with Summit Co HD		
2010	Pickerington contracts with Franklin Co. HD		
2010	Pickerington City separates from Fairfield County and contracts with Franklin		
2011	Akron combines with Summit Co HD		
2011	St. Bernard transitioned to village status, to Hamilton Co. HD		
2011	East Palestine City transitioned to village status, to Columbiana County HD		
2011	Crestline transitioned to village status, to Crawford Co. HD		

*Union: two or more jurisdictions combined. Sometimes referred to as a "merger" or "consolidation."
**Contractual agreement between two jurisdictions. For example, a city retains health district status and contracts with a general/combined/county department to provide public health services in their district, or city transitions to village status and contracts or combines with general/combined/county department.
Source: LHD District History, Ohio Department of Health, 2012.

Status of current collaboration: Results of 2012 Association of Ohio Health Commissioners Collaboration Survey

In order to document services already being shared by LHDs, AOHC conducted an online survey of its members in February 2012. Representatives of 93 LHDs completed the survey, for an overall response rate of 74%. (62% response rate for city departments; 80% response rate for county/combined departments) As shown in Table 9, a majority of LHDs are currently sharing some services. Contractual arrangements were the most common (90%).

Table 10. Percent of LHDs that report shared services (FY2012)

	All (n=90)	*City (n=21)*	*County/ Combined (n=69)*
Any shared services ("pooling") Does your jurisdiction have any shared services? (Jointly contributing funds or sharing governance responsibility for decision making in a given program, e.g., CFHS.)	66%	52%	70%
Shared services with non-LHDs Do you share program services in your jurisdiction with agencies other than LHDs? (e.g., FCFC)	60%	52%	62%
Contractual arrangements Does your jurisdiction either provide or receive contractual services? (health department providing a service to another under some funding arrangement, e.g., epidemiology, plumbing)	90%	91%	90%
Cross-jurisdictional services Does your agency provide cross-jurisdictional services? (A program or service provided by your agency on behalf of several health departments through a regional or district contract, e.g., BCCP, PHEP regional coordination, HIV/AIDS.)	54%	48%	57%

Source: AOHC LHD Collaboration Survey, 2012

Among jurisdictions that receive contractual services, 86% said that these services were funded by grants. Another 50% reported that these services were "billed by the other health department," 29% said they were paid for by fees, and 15% indicated the costs were billed to health insurance. Among departments that provide cross-jurisdictional services, 51% reported that these projects involve 4 or fewer different jurisdictions.

When asked how their use of shared, cross-jurisdictional, and contractual services had changed over the past four years:

- 51% reported more sharing,
- 42% reported no change, and
- 8% reported decreased sharing.

As shown in Table 11, grant requirements were the main driving force behind increased collaboration. Much of this may have been driven by emergency/disaster preparedness funding.

Table 11. "What is the reason(s) for changes to your levels of shared/cross-jurisdictional/ contractual services?" (n=60)

	Percent
Grant funding requires multiple county collaboration	68%
Local funds could not support this program entirely	47%
Unable to meet minimum grant funding levels as a single county	37%
Loss of qualified staff to continue the program ourselves	17%

The survey listed several services commonly provided by LHDs and asked respondents to indicate if their department received the service from another agency or provided the service to another jurisdiction, including other LHDs, state agencies, and non-LHDs. LHD representatives that did not report any sharing for a specific service were then asked to rate their interest in future sharing as "high," "low," or "not interested." Tables 12-15 display the results of a series of questions.

Overall, respondents indicated some degree of collaboration for every service listed, although the number of departments reporting collaboration varied widely by the specific type of activity. The services with the largest proportion of LHDs reporting sharing were:

- Epidemiology services for outbreaks and trending (53%)
- HIV testing (46%)
- Lead assessment (44%)
- STD testing and treatment (40%)

Primary medical care was among the services with the least sharing. Only 10% of LHDs said that they provided or received this service from another agency.

Among those who were not currently sharing, the following services received the greatest amount of "high interest" for future sharing:

- Subject matter experts (41%)
- Leadership development (36%)
- Information technology (34%)
- Policy development (33%)
- Accreditation guidance (33%)

Overall, the Administrative/Planning category had the least amount of current sharing and generated the most interest in future collaboration. Administrative tasks, often referred to as "back office" functions, and expert guidance appear to be areas of opportunity for future cross-jurisdictional relationships. These are areas that do not typically have discrete funding sources.

Table 12. Nursing Services: Current and potential sharing (n=93)

	Current Sharing Percent of responding LHDs that receive this service from another agency or provide this service to another jurisdiction*	**Potential Future Sharing** Percent of responding LHDs that report high interest in future sharing (among those not currently providing or receiving)
HIV Testing	**46%**	14%
STD Testing & Treatment	**40%**	**27%**
Local Disease Investigation	**38%**	**22%**
Breast and Cervical Cancer Project	**37%**	19%
TB Services	**31%**	9%
Family Planning	28%	**22%**
Help Me Grow	28%	**21%**
Child immunizations	26%	14%
Lead Screening	23%	19%
Adult immunizations	22%	**27%**
Prenatal Care	22%	**21%**
School Nursing	19%	9%
Infant Home Visiting (not HMG)	18%	18%
Vision/ Hearing with ODH	17%	10%
Blood Pressure Screening	17%	6%
Primary Medical Care	10%	14%

*Provide or receive this service from another LHD, multiple LHDs, a state agency, or a non-LHD agency.
Note: This table is sorted by frequency of current sharing (column 2). Bold font indicates top five responses in each column.
Source: AOHC LHD Collaboration Survey, 2012

Table 13. Environmental Health Services: Current and potential sharing (n=93)

	Current Sharing Percent of responding LHDs that receive this service from another agency or provide this service to another jurisdiction*	**Potential Future Sharing** Percent of responding LHDs that report high interest in future sharing (among those not currently providing or receiving)
Lead Assessment	**44%**	**25%**
Commercial Plumbing	**37%**	14%
Lead Abatement	**32%**	**21%**
Solid Waste	**26%**	12%
Smoke-free Ohio Enforcement	**25%**	**16%**
Water	19%	9%
Inspections of Food Service Operations	18%	9%
Inspections of Retail Food Establishments	18%	9%
Radon	18%	12%
General Sewage	18%	11%
Built Environment Initiatives	14%	**19%**
EPA Small Flow Program	13%	7%
Vector Control	12%	**15%**
Parks/Camps	11%	7%

*Provide or receive this service from another LHD, multiple LHDs, a state agency, or a non-LHD agency.
Note: This table is sorted by frequency of current sharing (column 2). Bold font indicates top five responses in each column.
Source: AOHC LHD Collaboration Survey, 2012

Table 14. Health Education/Other Services: Current and potential sharing (n=93)

	Current Sharing Percent of responding LHDs that receive this service from another agency or provide this service to another jurisdiction*	**Potential Future Sharing** Percent of responding LHDs that report high interest in future sharing (among those not currently providing or receiving)
Epidemiology Services for Outbreaks and Trending	**53%**	**25%**
Emergency Preparedness	**34%**	15%
Medical Reserve Corps	**31%**	17%
Community Health Assessment Services	**31%**	**28%**
WIC	**27%**	16%
Vital Statistics	23%	8%
Safety Net Dental	22%	19%
Car Seats	20%	15%
Community Health Improvement Planning	19%	**27%**
Citizens Corps	18%	9%
Recycling/Litter Prevention	18%	9%
Corporate Wellness Program	16%	18%
General Health Education	13%	**23%**
Traffic Safety	13%	9%
Chronic Disease Reduction	11%	**30%**

*Provide or receive this service from another LHD, multiple LHDs, a state agency, or a non-LHD agency.
Note: This table is sorted by frequency of current sharing (column 2). Bold font indicates top five responses in each column.
Source: AOHC LHD Collaboration Survey, 2012

Table 15. Administrative/Planning Services: Current and potential sharing (n=93)

	Current Sharing Percent of responding LHDs that receive this service from another agency or provide this service to another jurisdiction*	**Potential Future Sharing** Percent of responding LHDs that report high interest in future sharing (among those not currently providing or receiving)
Legal Services	**33%**	16%
Laboratory	**32%**	27%
Information Technology	**24%**	**34%**
Insurance	**20%**	15%
Purchasing	**15%**	23%
Fiscal	**15%**	8%
Subject Matter Experts	**15%**	**41%**
Leadership Development	14%	**36%**
Public Relations/Public Information Officer	13%	17%
Policy Development	13%	**33%**
Human Resources/Recruiting	11%	22%
Evaluation/Quality Improvement	11%	29%
Marketing	10%	19%
Accreditation Guidance	8%	**33%**

*Provide or receive this service from another LHD, multiple LHDs, a state agency, or a non-LHD agency.
Note: This table is sorted by frequency of current sharing (column 2). Bold font indicates top five responses in each column.
Source: AOHC LHD Collaboration Survey, 2012

Characteristics of successful collaboration

The survey asked respondents to identify what has made collaboration successful for them in the past. Qualitative analysis of these comments identified the following characteristics of collaborative arrangements that have worked well for LHDs:

- Mutual trust and a history of collaboration
- Willingness to "set aside turf issues and work for the betterment of public health and customer service"
- Strong commitment from top-level leadership
- Partnerships between communities with similar demographics and/or ability to customize to local needs for each community; equity for all partners, while being sensitive to unique local needs
- Success at increasing efficiency and/or cost reductions and arrangements that "make good business sense"
- Ability to maintain services that are needed and expected by the community but are no longer feasible for one LHD to provide, for example,

  "In one case [collaboration] allowed us to offer a service we otherwise couldn't because of licensure, training, and level of work required to maintain a person in the program, while at the same time it allowed our neighboring department to keep an inspector full time. A win-win for both agencies."

1.3 Expected, Required, and Funded Services

This section presents expectations about what services local public health agencies should provide, as guided by the Public Health Accreditation Board (PHAB) standards. The Health Impact Pyramid provides additional guidance on the specific types of public health activities that have the greatest impact on improving population health. Together, the PHAB standards and the pyramid model provide reference points for what the national public health community has identified as "good public health." Second, this section discusses what services LHDs are required to provide in Ohio, as specified in the Ohio Revised Code and the Ohio Administrative Code. Finally, this section assesses the extent to which there is alignment between the services LHDs are expected, required, and funded to provide.

What services are LHDs expected to provide?: National standards for essential public health services

Background: What are essential public health services?

There is a great deal of variation in the types of services local public health agencies provide and the way they are structured and governed. In order to clarify the role and functions of public health, the US Centers for Disease Control and Prevention (CDC) developed the Ten Public Health Essential Health Services in 1994, which served as the foundation for further efforts to define the functions of public health departments and to set standards for assessing the quality and performance of public health agencies. The new accreditation standards launched in September 2011 grew out of that work.

A 2003 IOM report, *The Future of Public Health*, called for the establishment of a national Steering Committee to examine the benefits of accrediting governmental public health departments. This led to the development of the Public Health Accreditation Board (PHAB), an independent non-profit entity charged with developing and implementing the new accreditation process. The Ohio Department of Health is in the process of completing prerequisites for state-level accreditation. Accreditation is voluntary at the state and local levels, although LHDs are now required to conduct annual "improvement standard" self-assessments using the PHAB measures.

Table 16 illustrates the evolution of national standards and alignment across models.

Table 16. National public health standards

10 Essential Public Health Services CDC, 1994	**Operational Definition of a Functional Local Health Department, 10 standards** NACCHO, 2005	**Public Health Accreditation Board Standards, 12 domains** PHAB, 2011
"Guiding framework for the responsibilities of local public health systems."	"…Everyone, no matter where they live, should reasonably expect the local health department to meet" the following standards….	"…the range of public health services a department should provide"
1. **Monitor** health status to identify and solve community health problems.	Monitor health status and understand health issues facing the community.	**Assess.** Conduct and disseminate assessments focused on population health status and public health issues facing the community
2. **Diagnose and investigate** health problems and health hazards in the community.	Protect people from health problems and health hazards.	**Investigate.** Investigate health problems and environmental public health hazards to protect the community.
3. **Inform, educate, and empower** people about health issues.	Give people information they need to make healthy choices.	**Inform & Educate.** Inform and educate about public health issues and functions.
4. **Mobilize** community partnerships and action to identify and solve health problems.	Engage the community to identify and solve health problems.	**Community Engagement.** Engage with the public health system and the community to identify health problems.
5. **Develop policies and plans** that support individual and community health efforts.	Develop public health policies and plans.	**Policies and plans.** Develop public health policies and plans.
6. **Enforce** laws and regulations that protect health and ensure safety.	Enforce public health laws and regulations.	**Public health laws.** Enforce public health laws
7. **Link** people to needed personal health services and assure the provision of health care when otherwise unavailable.	Help people receive health services.	**Access to care.** Promote strategies to improve access to health care services.
8. **Assure** competent public and personal health care workforce.	Maintain a competent public workforce.	**Workforce.** Maintain a competent public workforce.
9. **Evaluate** effectiveness, accessibility, and quality of personal and population-based health services.		**Quality Improvement.** Evaluate and continuously improve processes, programs and interventions.
10. **Research** for new insights and innovative solutions to health problems.	Contribute to and apply the evidence base of public health.	**Evidence-based Practice.** Contribute to and apply the evidence base of public health.
		(11) Administration & Management. Maintain administrative and management capacity.
		(12) Governance. Maintain capacity to engage the public health governing entity.

LHD capacity: Results of the 2012 Performance Improvement Assessment
The 2012 results of Ohio's Profile Performance system provide an initial self-assessment of LHD capacity to provide the 10 Essential Public Health Services, as captured in the 12 PHAB domains. LHDs submitted their first-ever Profile Performance self-assessment in March 2012 using an online reporting system developed by ODH. All but one of the 125 LHDs participated. The results are presented in Part 3 of this report.

Implications of PHAB standards for cross-jurisdictional sharing and/or regionalism
The primary relevance of the PHAB standards is that they provide an agreed-upon list of the essential functions of LHDs. Any attempts to change the current LHD structure must keep in mind the basic services LHDs are supposed to provide. Criteria for assessing cross-jurisdictional sharing models should likely address questions such as:

- To what extent is the LHD currently providing the essential functions? Is there currently capacity to provide these essential services? What is the current level of performance and quality?
- How would the new model affect LHDs' ability to provide these essential functions? How would it affect the LHD's performance and the quality of its services?
- To what extent do current funding streams, service categories, and governance structures foster alignment with the PHAB domains? Where are there opportunities for re-alignment?

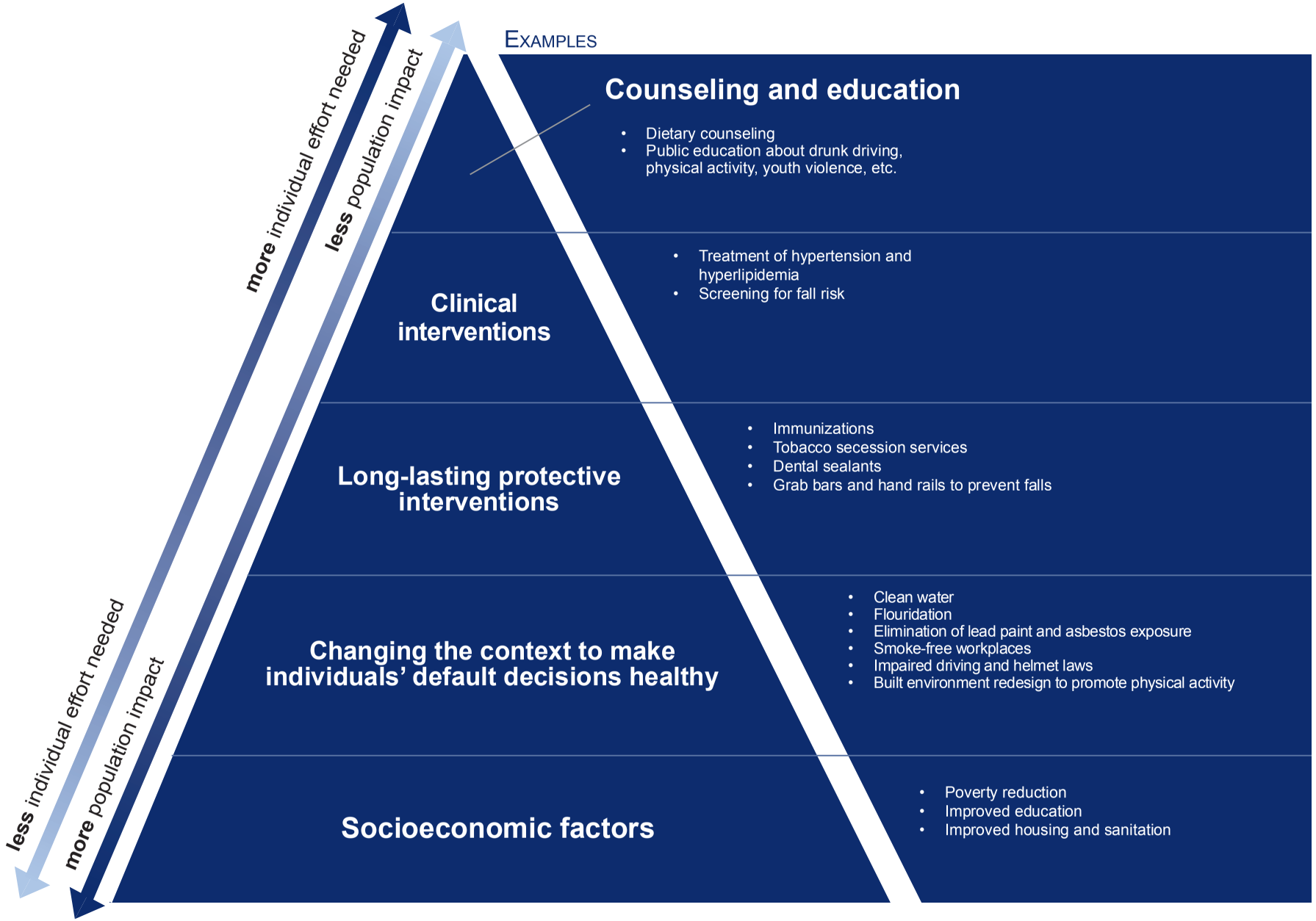
What services have the greatest impact on population health?: The Health Impact Pyramid

Frieden (2010) offers the useful construct of the Health Impact Pyramid to illustrate the types of interventions that evidence shows are most likely to result in improved population health (see Figure 11). Unlike the PHAB domains, which establish a list of core service categories that help form the basic minimum capacity of a public health agency, the pyramid gets at the effectiveness of public health—moving beyond capacity and performance toward outcomes and impact. It provides a framework for prioritizing which types of LHD activities are likely to have the greatest impact on the overall health of the community. With a focus on improving population health, the pyramid helps to emphasize the types of activities that are unique to public health and that public health does well. Specifically, local public health is often the primary provider of activities at the "changing the context" and "long-lasting protective factors" levels. The "socioeconomic factors" level is often seen as being the responsibility of the education sector and poverty-reduction programs. The "clinical interventions" and "counseling and education" levels have traditionally been shared between the health care system and public health, with LHDs providing "care of last resort" to underserved populations and health education services (e.g., school-based tobacco prevention).

Figure 11 displays the Health Impact Pyramid side-by-side with 2010 LHD expenditure amounts and categories in order to assess alignment. The bulk of LHD expenditures appear to be concentrated toward the middle of the pyramid, revealing some strengths and some opportunities to re-align funding. According to this model, it appears that local public health in Ohio could do more to improve its impact on population health by shifting resources away from "counseling and education" and "clinical interventions" and towards "socioeconomic factors," and by maintaining or strengthening current investments in "changing the context to make default decisions healthy" and "long-lasting protective interventions."

Figure 11.

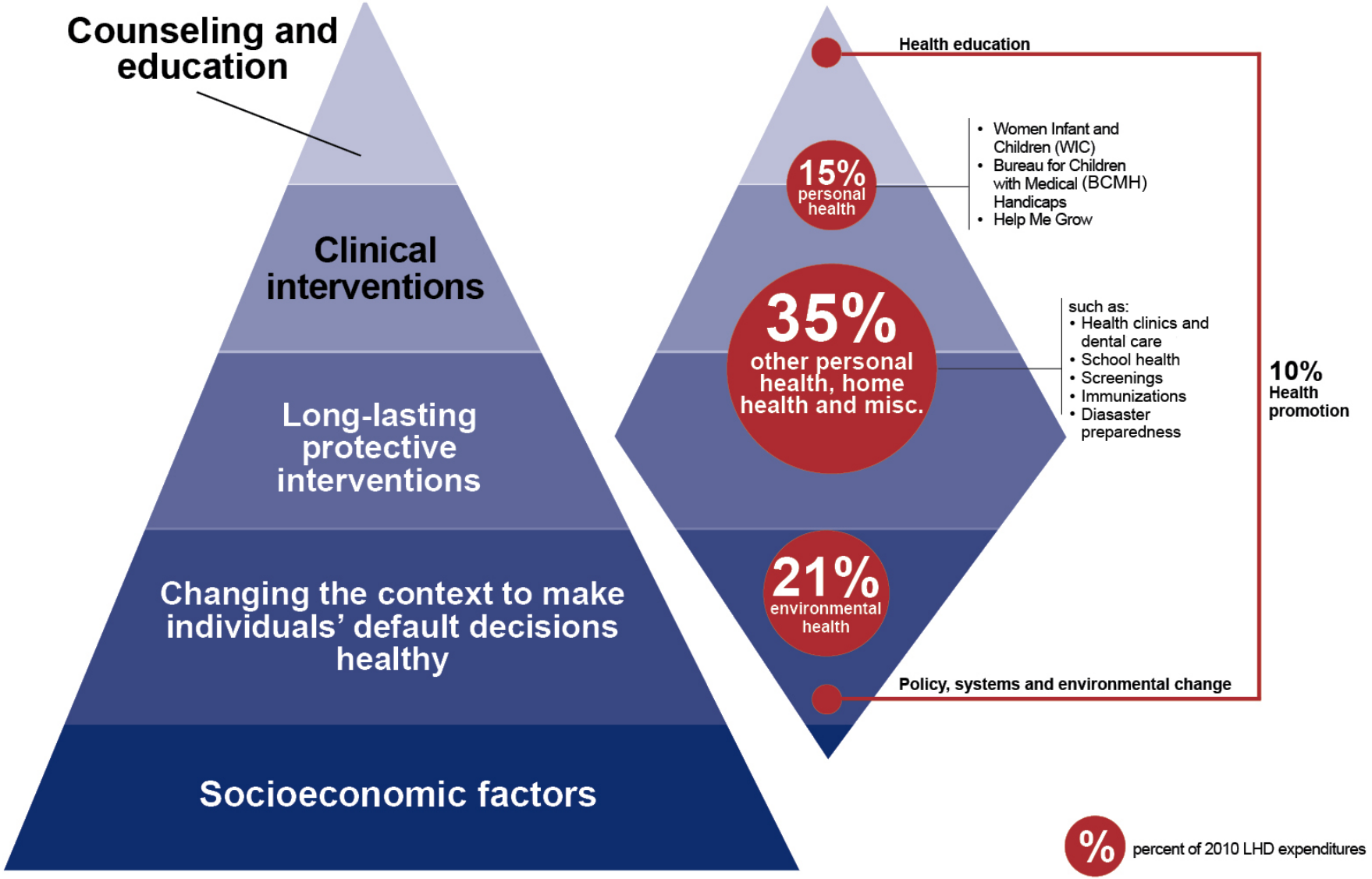
The Health Impact Pyramid



Source: A Framework for Public Health Action, The Health Impact Pyramid, Frieden, M.D., Thomas R, American Journal of Public Health, April 2010.

Figure 12.

Relationship between the Health Impact Pyramid and Ohio LHD Expenditures (2010)



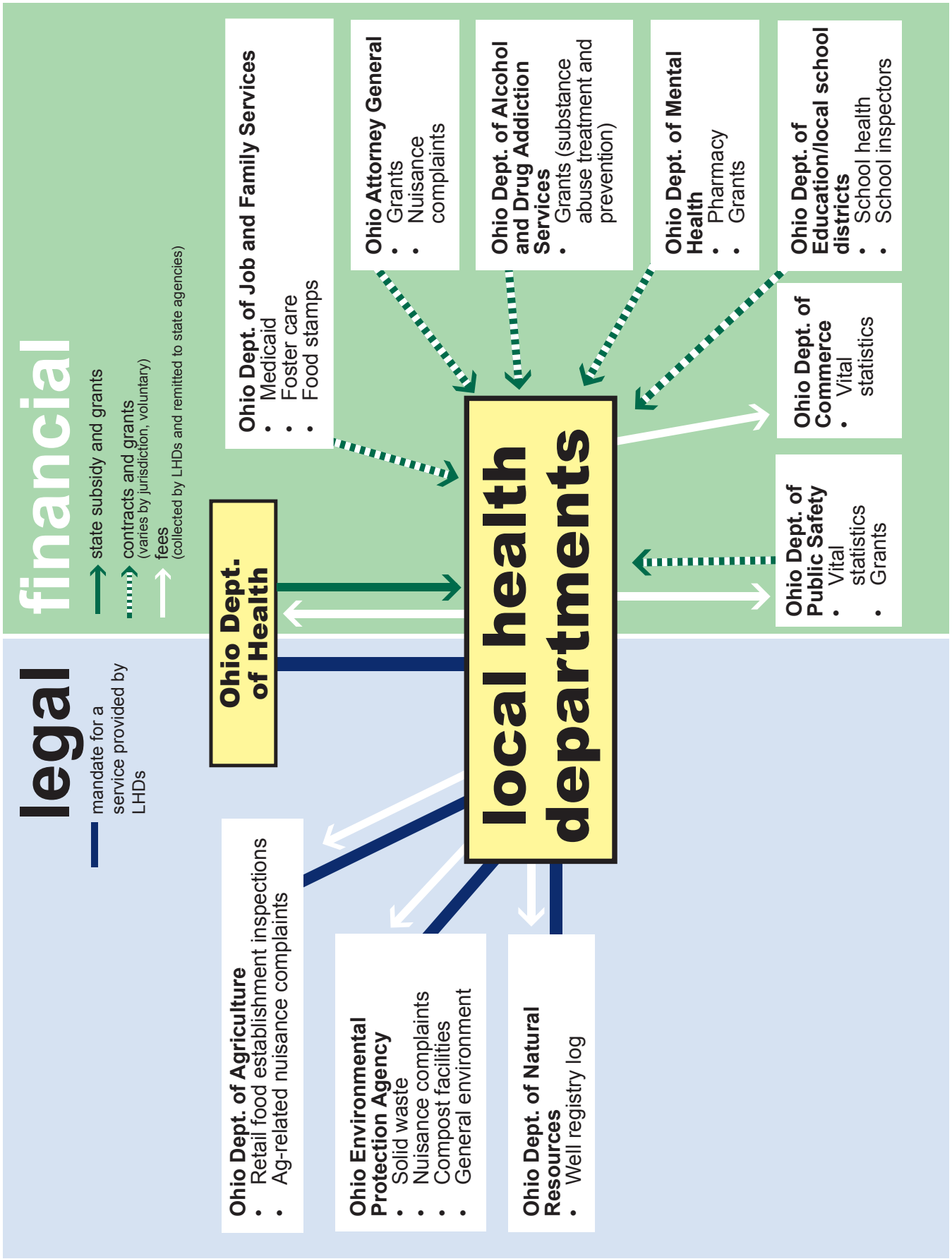
Note: Expenditure category percentages do not add up to 100% because the following categories were excluded: General Administration, Vital Statistics, and Laboratory.
Source for expenditure data: 2010 LHD Annual Financial Report (AFR)

Mandated services

The Ohio Revised Code specifies a set of services LHDs are required to provide. Included are many specific requirements related to environmental health, including water system inspections and the abatement and removal of nuisances, and communicable disease surveillance and reporting. These statutes reflect public health's historical focus on controlling the spread of infectious diseases. The statutes and regulations in the Ohio Administrative Code also include some direct care requirements, such as involvement in the medically handicapped children program and a more general requirement for provision of access to primary care for medically underserved individuals. Although the ORC does include a general mandate for LHDs to provide health promotion and health education services, there is little reference to chronic disease prevention in the statutes. The LHD requirements in Ohio statutes, for example, have not been updated to reflect the epidemiologic shift in threats to health from infectious disease toward chronic disease. On the whole, the bulk of the statutory mandates continue to emphasize the earliest understanding of what LHDs should provide. Table 16 provides a list of mandated services and related relevant statutes are provided in the appendix.

Although the Ohio Department of Health is the primary state agency LHDs report to and receive funding from, LHDs also have legal and financial relationships with many other state agencies. As shown in Figure 13, LHDs are mandated to provide a range of inspection and registry services on behalf of the Ohio departments of Agriculture, Environmental Protection, and Natural Resources. In some cases, LHDs collect fees or fines related to these inspections and registries that are then remitted back to the relevant state agency. Some LHDs also receive grants from or enter into contracts with other state agencies, such as the Department of Job and Family Services. LHDs also have other voluntary interactions with additional state agencies, such as the Department of Commerce, the Department of Public Safety, and the Attorney General's Office.

Figure 13.
Legal and Financial Relationships between LHDs and State Agencies



Relationship between mandated, permitted, funded, and expected services

Figure 14 displays examples of the types of services provided by local health departments in Ohio. The seven Public Health Accreditation Board (PHAB) domains represent service categories recognized by the public health community as essential services that should be provided by health departments. Mandated and permitted services are specified in the Ohio Revised Code (ORC) and the Ohio Administrative Code (OAC). The services in the "funded" column refer to relevant revenue categories reported by LHDs. Based on this analysis, it appears that locally generated funds (often in the form of fees) are largely responsible for funding services related to the Assess, Investigate and Public Health Law functions, which overlap heavily with environmental health services. The Access to Care function is funded by a mix of local healthcare reimbursements (Medicaid, Medicare, insurance, fees) and state and federal grants (including Help Me Grow, WIC, and women's health). Dedicated funding streams for the Inform and Educate, Community Engagement, and Policies and Plans functions are more difficult to identify, possibly indicating a lack of direct revenue in these areas.

The remaining PHAB domains — Workforce, Quality Improvement, Evidence-Based Practice, Administration and Management, and Governance — typically do not have dedicated funding streams. Ohio law does include some mandates related to workforce, quality improvement, and governance (see Appendix for full list of provisions).

Figure 14.

Expected, mandated, and funded services provided by local health departments in Ohio

Essential Public Health Services PHAB Domains related to service provision	Summary of Services Specified in ORC Statutes and OAC Regulations (see appendix for detail) Mandated Services	 Permitted Services	Funded Services Relevant revenue sources (AFR)
Assess Conduct and disseminate assessments focused on population health status and public health issues facing the community **Investigate** Investigate health problems and environmental public health hazards to protect the community	• Water supply and sewerage investigation and reporting; heating, plumbing, and ventilation investigation in public buildings • Communicable disease investigation, reporting, and control (including HIV/AIDS) • Analysis of causes of morbidity and mortality • Private water system assessment • School inspections • Disease vector inspection • Disease prevalence reporting	• Community health assessment • School, jail, and other public facility inspections • Restaurant inspections • Laboratory services • Public nuisance inspections	Local: Environmental Health fees and contracts **11% of total revenue** Local: Vital Statistics fees **4% of total revenue** Local: Laboratory (environmental) **<1% of total revenue** Portion of other local and state sources (dedicated sources and amounts not identified)
Inform & Educate Inform and educate about public health issues and functions	• Health promotion and health education	No specifically relevant statutes	Portion of some State and Federal grants (dedicated sources and amounts not identified)
Community Engagement Engage with the public health system and the community to identify health problems	• Participation in the county Children and Family First Council	• Promote cooperative arrangements and coordinate with other agencies of local or state government, including area-wide planning	No discrete identifiable funding source
Policies and plans Develop public health policies and plans	No specifically relevant statutes	• Coordinate area-wide planning • Review and make recommendations on public facility projects, programming, and policies	No discrete identifiable funding source
Public health laws Enforce public health laws	• Exclusive power to establish fees for administering and enforcing rules regarding private water systems and water system inspections • Quarantine and isolation authority for individuals • Abate and remove all nuisances within jurisdiction	• Ability to petition the court of common pleas to require an individual to comply with a quarantine order • Regulate location, construction, and repair of privies, cesspools, drains, plumbing, yards, pens, stables, etc. • Cause arrest or prosecution of persons who disregard a board of health order • Quarantine authority for vehicles • Ability to destroy infected clothing, bedding, etc. • Ability to make regulations regarding the prevention or restriction of disease, and the prevention, abatement, or suppression of nuisances	Portion of local Government Funds, Fees and Contracts for Environmental Health, and other local funding (dedicated sources and amounts not identified)
Access to care Promote strategies to improve access to health care services	• Provide for access to primary health care for medically underserved individuals (to the extent included in minimum standards) • Distribute anti-toxin for diptheria	• Provide free or low-cost vaccinations • Provide or contract for home health care • Provide prenatal clinics and infant care (“infant welfare stations”) • Medical and dental supervision of school children • Provide free treatment and quarantine for sexually transmitted diseases • Establish and run detention hospitals for cases of communicable diseases • Medically handicapped children program: service coordination, public health nursing, transportation, and outreach (BCMH)	Local: Earned Healthcare Reimbursement **8% of total revenue** Local: Laboratory (clinical) **<1% of total revenue** Portion of State Grants **5% of total revenue** Portion of Federal Pass-through and Federal Direct Grants **20% of total revenue**

1.4 Other Regulatory and Policy Factors

Health care reform and related initiatives

The Affordable Care Act (ACA) contains numerous provisions relevant to public health agencies. Helpful lists and summaries of key provisions are available at www.naccho.org/advocacy/healthreform.cfm and www.ASTHO.org.

The following areas in particular provide the need and opportunity for LHDs to consider how their role can evolve in response to the ACA and other health care reform initiatives.

Access to care: Potential implications for clinical services, care coordination, and insurance outreach and "navigation"

Clinical services. If the ACA is implemented as planned, more Ohioans will gain coverage as a result of several provisions, including the extension of dependent coverage in private health plans, Medicaid eligibility expansions, insurance subsidies, and the individual mandate. An estimated 800,000 currently uninsured Ohioans may gain health coverage by 2017, although the number could range from a low of 500,000 to a high of one million (Milliman, 2011). Just as critical as the coverage expansions, the ACA requires first dollar coverage of clinical preventive services by all public and private insurers (new plans only).[i] In addition, essential benefit requirements will ensure access to a minimum level of benefits.[ii]

As a result, the role of local health departments in providing clinical services will need to evolve. While the leading example is immunizations, (97% of local health departments provide immunizations (2011) (Center for Public Health Statistics and Informatics, Ohio Department of Health, 2011),[iii] local health departments provide a range of clinical services, to which significantly more Ohioans will have access after full ACA implementation. LHDs may have a role in providing safety net care for those who remain uninsured (e.g., undocumented immigrants, those exempt from individual mandate) and may need to develop new business models to bill insurance for covered patients or contract to provide services.

Care coordination. The role of care coordination and case management has gained increasing support within Ohio and nationally. Along with that is recognition that community partners and auxiliary health workers are an important part of the equation for effective care and improved outcomes. The ACA includes a range of provisions that encourage greater case management and care coordination, including Accountable Care Organizations (ACOs), Medicaid Health Homes, and Integrated Care Delivery System (ICDS) for dual eligibles. Many LHDs have staff and experience with case management for programs such as Bureau for Children with Medical Handicaps (BCMH) and Help Me Grow, among others. LHDs may therefore have a role providing case management capacity, although the mechanism for doing so is not yet clear.

Insurance outreach and Navigators. The actual number of uninsured Ohioans who gain insurance coverage will depend somewhat on the effectiveness and

aggressiveness of Medicaid and insurance exchange outreach and enrollment efforts. Ohio officials, led by the Governor's Office of Health Transformation, are already moving forward to modernize and streamline Medicaid eligibility and enrollment systems. LHDs may have a role in leading or supporting outreach and enrollment efforts for Medicaid.

The ACA created a Navigator function to help people obtain insurance through their state's health insurance exchange. Navigators are meant to help individuals and families address their health care needs with the right health plan and to educate people about their health plan options. Navigators will be funded through grants provided by state exchange funds. While public health departments are not named specifically as a type of group who can serve as Navigators, the ACA indicates that other entities capable of carrying out the required duties can serve.[iv] LHDs may have a role serving as Navigators for underserved populations.

Data for community health assessments and quality improvement

Community Health Needs Assessments. For tax years beginning after March 23, 2012, the ACA requires nonprofit hospitals to conduct community health needs assessments (CHNAs). Failure to comply results in financial penalties and the potential loss of tax-exempt status. The primary purpose of a CHNA is to identify community health needs for the purpose of developing activities that improve community health status (The Hilltop Institute, 2011). Hospitals must:

- Conduct a CHNA within the 3-year period that begins on the first day of its first tax year beginning after 3/23/2010, and ending on last day of its first tax year that begins after 3/23/2012; and at least once every 3 years thereafter (Section 9007 (f)),
- Incorporate into its CHNA input from "persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health" (Section 9007(a), I.R. C. section 501(r)(3)(B)),
- Make its CHNA "widely available to the public" (Section 9007 (a), I.R.C. section 501(r)(3)(B)), and
- Develop an implementation strategy to meet the needs identified by the CHNA, describe identified needs not addressed by that strategy, and explain why these needs are not being addressed (Section 9007(a)-(b)).

This requirement provides a new opportunity for LHDs to collaborate with hospitals to conduct assessments, and may also provide LHDs with new sources of data and additional resources or capacity for conducting their own needs assessments.

Health Information Technology. Health information technology (HIT) can be used to track clinical conditions, coordinate care, report quality measures, and gather and report population health information. In the past seven years, Ohio has become a national leader in the adoption of health information technology (HIT). As of March 2012, Ohio had more primary care physicians (6,000) signed up to adopt electronic medical record systems through the Ohio Health Information Partnership than any other state in the nation. Cincinnati-based HealthBridge's Tri-State Regional Extension Center[v] serving southwestern Ohio signed an additional 997 providers with more than 50 percent of those having already adopted an electronic health records (EHR). Ohio's overall vision

is to build an infrastructure that will allow all health care providers to seamlessly share patient health records electronically across the state.

The US Department of Health and Human Services (HHS) has issued proposed Stage Two Meaningful Use Standards assuming that data submitted through the regional Health Information Exchanges will be the source for public health related data (including, for example, immunization records). In addition, standards for Electronic Health Records have been changed to reduce the need for provider-specific customization and /or paying for capacity unrelated to the provider's needs. These standards focus on interoperability.

The public health community will need to be engaged in Ohio's evolving HIT process in order to ensure that LHDs are able to contribute to and access new data systems. Key questions to be addressed include:

- Will Ohio structure a public health information system able to exchange data between programs within and across public health agencies **and** with clinical systems?
- Should the Ohio Department of Health relieve LHDs of their statutory registry report receiving responsibilities since pertinent information should be available through the EHRs submitted by providers through the HIE?
- What information will local public health agencies report and access in order to support the shift to population-based health?
- Do LHDs have the technology and workforce capacity needed to interact with new data systems?

Resources for prevention and public health infrastructure

Prevention and Public Health Fund. The ACA included the creation of the Prevention and Public Health Fund, the nation's first mandatory funding stream dedicated to a comprehensive approach to wellness. The Fund is to be used for community prevention, including the Community Transformation Grants (two capacity-building grants awarded in Ohio in 2011), clinical prevention, public health infrastructure and training, and surveillance and prevention research. Unlike most other prevention and public health funding which relies upon discretionary appropriations that are vulnerable to annual fluctuations and cuts, the Fund is separate from the annual federal budget process. The Fund was intended to add to existing public health resources, although some observers are concerned that the funds will simply be used to offset cuts in existing prevention programs (Health Policy Brief: The Prevention and Public Health Fund, 2012). The ACA initially allocated $15 billion over its first 10 years—a significant investment when compared to the CDC's FY2010 core program budget of $6.46 billion. However, legislation signed by President Obama in February 2012 cuts the fund by $5 billion over ten years starting in fiscal year 2013, a 33 percent reduction. LHDs will have opportunities to compete for the grant-funded programs, which will focus largely on community-based prevention of tobacco and obesity, improving awareness and access to preventive clinical services, and public health infrastructure. LHDs may also have a role in advocating to protect the Fund from future cuts or elimination.

National Prevention Strategy. Developed by the newly-formed National Prevention, Health Promotion, and Public Health Council, the National Prevention Strategy is the nation's first comprehensive prevention plan that includes all federal agencies. The Strategy may be useful to LHDs in that it provides a useful framework for planning and prioritizing prevention activities, specifies relevant evidence-based practices, and includes key indicators for assessing impact.

Ohio's health care reform strategies

At the state level, the Governor's Office of Health Transformation (OHT) is implementing several initiatives (many that flow from ACA provisions) that are relevant to public health. These include:

- Provide Accountable Care for Children
- Encourage Patient-Centered Medical Homes
- Health Homes for People with Chronic Conditions
- Reduce Tobacco Use
- Improve Medicaid managed care plan performance
- Improve Services for People with Mental Illness
- Provide GRF Funding for Pneumococcal Vaccines for Children
- Lower Infant Mortality Rates
- Accelerate the Adoption of Health Information
- Share Information across state and local data systems
- Modernize Medicaid and Health and Human Service programs eligibility

Several themes are common across these initiatives, including care coordination, integrated care, person-centered care (as opposed to provider-centered), focusing on "hotspots" (high cost centers that can yield savings with intervention), and payment reform. As LHDs plan for how their roles must evolve, considering these themes is essential.

State Health Improvement Plan (SHIP)

In 2010 and 2011, ODH convened a Planning Council made up of representatives from local health departments, academia, provider organizations, other health and human services state agencies, consumer advocacy groups, health professionals, and health policy and regional planning experts to conduct a State Health Assessment (SHA) and develop a State Health Improvement Plan (SHIP). According to ODH, the SHIP Planning Council will develop measurable and achievable goals, identify strategies and specific activities, identify key partners and funding sources, and establish 12-month and 24-month outcomes for 11 priority areas:

Health Improvements

a. Chronic disease prevention
b. Injury
c. Infectious disease
d. Infant mortality/pre-term birth
e. Mental health and addiction

Service Improvements

a. Access to care

b. Patient-Centered Medical Home
c. Integrate physical and mental health/addiction

Operational Improvements

a. EHR/HIE/Data exchange
b. Workforce development
c. Funding (capacity building and technical assistance for grants)

ODH anticipates releasing the SHIP by fall 2012.

Relevance to cross-jurisdictional sharing

The SHIP provides guidance on statewide public health priorities and topics that ODH will likely be focusing on in the coming years. The priorities in the Health Improvements category highlight community needs that public health professionals in Ohio feel are the most important to address. As LHDs consider the range of services they will provide in the future, these areas warrant attention. All of the Service Improvements relate to direct health care services and are therefore relevant to LHDs that provide clinical services or work closely with health care providers. The Operational Improvements category may be more directly relevant to cross-jurisdictional sharing. In particular, the Funding work group will be exploring ways for public health agencies to leverage more funding, particularly from federal sources.

Ohio's health outcomes

Ohio's health outcomes lag behind those of many other states. Ohio ranks 42nd on the Commonwealth Fund State Scorecard Healthy Lives dimension and 39th in infant mortality. Ohio has more residents who are obese or are smokers compared to other states and Ohio's health care spending is relatively high (see Table 16). As discussed earlier, Ohio also ranks quite low when it comes to investments in public health. Efforts to modernize local public health will need to identify health outcome improvement as a top priority and make the case for the value of public health investment in reducing the burden of disease and health care costs in Ohio.

Table 16. Health Outcomes & Investments in Public Health: How does Ohio rank?

	State Rank (1= best)
Health outcomes	
Commonwealth Fund State Scorecard: Healthy Lives dimension ±	42
America's Health Rankings: All Outcomes €	37
Infant mortality €	39
Premature death €	32
Health factors	
America's Health Rankings: All Determinants €	36
Obesity €	35
Smoking €	45
Health care costs	
Health care expenditures per capita (better rank indicates lower per capita spending on personal health care services) ◊	33
Investment in public health	
State public health budget per capita* (better rank indicates higher per capita budget)	41
Centers for Disease Control and Prevention funding per capita*	50
Health Resources and Services Administration (HRSA) funding per capita*	39
Local health department expenditures, median annual per capita** (rank among 44 states with available data)	33
Tobacco prevention spending***	50

Sources:
*Investing in America's Health: A state-by-state look at public health funding and key health facts. Trust for America's Health, 2011.
**2010 National Profile of Local Health Departments, National Association of County and City Health Officials, 2011)
*** Campaign for Tobacco-Free Kids Key State-Specific Tobacco-Related Data & Rankings, 2012
± Commonwealth Fund State Scorecard on Health System Performance, 2009, http://www.commonwealthfund.org/Maps-and-Data/State-Data-Center/State-Scorecard.aspx
€ America's Health Rankings, United Health Foundation, 2011 http://www.americashealthrankings.org/
◊ Kaiser Family Foundation, statehealthfacts.org, Health Care Expenditures per Capita by State of Residence, 2009, http://statehealthfacts.org/comparetable.jsp?ind=596&cat=5&sub=143&yr=92&typ=4&sort=a

PART TWO: STAKEHOLDER CONSIDERATIONS AND LESSONS LEARNED

Objectives

- Identify key factors impacting the future of local public health and considerations for cross-jurisdictional sharing, as expressed by local health commissioners and state-level stakeholders
- Identify lessons learned from experiences with collaboration and consolidation within public health and related systems
- Introduce guiding concepts that may help to inform decisions about new models
- List criteria and considerations for assessing available models

2.1 Stakeholder Considerations

Key-informant interview results

Purpose and methods

The purpose of the key-informant interviews was to obtain feedback from key stakeholders on the following issues:

- Future role of public health and implications for the new model
- Current climate of collaboration
- Factors making future sharing/collaboration appealing and/or necessary
- Factors that might impede future sharing/collaboration
- Other considerations

HPIO conducted 25 key-informant interviews in January and February 2012. The interviewer used a semi-structured set of questions (see Appendix) and conducted 60-minute interviews by phone or in person based on participant availability and logistical considerations. HPIO worked with the Steering Committee to identify individuals with first-hand knowledge and experience with issues affecting the public health and the governmental collaboration landscape. All key-informants who were asked to participate agreed to do so (100% response rate). A full list of participants is provided in the Appendix. The key-informants represent two distinct groups:

- *Local Public Health Group* (n=18): All of the Public Health Futures Steering Committee members and its staff (Executive Director, AOHC). The Committee members were appointed by the AOHC Board of Directors and represented all geographic areas of Ohio and local district sizes.
- *Statewide Policy Group* (n=7): Senior officials from the Ohio Department of Health and the Governor's Office of Health Transformation were pre-selected by the Steering Committee (n=5). HPIO also identified additional informants with relevant knowledge and experience with "leaner government" and shared services (large regional Educational Service Center and Kent State University's College of Public Health and Center for Public Administration and Public Policy; n=2).

Interview questions were tailored somewhat to reflect the different experiences of the two groups. Both groups were asked to comment on the value and role of public health in the future and the current climate of collaboration. Two questions were asked only of the Statewide Policy Group:

- In what ways can your department or organization assist with opportunities for sharing or consolidating?
- Discuss information technology, performance measurement, and the preferred focus of locally delivered services.

Most Local Public Health Group members were interviewed first, followed by the Statewide Policy Group, although some deviations in staging occurred to accommodate interviewees' schedules.

Key Messages

The following themes emerged as strong messages and areas of consensus across both groups of stakeholders:

- Nearly every key informant believes that *the time is right* for a systematic approach to develop a model for the future. Almost all felt that figuring this out may be difficult, but is necessary.
- There is broad agreement that the new model should define and be developed with a *minimum standard of health protection* being available statewide in mind. Most informants believe that the new model needs to address ways of organizing, funding, and providing capacity to support such a standard as a high priority.
- Everyone in the Local Public Health group reported that they are *already doing a great deal of collaborating* within the public health system. All but a few view this positively and most are motivated to do more for reasons other than pure necessity. Only a few were negative or skeptical about collaboration in general; these respondents tended to view resource sharing as a necessity related to factors beyond their control.
- *Motivations are high and interest in new approaches is pervasive* among representatives of nearly all types of jurisdictions and sizes. Informants pointed to many examples of success in their current ways of collaboration, along with acknowledging that there are probably more efficient ways to organize and do things together.
- Nearly everyone prefers that *next steps taken should be initiated from within the public health system*, rather than being imposed externally.
- *Deciding what are truly local needs* was a common theme, as is figuring out how to address those needs within a new model.
- Most interviewees urged that the future model should *prioritize services and activities that public health can do and others systems cannot or do not do*.
- Most believe that public health should be *more connected with and do more partnering with the broader health care system*. Nearly all in the Local Public Health group and all of the Statewide Policy informants talked about needs and benefits related to this in terms of playing a role that helps achieve measurable outcomes or

that helps affect costs (administrative and/or health care). Most suggest factoring more connectedness into how public health's future model can think about ways to afford the capacity needed to meet a minimum standard of health protection.

No single strategy emerged about what future models of cross-jurisdictional sharing should look like. However, nearly everyone believes the future model has to address organizing, funding, and capacity needed, although the specifics vary. For example, the question of how many local public health agencies there should be is an area of disagreement, as is how to get there. Most participants mentioning a specific number talked about a number and size tied to the 88 counties. For example, one interviewee said, "I can't see any reason why we shouldn't or couldn't get to 88." In terms of how, as one informant put it, "consolidation isn't a silver bullet" and most people talked about doubting that "one size fits all."

Most informants feel there is a need to develop a better understanding of the variety of ways cross-jurisdictional sharing can be done, and to specify the purpose of different models. Most in the Local Public Health group talked about how they currently spend so much time trying to patch together funding that they have not had the luxury of researching models of successful consolidation and resource sharing. Of the few in the Local Public Health Group who mentioned a specific model, most pointed toward models from inside public health. On the other hand, in the Statewide Policy Group, there was more talk about looking at models and collaborative experiences from outside public health. Information about collaboration models mentioned in the interviews will be reported separately.

Future role of public health and implications for the new model

In describing the future role and value of public health, most key informants used the following words: preventing, promoting, protecting, and partnering to achieve outcomes. These terms therefore provide a useful starting place for describing the role of public health and the specific services and functions local public health should continue to provide.

All Local Public Health Group informants stressed that public health is a critical part of providing the health protection and promotion infrastructure in Ohio and that local authority and capacity is important. All mentioned the importance of roles that fall within the traditionally accepted three core functions of public health (Assessment, Assurance, and Policy Development). Nearly all mentioned at least several roles consistent with the ten standards in NACCHO's Operational Definition of a Functional Local Health Department (2005). Some informants described the future role more generally by simply referring to the Public Health Accreditation Board Standards (PHAB). One informant responded succinctly, "the PHAB standards tell us what we are supposed to be doing and that's what we should do." One informant in the Statewide Policy Group observed that "accreditation is fine, and should be pursued if public health thinks it is of value." This informant emphasized that accreditation is not considered to be a key strategy for getting to fewer entities.

Access to care. The idea that local public health's traditional role "no longer fits" was frequently mentioned. Most respondents in both groups felt that the new model should "scrutinize" public health as a provider of primary health care. While interviewees expressed this idea in various ways, key phrases included the need to consider future roles in primary care provision using a "last resort" standard, to be defined by thinking about factors like "providing low volume/high need preventive services no one else is likely to do." For example, questions about who would do travel immunizations were mentioned. Most people also mentioned the need to think about factors related to geographic disparities around access to primary care through the local health delivery system. This was especially prevalent among the informants from smaller sized districts in the Local Public Health group.

Most informants in both groups talked about public health's future model needing to shift the focus away from providing primary health care services (individual impacts), toward more population-based health, policy change, social norms marketing, and systems and environmental change. Most holding this view described "disease" in terms of focusing on chronic disease prevention. In general, there are varying views on what "population-based" means in terms of what should be done locally, regionally, or statewide. People in the Statewide Policy Group and also those from larger agencies in the Local Public Health Group emphasized regional or statewide markers for the population size. "Partnering" with the state or the broader health care system also was mentioned frequently.

Most informants in both groups also mentioned looking at the emphasis of "care coordination" for people with chronic diseases in state and federal health reforms, while considering where to go around the provision of health care.

Those in the Statewide Policy Group expressing a specific view emphasized that if a local public health agency is going to provide primary health care, it should consider local market conditions and focus on being a good provider. Models such as the primary care medical home initiative, or seeking health care provider accreditation/credentials were mentioned. Nearly everyone in the Statewide Policy Group talked about using shared services for "back room" and population-based activities, so that local agencies could focus on what they need to do or are best situated to do. For example, more than one interviewee cited the advantage of models like the Educational Service Centers that lets school districts focus on teaching, instead of administering.

Disease prevention. Nearly all the stakeholders interviewed said that the role around communicable disease prevention, intervention, and follow up is very important. Informants in the Local Public Health Group tended to emphasize environmental and food inspection functions more often than informants in the Statewide Policy Group. Of those, interviewees from smaller sized districts talked about disease prevention and environmental and food inspections, while informants from larger sized districts and the Statewide Policy Group were more likely to discuss disease prevention in the context

of broader health care reform impacts, mentioning the need to focus more on "chronic" disease prevention.

Convening and planning. The idea of public health being a convener and planner was mentioned by nearly everyone in the Local Public Health Group. Again, there are varying views about who should be being convened and what the purpose of the convening and planning roles ought to be. Frequently, people mentioned the idea that public health can be effective in this role when it can be perceived as "neutral" and concepts like "public versus private financial interests" and "a source for credible, science-informed health information" were also mentioned. The Statewide Policy Group informants discussed the convening and planning function in relation to looking at market conditions and partnering with other health or public systems (assisting a hospital-based system, for example; the key message was flexibility and "partnering" around the planning role).

Emergency preparedness. There is broad agreement across groups that maintaining Public Health Emergency Preparedness and Response is very important. Frequently mentioned ideas within the Local Public Health Group centered around the importance of paying attention to having local officials with the ability to act because they have "unique statutory powers no else has locally." Many respondents in this group and some in the Statewide Policy Group also cited the regional approaches arising from grants and the response to 9/11/2011 as positive examples where sharing is occurring while this local capacity is being maintained. Two in the Statewide Policy Group encouraged thinking about a variety of ways to provide local response capacity, including through regional arrangements, or having the Ohio Department of Health being able to "deploy" what's needed.

Current Climate of Collaboration

All but very few informants are open to and are currently doing collaboration. Overall, nearly everyone mentioned success in current regional and cross-jurisdictional approaches for some public health functions, some administrative functions, and especially making limited, but needed, specialized expertise available to local public health agencies who can not afford or attract people with these skills.

Most people in both groups feel good about what has been accomplished, although the Statewide Policy Group would like to see "more." Nearly everyone in the Local Public Health Group feels that the positives around the current climate are something they should have a chance to build upon.

Most from the Local Public Health Group are open to the possibility of using regional shared services for some public health roles and functions. The most prevalent message among Local Public Health informants was one of being "open" to looking at regional distribution or pooling of funding and specialized expertise, if how can be determined. Most in the Statewide Policy Group also expressed being "open" and said they "look forward to specific proposals" from public health.

Almost no one in the local public health group wants regional solutions imposed externally. Most of the informants in the Local Public Health Group said that local autonomy is important and they would like to have more options than just consolidation. Most people in the Statewide Policy Group think that changes in governance are essential. Several in the Local Public Health Group mentioned that "it depends" on the local situation, whether changes in governance are the right approach. For example, one informant noted that they have to contract with "18 tiny jurisdictions" which each want different things and have varying ability or willingness to pay for "the basic infrastructure." Several mentioned that too many jurisdictions within a county, for example, can lead to confusion for business, and can preclude greater economies of scale (citing inability to agree on county-wide food inspections rules and processes, for example).

Informants in the Statewide Policy Group emphasized that public health needs to look at what is being accomplished around the leaner government initiatives at the state level and locally and how fast. Several people in this group mentioned that they were open to hearing from public health "how they could help as soon as possible." They pointed toward changes in the law to make contracting for shared services easier, mentioned examples of successes, noted trends, and in general expressed preferences for regional or consolidated approaches. These people view these as positive factors making the environment for cross-jurisdictional sharing more "conducive."

Factors making future sharing/collaboration appealing and/or necessary
Statewide Policy Group members pointed out that "everyone" is looking at consolidating and sharing services, and that public health "is no different." Most everyone in the local public health group agrees.

There is a perception among informants in the Statewide Policy Group that there is some "inertia" within public health. Everyone in this group noted that the environment is changing "around" public health. Words like "momentum" and "speed" were used when talking about systems or local governments outside public health. Several mentioned that a policy of "carrots and sticks" should be taken into account and that it ought to be expected to affect the future model for public health.

Areas mentioned often by most in both groups included pressures on county commissioners around millage, the erosion of the state employee workforce, cuts in state funding, and that most don't have the resources to maintain a basic infrastructure within the status quo. The Statewide Policy Group reiterates that this is the case in many areas of government, not just public health, and that's why the leaner government initiatives are so important. The agenda around the goal of reducing the number of local governmental entities is being aggressively pursued.

Both groups agreed that while much sharing is already being done, the costs of current approaches are still too high. Local public health group members most frequently

mentioned how the fragmented and uneven funding are what has been driving a lot of the collaboration to date. The Statewide Policy Group pointed toward consolidation and model shared service arrangements in other systems.

Many informants in the Local Public Health Group and all in the Statewide Policy Group talked about the costs and effort around the status quo. As one person in the local public health group put it, "we have a system that is being figured out one grant, one staff position, one tiny jurisdiction, or one program at a time." Another said, "most of us cannot afford the basic infrastructure – we are too small." One informant in the Statewide Policy Group said, "you need to identify the high-value targets for consolidation and sharing."

Everyone agrees that costs have to be reduced. There are varying views about the best ways to do that. The Statewide Policy Group mentioned "standardizing regulations and processes" and "there are too many local public health districts."

Most people in both groups mentioned that some public health functions could be at statewide or regional or "at least" the county level. Most people believe that figuring this out quickly is essential.

Everyone mentioned funding issues, with most pointing out that Ohio's per capita funding for public health is low. On funding, interviews from the Statewide Policy Group emphasized that the overall amount of funding is not going to change in the near term (one said "well, it isn't going to get any better, is it?") and so public health and everyone else need to "figure it out" and "soon." Another said " the issue isn't that there isn't more funding. People should think about how much funding there already is and figure out how to optimize those resources."

Most in the Statewide Policy Group believe that time is running out for public health to get its proposals together. They pointed out that the health transformation and leaner government initiatives are proceeding quickly. One informant said "the world is changing around them so they had better hurry." All described specific models and resources that public health should be considered.

Factors that might impede future sharing/collaboration

Financial issues

- There is broad agreement among informants in both groups that the fragmentation and complexity of the current funding streams are disincentives to sharing.
- Nearly everyone in both groups agrees that responsibilities, state and local expectations, and funding are not currently aligned. Frequently mentioned is the idea that current dependence on local funding is misaligned with where public health needs to go. About half in the Local Public Health Group think the state should provide more funding. Some in both groups mentioned the need to at least "take a look" at the subsidy distribution formula, which as more than one person said, "makes absolutely no sense whatsoever."

- Many in the Local Public Health group talked about funding factors making it more difficult to pursue cross-jurisdictional sharing. For example, they mentioned that state agencies provide too little funding for public health to "really matter" or that the state distributes funds in regional ways "without consulting local agencies about the best configurations." Many in Local Public Health Group point toward the overall "dependence" on local revenues tied to jurisdictional authority "built into" the system. One interviewee from Local Public Health pointed out that the state "loves having my small agency because we are revenue collectors for them."
- Many people in the Local Public Health Group mentioned that there would be better ways to use state funding than parceling it out the way it's being done now. It is not clear who "gets to decide" a new way. One person captured the idea by saying, "it's a mystery how ODH makes decisions around how funding is distributed" and several mentioned that ODH draws regional boundaries for different grants or programs that have little to do with "reality here on the ground." In addition, people mentioned that regional grants often carry "strings" that are irrelevant or "low priorities" in many jurisdictions under the grant, "diverting" or "diluting" resources from what would be most effective considering local conditions.
- Most people in both groups also mentioned that figuring out how to get more federal grants is important. Several noted a relationship between how state and local funding is "sliced and diced" as a factor impeding more success. Informants in the Local Public Health Group frequently mentioned the issue of having to "compete with each other" which affects Ohio's overall competitiveness for federal money.
- Everyone in the Local Public Health Group thinks the funding issues "will" or "could" make it hard to figure things out for the future model. A few tied this to changes in governance and barriers to consolidation under current laws. For example, smaller jurisdictions would have disproportionate power (to their size and contributions in funding) if say a large city district and many smaller districts within in the county were to come together.

Lack of consensus on structure for change

- Areas of disagreement are a major impediment to moving forward. A member of the Statewide Policy Group said, "that is one reason why we asked public health to bring forward a proposal."
- Most in the Statewide Policy Group acknowledge that these can be "thorny" issues, and mentioned that they were "open to proposals." They again point toward changes in governance being looked at. Some expressed willingness to consider needed changes in the law around consolidation, stating again "we look forward to specific proposals from public health."
- There are varying views around governance and jurisdiction size issues. One informant in the Local Public Health Group said "different solutions fit different communities and situations" – this is an idea that is very common among the local public health group members. Most respondents in the Statewide Policy Group expressed views about how many agencies or jurisdictions there ought to be more concretely, including "everyone knows there is a minimum number of population served and borders that will work." Statements included "you can't tell me that the

way it is now works" and "figure it out and we're open to discussions" but it is "not 125." One informant in the Statewide Policy Group suggested that research should be done into what the minimum size should be in public health.

- Statewide Policy Group informants consistently pointed toward systems outside public health as having similar issues, but taking action, and suggested that public health notice the trends toward consolidation.
- A few members in the Statewide Policy Group said they are "reluctant" to be too aggressive around the size issue because relationships with the current local agencies are "important" and "trying to be accommodated." Others are very willing and can be expected to "lay out expectations" and the phrase "carrots and sticks" was again mentioned as ways being used to shape or incentivize decision-making. The common message is "figure it out" and "we are open to discussions."
- Both groups mentioned back room functions being embedded in local governments (city or county) as an issue. Most agree this affects being able to invest or maintain the basic capacity desired. Nearly all Local Public Health members and all Statewide Policy Group informants identify this as something to "figure out." Across both groups, several informants mentioned that embedded functions are "not aligned" with either public health's future role or "available resources." Most people in both groups see that it is challenging to reconcile "what we need or our local politicians want" with what "health care reform means" and the state "politicians" want. Several people in the Statewide Policy Group point toward consolidation and shared services through new contracting laws as the answer.
- Both groups are looking at mergers or consolidation as an issue, concern, or as a solution. Most respondents in the local public health group identified merger or consolidation as a less attractive option compared to other ways of achieving efficiencies. But among them, they talked about many different reasons for this and not all sound like pure "resistance." Several mentioned impediments around specific statutory, political, or transitional barriers. There is more "reluctance" than "resistance." One informant very clearly stated "I wish they would just leave me alone and let my local government continue to fund me they way they do." Most Statewide Policy Group members see consolidation as a solution, if not an expectation.
- Most people in both groups believe that as one person put it, "great things can be done through contracting" but better ways should be found to achieve economies of scale not only around supplying the service but also how that is funded and purchased.
- Several informants in the Local Public Health Group mentioned conflicts around local political pressures versus the role of public health. Examples included looking to the city health department as a "jobs program." More than a few cited conflicts between local economic development goals -- "we need jobs in our community" – and how regulations and enforcement should be done to protect public health. This appears to be tied to the "reluctance" to give up local authority mentioned by some.
- Many in the Local Public Health Group said they could see how governance changes might help but also mentioned downsides, especially around environmental health, inspections, and enforcement. The Statewide Policy Group mentioned that

standardizing processes can help, and more systems thinking can help in these areas, along with consolidation.
- Many in both groups mentioned how parochial and individual personalities/career issues can affect the difficulty and "timing" around considering consolidation.

Other considerations and concerns
- Both groups mentioned how ODH capacity has been weakened and acknowledge that weakening has occurred at the local level, too. The common message from both groups was for the new model to address those areas where ODH or regional shared services could be the right place for the resources around a function.
- Most people in both groups believe that it is necessary to clarify and "harmonize" perceived responsibilities, actual responsibilities, appropriate essential services, available funding and personnel and then determine what "platform" for where and how to do something "makes the most sense."
- There are disagreements about whether consolidation should be the most useful tool to use. Information from the Local Public Health Group suggests a preference for a combination of approaches, while preserving local autonomy or authority. The Statewide Policy Group sees consolidation and shared services through contracting as the most effective tools to consider and is not very convinced about how much local autonomy is necessary.
- An area of disagreement among Local Public Health informants is what "regional" means, although there is agreement that it probably looks different in different areas of the state.
- With regard to health information technology, most in the Local Public Health Group expressed some frustration, citing the lack of incentive payments, confusions around where ODH is going, and being unable to afford the cost of adopting Electronic Health Records, or having to pay for EHR functionality they do not need. Statewide Policy Group members see the state's efforts around regional Health Information Exchanges as a major change in the infrastructure that local public health agencies need to consider when thinking about EHRs. These informants suggested that public health think about the purposes behind specific public health functions where EHR provides an essential connection that can be used around core functions ("whether the data is supplied by local public health, or supplied by broader health system providers" is something to think about). They stressed that this should not be limited to their role as a provider of primary health care.
- Every informant expressed concerns about the future, constraints on resources, finding the capacity to meet expectations, and the impacts in the public health workforce.

2.2 Lessons Learned and Implications for a New Framework

Although the Public Health Futures key informants expressed high motivation to engage in more collaboration, they indicated a need to first get a better understanding of the variety of ways cross-jurisdictional sharing is being done successfully in Ohio and elsewhere. Informants mentioned a number of examples in Ohio and suggested that HPIO investigate these models further. In addition, review of the comments from respondents in the AOHC member survey about their positive experiences with collaboration revealed their perspective on key elements that tend to produce successful collaborative endeavors.

Literature Review

This section of the report highlights lessons learned from others about the experiences of local governments pursuing cross-jurisdictional collaborative and shared service arrangements. The discussion is based on a targeted review of literature studying a variety of collaborative arrangements used by local governments sharing services and identifying factors associated with achieving success, based on experience. This inquiry was shaped in part by questions arising from the key messages and themes expressed by key informants and the Public Health Futures Steering Committee. The topics and resources researched were also informed by the local governmental collaboration work currently being done by some members of the State Policy Group. Factors associated with successful collaboration reported in the literature are discussed. Examples of interest from within Ohio's public health and related sectors are described. Finally, this section of the report concludes by applying the implications and relevance of these lessons learned to suggest criteria to help guide consensus building among AOHC members.

This discussion relies heavily on a review of literature performed by Sowards and Beechy (2010), colleagues of John Hoornbeek, a key informant who has conducted a series of case studies and other research supporting local governments collaborating. Recent articles prepared for The Robert Wood Johnson Foundation by Kauffman (2010) and Libbey and Miyahara (2011) supplement the findings of Sowards and Beechy.

The Process of Local Government Collaboration

In 2010 Sowards and Beechy reviewed articles considering the definition of collaboration, historical interpretations, examples and forms of collaboration, incentives and barriers, and selected case studies. Their review cites Thomson's definition of collaboration as a process involving "autonomous actors" who determine by agreement the contours of their relationships, what mutual benefits they hope to achieve, and how they will work together (Thomson, 2001). Sowards and Beechy's survey includes Thomson's identification of complexities in governance, administration, organizational autonomy, mutuality and norms as what's inside "the black box" of complexity influencing local governments collaborating, first described by Wood and Gray(1991). Summing up Thomson's discussion, Sowards and Beechy suggest a lesson learned: "Don't collaborate unless you are willing to thoughtfully consider and educate yourself

about the nature of the process involved."

The importance of thinking about the process element of collaboration is affirmed in Beechy, Hoornbeek, and Sell's case studies of eight collaborations occurring in northeast Ohio (2012). For example, among the findings in the case study of Summit County public health agencies consolidating is that the complexities of the process affected project goals and planning. Two lessons emerged. First, Summit County did not set out to consolidate agencies, but to work on improving data-sharing capabilities. As they encountered the barrier posed by the complexity of the information system issues, local public health leaders determined that the challenges were a symptom of the bigger problem – the degree of fragmentation. Beechy, Hoornbeek and Sell include a description of the process used following the discovery. Key elements included initial discussions with the separate health districts and communications with community leaders and stakeholders. The plan for the collaboration was then changed to reflect the new goal. The process used included oversight by community leaders, support from consultants, and deliberate examination of advantages and disadvantages, logistical and funding issues. In addition to being what "really made a difference," these are among the factors associated with successful local governments collaborating found elsewhere in the literature and discussed further below.

Factors Associated with Successful Collaboration

Choosing the Right Partners. The importance of choosing the right partners for collaboration underlies most of the success factors mentioned by AOHC survey respondents (mutual trust, prior history, setting aside turf issues, committed top-level leaders, and collaborations with similar communities focused on equity and sensitive to the needs of each partner). These are similar to Sowards and Beechy's list of good governance model characteristics as described by the National Association of State Chief Information Officers (2007) and the principles for the best social partnerships mentioned by Billett (2007).

Moreover, they are remarkably similar to one AOHC member's survey comment:

> *"1) We all WANT to work together; 2) We have a LONG history of working together successfully; 3) Our Boards expect us to work together well; 4) We accept that sometimes we can operate independently, and other times we must be dependent upon our neighbors; 5) We have a more competitive charge for funding as a group; 6) Our counties are very similar (similar demographics); and 7) We respect one another."*
>
> –Key Informant

Sowards and Beechy's reviews include another consideration for choosing the right partners: being aware of how many partners can successfully be managed in a particular collaboration (Berardo, 2009.)

Achieving Clarity of Purpose. In their initial summary report on information

learned through interviews and site visits about types of relationships among health departments, Libbey and Miyahara (2011) conclude that "elected policy makers and public health leaders…. must be very clear within themselves and with each other about the purpose of the endeavor." This observation followed from their finding that the goals of working on cross-jurisdictional collaborations in public health can differ among key influencers (e.g., aiming to save money versus improve health). Libbey and Miyahara's conclusions appear to validate the attention paid in crafting the intended outcomes statement of the Public Health Futures Committee, for example, and the project's emphasis on consensus-building about the future role of public health and how to assess available collaboration options. These aspects of the project are intended to help achieve clarity of purpose.

Managing Political Issues Affecting the Process. The politics of regionalism affect many aspects of the process of collaborating. Sowards and Beechy's review includes "five political challenges of regional action" identified in a case study by Parr, Rehm, and McFarland (2006):

- The Challenge of Regional Identity — highly important for collaborative success, but notoriously weak;
- The Challenge of Political Strategy — no consensus on speed, scope, or method;
- The Challenge of a Big Tent — mobilizing a broad base of support across multiple interests;
- The Challenge of Consensus — focusing on issues of consensus rather than conflict; and
- The Challenge of State and Federal Policy — encouragement of regional cooperation while institutions are undermined by the same mechanisms.

Because regional approaches can be fraught with political peril, Libbey and Miyahara observe that success requires elected officials and public health leaders to possess "a combination of openness to consider and willingness to implement" (2011).

A variety of issues, environmental pressures and opportunities, and areas of disagreement raised by key informants involve one or more of these challenges. Sowards and Beechy report on an exploration of collaboration practices that successfully manage highly controversial or divisive issues; these include bringing to the table the right kinds of people representing conflicting constituents' interests and using certain consensus building techniques as tools to manage the issues (Booher, 2004). Bentrup's 2001 case study of a process model for watershed planning collaboration emphasized the importance of involving stakeholders in "data collection and analysis, the establishment of measureable objectives, in-person communication, and the inclusion of stakeholders in each stage of the process." As political considerations arise throughout the process, investments in stakeholder engagement provide an "up to speed" group of key constituents who can be called upon to negotiate and navigate the multi-faceted political dynamics accompanying any significant change in local government.

Anticipating Systems and Business Process Barriers. Dawes and Pardo's case studies of collaborative digital government initiatives in New York, included in Sowards and Beechy's review, cites other difficulties to anticipate. Multiple organiziations working together toward a common goal have to deal with the potential for wide variation among participants in terms of roles, missions, operations, technology, and adaptability (Dawes and Pardo, no date). Participants' diverse business processes and capabilities, especially where information technology is involved, bring a number of challenges that can affect success. Sowalds and Beechy include a list developed by Artigas, Elefante, and Marti (2009).

These are similar to types of systems and business process barriers discussed in Hoornbeek's case study of Summit County public health consolidation. They are also consistent with the kinds of challenges mentioned by key informants with regard to administrative functions being embedded in city or county agencies outside public health. It can be challenging, time-consuming, and/or costly to do the work necessary to map and reconcile participants' processes, resources, and ability to accomplish changes necessary to transition to something new. A lesson learned is that assessing and considering the potential pitfalls of potential systemic and business process barriers, from the outset, is an essential factor associated with collaboration success.

Weighing Costs of Collaboration. The complexity and fragmentation of Ohio's local public health system has implications, however, beyond the need to anticipate and plan for business process and systems barriers. One of the main ideas Soward and Beechy record after reviewing Thomson and Perry's 2006 discussion of the "black box" of collaborative process is that the "most costly resources of collaboration are not money but time and energy." Feiock, Steinacker, and Park's examination of voluntary service agreements among local governments, according to Sowards and Beechy, posits that whenever governments or agencies make decisions, the result is to create costs for others (2009). When the process of entering into service agreements is flexible and voluntary, rather than imposed externally by a "single central authority" the result is an environment where local governments can craft "customized" arrangements, which can bring both "collective" and "selective" benefits (Fieock, et al.). Sowards and Beechy's review includes Feiock's assertion that for the decision to voluntarily collaborate to be "rational" the benefits of collaborating must outweigh all of the costs of collaboration, including transactional costs (2007).

In other words, the process of cooperation carries a price in and of itself. Speaking of the time and effort of going to meetings with regional partners, for example, one key informant observed: "We will collaborate only of it meets a need in our community and makes financial sense." This is a factor that was mentioned frequently by key informants (although their views vary when it comes to identifying "silver bullets" to reduce the transactional costs of the patchwork of current arrangements). Weighing the transaction costs is a key factor associated with putting together "win-win" arrangements that "make good business sense."

Deciding Which Form of Shared Services to Use. If local public health leaders exploring a collaborative have considered all of these lessons learned, they should have important information to help them decide which of the several forms of collaboration, regionalism, or cross-jurisdictions sharing services they ought to use. Sowards and Beechy's summary of McGuire's 2006 article reviewing literature about public agencies collaborating, finds that the "size and type of network should be dependent upon task at hand."

As part of its effort assisting local public health agencies to accomplish the move to national accreditation standards, The Robert Wood Johnson Foundation asked Kauffman to study regionalism and collaboration outside the public health sector, to report on lessons learned and best practices (2010). Reviewing the history of regionalism, Kauffman finds that regional mergers "remain difficult to accomplish" despite the influence of external events (such as recessions or terrorism) and the desires of state and federal governments. Among her findings is that the "prime movers" motivating local governments to collaborate are improvements in quality, access, or the amount of services made available, along with the goal of reducing costs. Kauffman also found that accreditation "was not a factor that stimulates consolidation." Kauffman's list of key barriers and best practices are consistent with the findings of others summarized by Sowalds and Beechy.

One of the lessons learned, according to Kauffman, is that even the term "regionalism" can be a "non-starter." This is consistent with what may lay beneath statements from local public health key informants that they want options in addition to consolidation of agencies. While wide scale displacement of local governments through regionalism has not occurred, Kauffman finds instead that alternatives to complete mergers have proliferated.

Kauffman argues that given the "hot button" nature of regional action, a better term might be to replace "regionalism" with "shared services." Kauffman finds that local governments share services by using a number of forms of collaboration that obtain the benefits of regional arrangements, while avoiding the discomfort and political costs of giving up local identity and control. In addition, Kauffman's study describes a number of these models from non-health sectors; the details in her discussion help to reveal the contours of the variety of approaches being taken.

Kauffman asserts that these various vehicles for collaboration form a "shared services continuum." After defining the types of shared service arrangements she found, Kauffman lists their distinguishing features and arranges them from the least to the most formal. The categories Kauffman offers are driven by the details of what's being shared and the degree of formality or type of agreement memorializing commitments arising from the relationships and how the endeavor will be governed. The closer the form of collaborating comes to regionalism—mergers across county lines—the greater the

difficulty, complexity, and the risks (as well as potential benefits).

Examples from other systems

Figure 15 reproduces the five categories along Kauffman's "Shared Services Continuum" and provides examples of general types of collaboration that are currently happening in Ohio within the local public health system and other governmental systems. The last row of the graphic displays specific Ohio-based examples of shared services that are described in this section.

Figure 15.

Examples of Collaboration among Local Ohio Government Agencies on the "Shared Services Continuum"

Informal arrangements	Service contracts	Interlocal agreements	Consolidation	Regionalization
• Verbal or hand-shake agreements • MOUs • Sharing information • Sharing equipment • Coordination	• Another govt. provides • Sharing facilities • Joint ownership • Mutual aid (MAAs) • Inter-state compacts	• Joint powers and authority • Functional consolidation (merged depts.) • Special districts • Regional councils • Shared purchasing	• City/county mergers • Annexation	• Merger across county lines • Merger across state lines
General types of collaborative shared service models currently used in Ohio				
Coordination between LHDs for specific grants, projects, or services	Educational Service Centers (ESCs) LHDs contracting with each other to provide/ receive specific services	Regional Council of Governments (COGs)	Unions between health districts	Agency consolidation across county lines
Specific collaborative shared service examples in Ohio				
"Collabor8" County DJFS Departments	DD Boards: Sharing Superintendents OCALI Center at Central Ohio ESC Central Ohio Shared Fleet Maintenance/ Repair	DD Boards, Ohio Dept. of DD and COGs: County Collaborative Project and Project PLAY Three C Recovery and Health Care Network Hocking, Vinton, Ross County DJFS functional consolidation	Summit County Health District and Akron Health Department Consolidation Cuyahoga Community Mental Health and Alcohol Drug Addiction Services Board consolidation	Mental Health and Recovery Board of Clark, Green and Madison Counties

Source: The "Shared Services Continuum" is presented in Kauffmann, N.J, Regionalization of Government Services: Lessons Learned & Application for Public Health Delivery, July 2010. Prepared for Robert Wood Johnson Foundation.

"Collabor8" County Departments of Job and Family Services Departments. This is a pilot project, initiated by the Ohio Job and Family Services Director Association, that brings eight county departments together to modernize, streamline, and share a platform for eligibility determinations. Currently, seven of the eight counties are participating, while the eighth, is waiting for implementation results from the first seven counties.

OCALI Center at Central Ohio Educational Services Center. There are two examples of interest. First, "ESCCO" provides a wide variety of services to 25 school districts serving more than 200,000 school children in Delaware, Franklin, and Union counties. The ESSCO website includes a "Shared Services Section" which includes a wealth of information about shared services, including how they are evolving. An example for public health to consider is that ESCCO had provided background checks and training for substitute teachers; the agency still does that, but now also offers substitute staffing services beyond background checks and training. Second, housed at ESCCO is the Ohio Center for Autism and Low Incidence disabilities ("OCALI"). Although it is housed (by statute) at a regional Educational Service Center, OCALI has a statewide reach and has received national recognition for its offerings. It is a good example of how to use statewide and regional approaches providing access to "specialized expertise."

Central Ohio Shared Fleet Maintenance/Repair. The Central Ohio Education Service Center, Mid Ohio Regional Planning Consortium, Franklin County, and cities within the county worked to put together agreements enabling central Ohio political subdivisions to share fleet maintenance and repair services.

DD Boards, Ohio Department of DD, and COGs: County Collaborative Project. The Ohio Department of Developmental Disabilities and Mid East Regional Council of Government (a "COG" established by 18 collaborating DD county boards in southeastern Ohio) are working to develop ways to standardize processes like administering waiver services and payment procedures, as well as creating a shared IT platform to reduce financial and administrative burdens (the "County Collaborative Project").

DD Boards, Ohio Department of DD, and COGs: Project PLAY. Another example is DODD working with a number of Northwestern Ohio county boards around a new model (and the training and capacity to deliver it) for in-home, multi-county early intervention services for families affected by autism ("Project PLAY"). DODD, in conjunction with the Ohio Center for Autism and Low Incidence (OCALI), provided training for autism early intervention and autism therapy to 42 County Boards of Developmental Disabilities employees from 18 different counties. The training is part of a pilot program called Play and Language for Autistic Youngsters (P.L.A.Y. Project). The project is a relationship-based therapy program that emphasizes helping parents become their child's best P.L.A.Y. partner. The project empowers parents to have access to effective, family-focused, and affordable therapy and intervention for young children with autism, which will help children with autism connect, communicate and build relationships with others.

Three C Recovery and Health Care Network ("Three C"). The Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) Board of Cuyahoga County; The Alcohol, Drug and Mental Health Board of Franklin County (FCADAMH) and the Hamilton County Mental Health and Recovery Services Board (HCMHRSB) have jointly formed a Council of Government (COG) entity known as the Three C Recovery and Health Care Network (Three C). The COG is working on multiple potential offerings for the three boards, and potentially other ADAMHS boards and other health-related local governmental entities. Three C, formed pursuant to Chapter 167 of the Ohio Revised Code, will provide a forum for the planning and development of an integrated system of behavioral health care and primary health care in a manner which is cost-effective and efficient to promote and protect the best interest of persons being served by the Boards. The arrangement is also a vehicle for developing common health information technology infrastructure that would be shared. ("Columbus/Cincinnati/Cleveland 3c's SHARES Information Technology Platform"). Three C is currently planning and developing a new health care management information system known as the Shared Health and Recovery Enterprise System (SHARES). SHARES will be a health care management information system that will support management of client enrollment, benefit management, provider contracting, payment processes, and utilization and outcomes management.

Hocking, Vinton, Ross CDJFS functional consolidation. This is pilot project involving County Commissioners from three counties electing to do a "functional consolidation" of three county departments of job and family services, by entering into an operating agreement, pursuant to statutory authority to conduct the pilot. Legislation introduced for Governor Kasich's Mid-Biennium Review includes proposed revisions to R.C. 329.40 expanding the pilot project authority to any county in Ohio.

Summit County Health District and Akron Health Department Consolidation. After Summit County idenfied fragmentation in governance as the root cause if it information system challence, it moved toward consolidating agencies. The result has bee better coordiated disease tracking and response systems. Consolidation also saved taxpayers money while providing expected services. Personnel changes associated with the consolidation yielded savings estimated to run into the hundreds of thousands of dollars. Facilities expenses were reduced, as well. (Tegan Beechey, John Hoornbeck, Heather Sell, "Improving Efficiency and Effectiveness for Public Health Services," Kent State University ,(1/25/2012), (p.3). http://www.kent.edu/cpapp/upload/jan-2012-improving-efficiency-and-effectiveness-for-public-health-services.pdf)

Cuyahoga Community Mental Health and Alcohol Drug Addiction Services Board Consolidation. Formerly separate behavioral-health related boards consolidated effective July 1, 2009.

Mental Health and Recovery Board of Clark, Greene, and Madison Counties. In the mid-1990s, three formerly "single county" alcohol, drug, and mental health service boards combined to form a three-county jurisdiction, using statutory authority providing that county commissioners can determine how to organize the community mental health and substance abuse services boards in their jurisdictions. The board plans and coordinates services for residents in the three counties. A similar multi-county merger occurring within Ohio's behavioral health system is between Crawford and Marion counties.

2.3 Concepts and Considerations for Decision Making

Key concepts

The following set of terms and "touchstone" concepts emerged from the research literature and were useful during the Public Health Futures consensus-building discussions and for the Steering Committee's development of recommendations.

Shared Services Continuum. This model describes the range of governmental shared service arrangements, from informal and contract arrangements that retain current jurisdictional autonomy to consolidation and regionalization of jurisdictions. (See Figures 1 and 14 in this report) (Kauffmann, 2010).

Clarity of Purpose. According to Libbey and Miyahara (2011), "elected policy makers and public health leaders … must be very clear within themselves and with each other about the purpose of the endeavor." For instance, is the purpose of a potential future model to realize cost efficiencies and improve sustainability? Or is the purpose to build capacity or improve performance? How will the parties involved know whether or not the model was successful?

Determinants of LHD Performance. Public health systems and services research (e.g., research about how to best structure public health systems) is an emerging field. Thus far, larger population size has surfaced as one of the most consistent predictors of stronger LHD performance (Bhandari, et. al., 2010; Cook, 2012; Mays, et. al, 2006; Minnesota Public Health Research to Action Network, 2011; Suen and Magruder, 2004). This research has found that performance on the Ten Essential Public Health Services is typically stronger for LHDs serving over 100,000 residents. After a replication of two earlier studies on this topic, Bhandari et al (2010) conclude that "population size is one of the strongest predictors of performance…. Particular attention should be given to improving performance when the population size is small or the jurisdiction is of the city/county type rather than of the county or multi-county type."

Minimum Efficient Scale. In this context, the MES refers to the minimum population size that is most efficient for a LHD to serve. Looking at per-capita costs alone, Santerre (2009) found that the MES for LHDs is a population of approximately 100,000. Beyond 100,000 he finds little impact on per capita spending. Below 100,000 LHDs are less able to minimize per capita costs.

Public Health Accreditation Board Standards. An outgrowth of the "10 Essential Public Health Services," the PHAB domains provide a list of core public health services. This framework provides a description of the basic minimum capacity for public health agencies and specific indicators of LHD capacity and performance. (See Table 16 in this report.)

Health Impact Pyramid. This construct illustrates the types of interventions that evidence shows are most likely to result in improved health. Public health activities that

reach broader segments of society and require less individual effort have been found to have a greater impact on population health and should therefore be a priority for state and local public health agencies. (See Figures 11 and 12 in this report.) (Frieden, 2010)

Minimum Package of Public Health Services. The April 2012 Institute of Medicine (IOM) report *For the Public's Health: Investing in a Healthier Future*, presents the minimum package concept as a way to delineate a specific set of basic public health services that can be linked to costs and outcome tracking. This Minimum Package of Public Health services includes Basic Programs, services commonly provided by LHDs, and Foundational Capabilities, which are the skills and resources that support Basic Programs.

Part Three: Consensus and Recommendations

Objectives

As stated in the project plan, the intended purpose of the Public Health Futures project is to "develop a proposed model for Ohio's local governmental public health system that includes a mechanism for governance and sustainable financing, considers *cross jurisdictional sharing and/or regionalization*, enhances quality and assures value." While cross jurisdictional sharing and/or regionalization was initially the primary focus of the project, it became clear during the consensus-building process that *enhancing quality and assuring value* were equally—if not more—important. Recognizing that mechanisms for governance and financing are means, not ends, AOHC members voiced the need to first describe a vision for *what* local public health should be doing, and then to develop a framework for *how* to fulfill that vision.

After describing the Public Health Futures consensus-building process, this section of the report describes a vision for local public health in Ohio and then goes on to suggest the recommended structure and financing to support the vision.

The objectives for this section of the report are:

- Describe the process used by the Public Health Futures project to consider options and build consensus among Steering Committee members and the general AOHC membership regarding recommendations for modernizing local public health in Ohio.
- Clarify the role of local public health in Ohio and describe a compelling vision for the local public health system.
- Provide a framework for improving the structure, financing, and quality of local public health.
- Make specific recommendations regarding changes to the structure, governance, and financing of LHDs.
- Provide guidance for LHDs and AOHC on next steps to implement the report's recommendations.

3.1 Consensus-building process

The Public Health Futures project was designed to engage AOHC members in a discussion about the future of local public health in Ohio and to build consensus around new approaches to jurisdictional structure and financing. Steering Committee members served as the primary representatives of the AOHC membership, although all members were invited to engage in the discussion and provide feedback at several points in the process.

Ohio's 125 LHDs represent widely different local communities with varying needs, assets, funding sources, and political dynamics. Steering Committee members were selected to be representative of this diversity. Obtaining consensus within such a diverse group was a challenging task, particularly related to developing a Minimum Package of Local Public Health Services and potential changes in jurisdictional structure

that could affect the autonomy of local health departments. After many spirited and rich discussions, the Steering Committee unanimously approved the 19 recommendations put forth in this report at its final meeting on June 1, 2012.

The series of consensus-building meetings from March to June 2012 facilitated by HPIO are described below.

All-member meeting

On March 30, 2012, HPIO presented Parts 1 and 2 of the Public Health Futures report to an all-members AOHC meeting at the Union County Health Department. After reviewing the results of this preliminary report, members voted on "clarity of purpose" priorities and participated in small group discussions designed to elicit feedback regarding potential directions for cross-jurisdictional sharing and consolidation. HPIO presented 10 reasons for developing a new framework for local public health in Ohio that were generated by Steering Committee discussions and the key-informant interviews and asked members to vote for their top three priorities. **As shown in Table 17, addressing financial issues, improving quality, and clarifying the role of local public health were the top priorities**. All of these priorities guided the Public Health Futures process, and this report's recommendations aim to address the top seven priorities in particular.

Table 17. Clarity of Purpose: "What are the most important reasons for developing a new framework?"

(priority vote tallies from March 30, 2012 AOHC all-members meeting)	Number of votes
Improve the stability and sustainability of revenue for LHDs.	39
Improve alignment between funding streams, mandated services, and the essential public health services. (Simplify funding streams, stop "robbing Peter to pay Paul," and adequately fund mandated and expected services.)	37
Improve the quality of LHD services and improve health outcomes in local communities.	31
Clarify the role of local public health in Ohio, including greater clarity on services that should be provided by LHDs versus the broader health care system.	30
Retain local control, authority, and flexibility.	29
Retain and/or build upon current collaborative arrangements.	21
Specify a minimum standard range of services and ensure that LHDs have the capacity to provide those services.	20
Proactively propose a revised structure for the local public health system, facing the prospect of an externally imposed structure.	16
Reduce costs. Improve the efficiency of LHDs within the context of "leaner government."	11
Reduce disparities in capacity and funding across LHDs.	8

Regional district meetings

Drawing upon the feedback gathered at the all-member meeting and guidance from the Steering Committee, HPIO prepared descriptions of three structural models for AOHC members to discuss at a series of regional meetings in April 2012. The three models were selected from the center of the "Shared Services Continuum:" 1) ad hoc

contracting with a shared services center (similar to Educational Service Centers), 2) Council of Governments (COGs), and 3) Consolidation. The *Characteristics and Issues to Consider for Potential Cross Jurisdictional Sharing (CJS) and Consolidation Models* matrix in Appendix F provides a description of the three recommended models and was used as a discussion guide in the regional meetings. HPIO traveled to each of the five AOHC district regions to facilitate discussions about the advantages and disadvantages of these models and other considerations. Each regional group provided a "message to the Steering Committee" that was shared with the committee at their May 4, 2012 meeting.

Although the content and tone of the five district meetings varied widely, the following themes emerged across multiple regions and helped to shape the Steering Committee's recommendations:

- It is critical to address the "what" before developing the "how." In other words, the Public Health Futures recommendations should first specify a core set of public health services and then design the structural changes to help LHDs to provide those core services. Cross-jurisdictional sharing and consolidation should be seen as "means to an end" not the end itself.
- The destination—high quality public health services—should be the same for all LHDs, but "how to get there" should be flexible enough to account for local political and financial conditions.
- LHDs should have choices and options in moving forward with new structural models. Arbitrary boundaries and/or strict population-size-based formulas without regard for local conditions would cause more problems than they would fix.
- Almost all participants were open to exploring the two CJS models (service centers and COGs), although some voiced skepticism about efficiency improvements. Members were very interested in learning more about the legal and financial aspects of inter-local agreements. They asserted that cost/benefit evidence, technical assistance, and incentives would help them to shift toward more formal CJS arrangements.
- Consolidation was described as a "nuclear strike" in one group and declared to be "off the table" in another group. Overall, there was consensus that "forced consolidation" would not work, but that voluntary consolidations may be beneficial in some cases. Participants described many barriers to consolidation, summed up as "right now it's hard to marry and easy to divorce."
- Members expressed frustration with the Local Health Department Support allocation and indicated that the relationship between ODH and LHDs is somewhat contentious. As one participant put it, "We can look out for each other better than they can look out for us."
- Strong local community engagement, the AOHC five-district model, and current collaborative relationships are highly valued and should be maintained.
- Some participants called for an increased emphasis on quality improvement, health outcomes, and new relationships with the health care delivery system in the Public Health Futures report.

Steering Committee meetings

The Steering Committee met on May 4 to review district meeting results and new information that became available in April (April 2012 Institute of Medicine [IOM] report and the Ohio Profile Performance results). Four small workgroups then met by phone in May to continue crafting draft recommendations (Minimum Package of Public Health Services, Finance, Structure, and Strategy). These workgroup discussions identified some extremely complex finance and legal issues that will require further study after the release of this report. The Steering Committee met on June 1, 2012 to review the list of draft recommendations generated by the work groups. After revising the recommendations as a group, the committee came to unanimous consensus on 19 recommendations. Fifteen of the eighteen Steering Committee members were present at the meeting.

3.2 Vision for the future of local public health in Ohio

The role of public health has changed substantially since Ohio's local public health system was established in 1919. The recommendations in this report aim to clarify the role of public health and re-shape the structure of local public health in Ohio in order to fully support what public health does best. Sections 3.3 and 3.4 of this report will focus on the mechanisms for *how* to move toward this vision (structure, governance, and finance). First, however, this section will describe *what* local public health should be doing. Given the current state of the health care system and the health status of Ohioans, this effort to clarify the role of local public health should take into account the following challenges and opportunities:

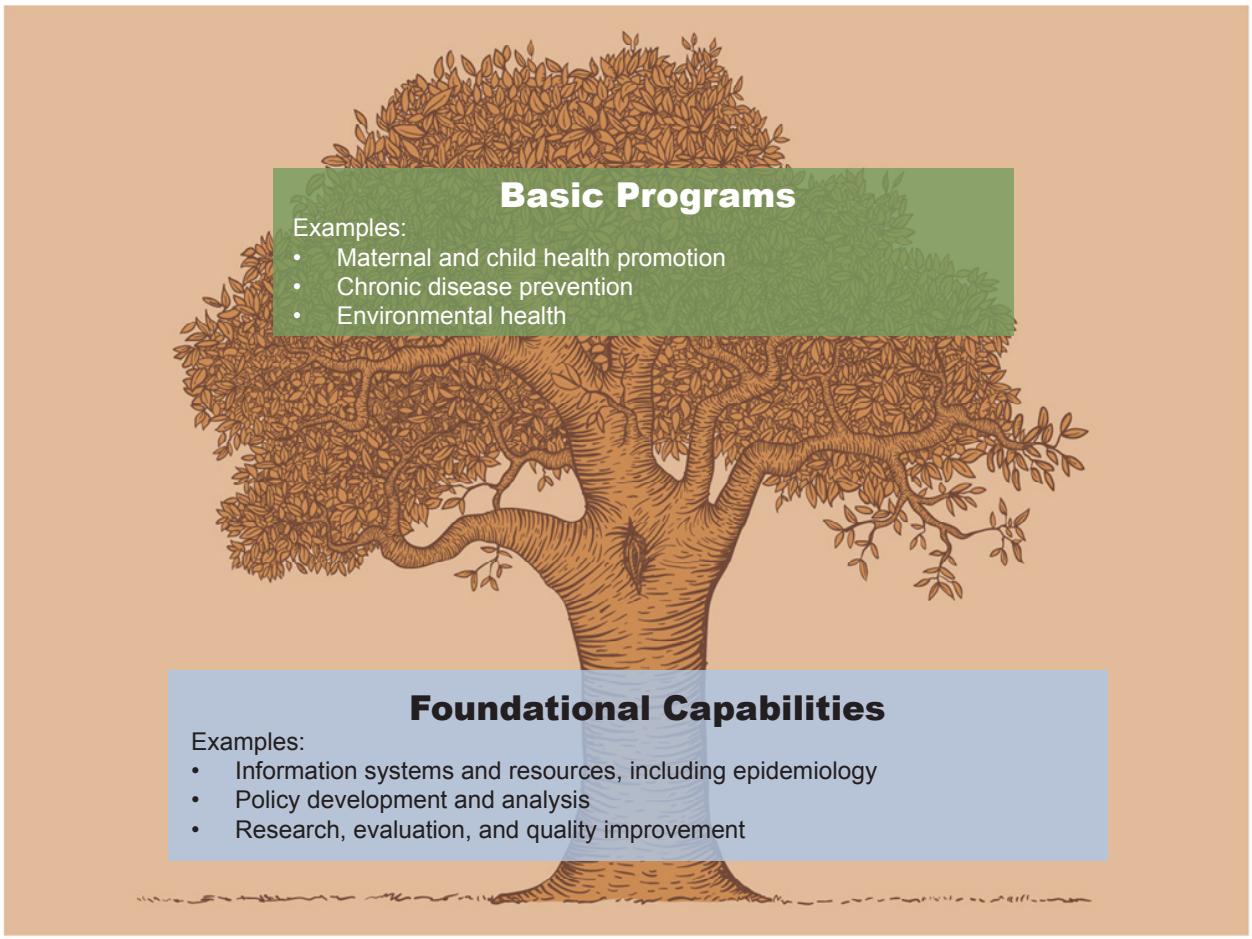
- Maintain the communicable disease prevention and environmental health protections that have historically been the core function of local public health.
- Respond to increasing recognition that public health has a strong role to play in preventing chronic disease and that the population health approach is critical to improving health outcomes.
- Re-balance public health's role in providing clinical services within the new healthcare landscape, and modernize payment and quality systems when medical services and care coordination are provided.
- Ensure that local public health is positioned to help achieve the outcomes prioritized in the State Health Improvement Plan and Local Community Health Improvement Plans in order to improve the overall health of Ohioans.

Public Health Futures stakeholders have called for a clear description of the role of local public health and the basic set of services that should be provided in all Ohio communities. The 10 Essential Public Health Services and the Public Health Accreditation Board (PHAB) standards provide a useful framework to begin developing this description, although, as discussed in the 2012 Institute of Medicine (IOM) report, *For the Public's Health*, these tools lack the specificity to link essential services to accountability data such as revenue and expenditures or health outcomes. It is also challenging to align the PHAB standards with the mandated services specified in Ohio law (see page 54). The IOM report presents the "Minimum Package of Public Health

Services" as an additional framework for specifying a basic set of services that should be available in all jurisdictions. This provides a structure for delineating services and capabilities in a way that is easier to align with current expenditure categories, grant programs, and mandates.

The Minimum Package includes Basic Programs, services commonly provided by LHDs, and Foundational Capabilities, which are skills and resources that support the Basic Programs. As shown in Figure 16, the IOM report uses a tree metaphor to describe the relationship between Foundational Capabilities (the trunk) and Basic Programs (the branches and leaves), and concludes that "Financially, the contemporary health department looks like a tree with heavy branches and a spindly trunk—an unsustainable state." Most of the current grant mechanisms narrowly focus on direct service "silos" and do not typically provide support for the Foundational Capabilities. As shown in Figure 14 on page 43, Ohio LHDs often lack funding sources designated for basic infrastructure needs such as quality assurance and information technology. Consequently, the vision for the future of the local public health sytem must identify mechanisms to fund these capabilities which are essential to effective and efficient service delivery.

Figure 16. The Minimum Package of Public Health Services, as presented in the 2012 IOM report *For the Public's Health: Investing in a Healthier Future*



Ohio's Minimum Package of Local Public Health Services

The IOM report provides a starting place for the Minimum Package and recommends that a more detailed description of this basic set of services be developed in the future. Working from the basic IOM framework, the Public Health Futures Steering Committee developed a Minimum Package specific to Ohio local public health which took into consideration categories from the following sources:

- Mandated services (ORC, OAC)
- Annual Financial Report expenditure categories (used by LHDs to report expenditures to ODH)
- Public Health Accredidation Board standards (PHAB)
- State Health Improvement Plan
- Commonly used service categories and major grant programs

The committee expanded the IOM's list of Foundational Capabilities to include a broader range of skills and resources, many of which are necessary to achieve the PHAB accreditation. The committee delineated a list of "core public health services" that all LHDs should be responsible for providing in their health district, either directly or by contracting with another LHD or other entity. Recognizing the wide variety in local needs and resources, the committee also specified a list of "other public health services." LHDs have a role in assuring that these services are provided in their district, either by public health or other organizations, including health care providers. For example, a LHD in a suburban community with many health care providers and small number of uninsured residents may not need to provide immunizations, while a LHD in a rural county with few providers may need to do so. The following diagram (Figure 2) provides a preliminary framework for describing the Minimum Package and may need to be further refined as new structures for supporting local public health and tracking accountability are developed. This list of services should be periodically reviewed and updated to reflect changes in state mandates, public health science, emerging needs and the capacity of the broader health care system (including the extent to which provisions in the Affordable Care Act are implemented).

All Ohioans, regardless of where they live, should have access to the Core Public Health Services. All LHDs, regardless of size, should have access to the skills and resources that make up the Foundational Capabilities in order to effectively support the core services.

Figure 17 displays the Minimum Package of Public Health Services developed by the Public Health Futures Steering Committee. Figure 18 illustrates the Ohio version of the IOM's Minimum Package tree metaphor. See Appendix E for a cross-walk between the Ohio Minimum Package and the Public Health Accreditation Board domains.

Figure 17.

Ohio Minimum Package of Local Public Health Services

Core public health services

All LHDs should be responsible for providing the following services in their district — directly or by contracting with another LHD

- **Environmental health services**,* such as water safety, school inspections, nuisance abatement, and food safety (restaurant and grocery store inspections)
- **Communicable disease control**, vaccination capacity, and quarantine authority*
- **Epidemiology** services for communicable disease outbreaks and trending* and disease prevalence and morbidity/mortality reporting*
- **Access to birth and death records**
- **Health promotion and prevention** (health education* and policy, systems, and environmental change)
  - Chronic disease prevention (including tobacco, physical activity, nutrition)
  - Injury prevention
  - Infant mortality/preterm birth prevention
- **Emergency preparedness**, response, and ensuring safety of an area after a disaster
- **Linking people to health services** to make sure they receive needed medical care*
- **Community engagement**, community health assessment and improvement planning, and partnerships

*Service mandated by state of Ohio (ORC, OAC) (Note: Ohio law mandates several specific services related to environmental health and communicable diseases. Not all are listed here. See Appendix D for complete list.)

Other public health services

(Varies by community need as determined by Community Health Assessments)
LHDs play a role in assuring that these services are provided in their community — either by local public health or other organization(s), including health care providers and other government agencies

Clinical preventive and primary care services
- Immunizations
- Medical and dental clinics (primary care)
- Care coordination and navigation
- Reproductive and sexual health services (including STD testing, contact tracing, diagnosis, and treatment)

Specific maternal and child health programs, such as
- WIC (Women Infants and Children) nutrition program
- Help Me Grow home visiting program (HMG)
- Bureau for Children with Medical Handicaps program (BCMH)

Non-mandated environmental health services, such as
- Lead screening, radon testing, residential plumbing inspections, etc.

Other-optional depending on community need and other available providers
- Home health, hospice care, home visiting programs (other than HMG)
- School nurses; Drug and alcohol use prevention; Behavioral health
- Municipal ordinance enforcement

Foundational Capabilities

All LHDs should have access to the following skills and resources. Access can occur through cross-jurisdictional sharing.

Quality assurance
- Accreditation
- Quality improvement and program evaluation
- Identification of evidence-based practices

Information management and analysis
- Data analysis expertise for surveillance, epidemiology, community health assessment, performance management, and research
- Information technology infrastructure
- Interface with health information technology

Policy development
- Policy analysis and planning
- Expertise for policy, systems, and environmental change strategies

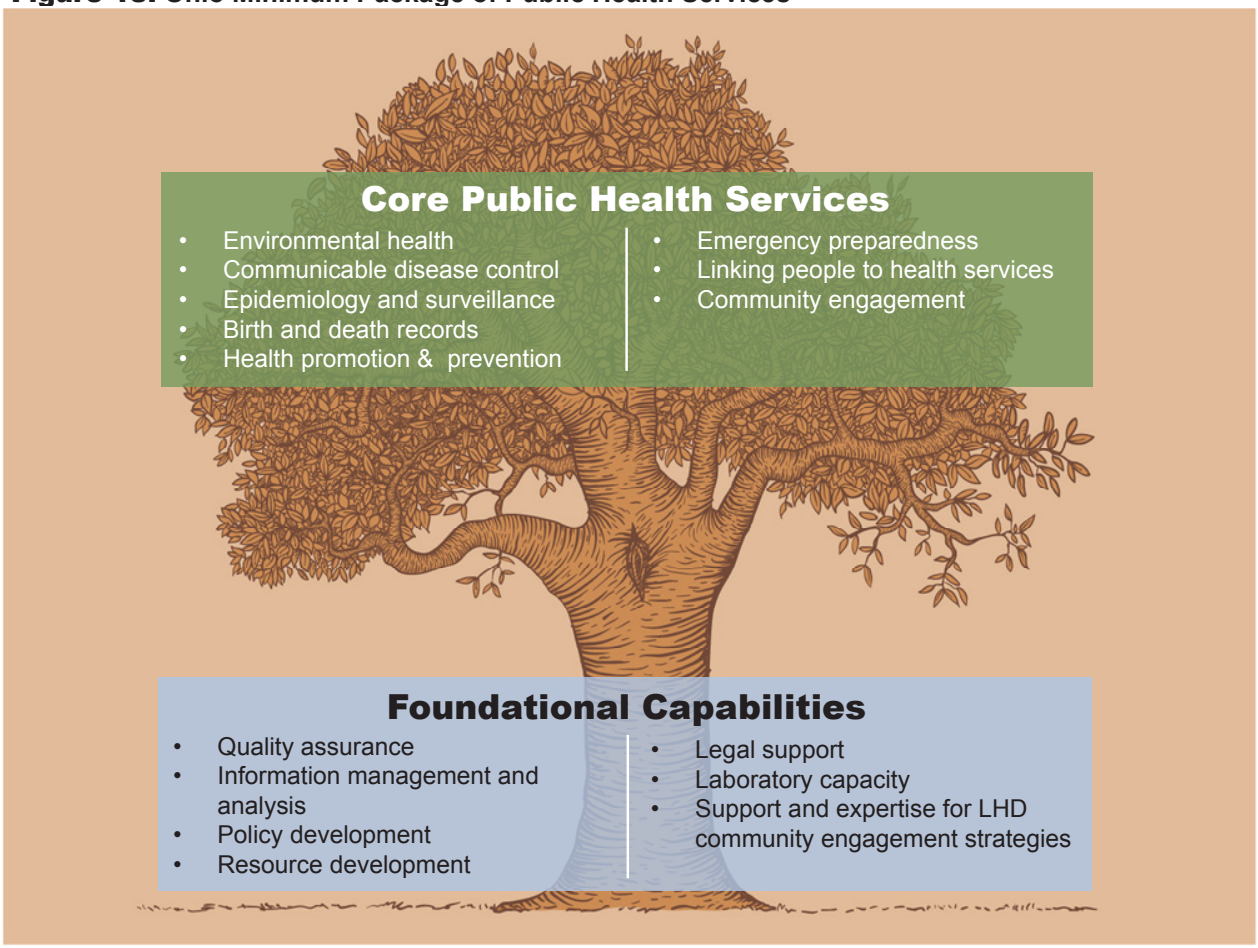
Resource development
- Grant writing expertise and grant seeking support
- Workforce development (training, certification, recruitment)
- Service reimbursement, contracting, and fee collection infrastructure (interface with third party payers)

Legal support
- Specialized consultation and analysis on public health law

Laboratory capacity
- Environmental health lab
- Clinical lab services (as appropriate)

Support and expertise for LHD community engagement strategies
- Community and governing entity engagement, convening and planning
- Public information, marketing, and communications
- Community health assessment and improvement planning
- Partnerships to address socio-economic factors and health equity

Figure 18. Ohio Minimum Package of Public Health Services



Ohio LHD capacity for Foundational Capabilities and Basic Services

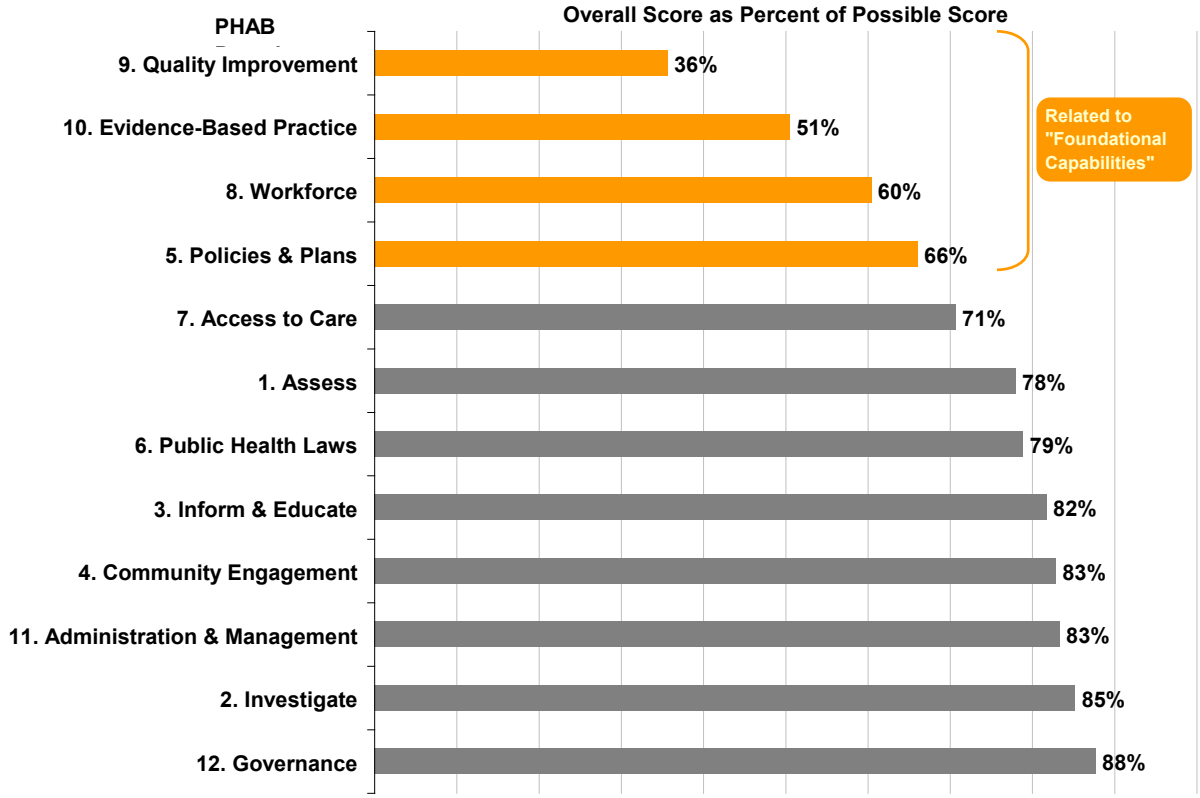
There is limited data available to assess the extent to which LHDs are currently providing the Minimum Package. Currently, the most accessible and comprehensive sources of this information are the Annual Financial Reports expenditure data (AFR) and the Ohio's Profile Performance results (self-assessment based on the PHAB accreditation measures). AFR expenditure categories do not align with the Foundational Capabilities and only align with three of the Core Services categories. As shown in Table 3 on page 19, 100% of LHDs reported Environmental Health expenditures in 2010, 78% reported Vital Statistics expenditures, and 64% reported Health Promotion expenditures. It is unclear, however, to what extent this data reflects actual services provided by individual LHDs, given the high prevalence of collaboration among LHDs.

Ohio's Profile Performance Results

The 2012 results of Ohio's Profile Performance system provide an initial self-assessment of LHD capacity to provide the 10 Essential Public Health Services, as captured in the 12 PHAB domains. LHDs submitted their first-ever Profile Performance self-assessment in March 2012 using an online reporting system developed by ODH. All but one of the 125 LHDs participated.

There is clear alignment between some PHAB domains and the Foundational Capabilities (e.g., Quality Improvement and Evidence-based Practices), while it is more difficult to align the Core Services with specific PHAB domains. However, the Profile Performance system results seem to indicate that LHDs have greater capacity in the domains related to Core Services and less capacity in the domains related to the Foundational Capabilities (see Figure 19).

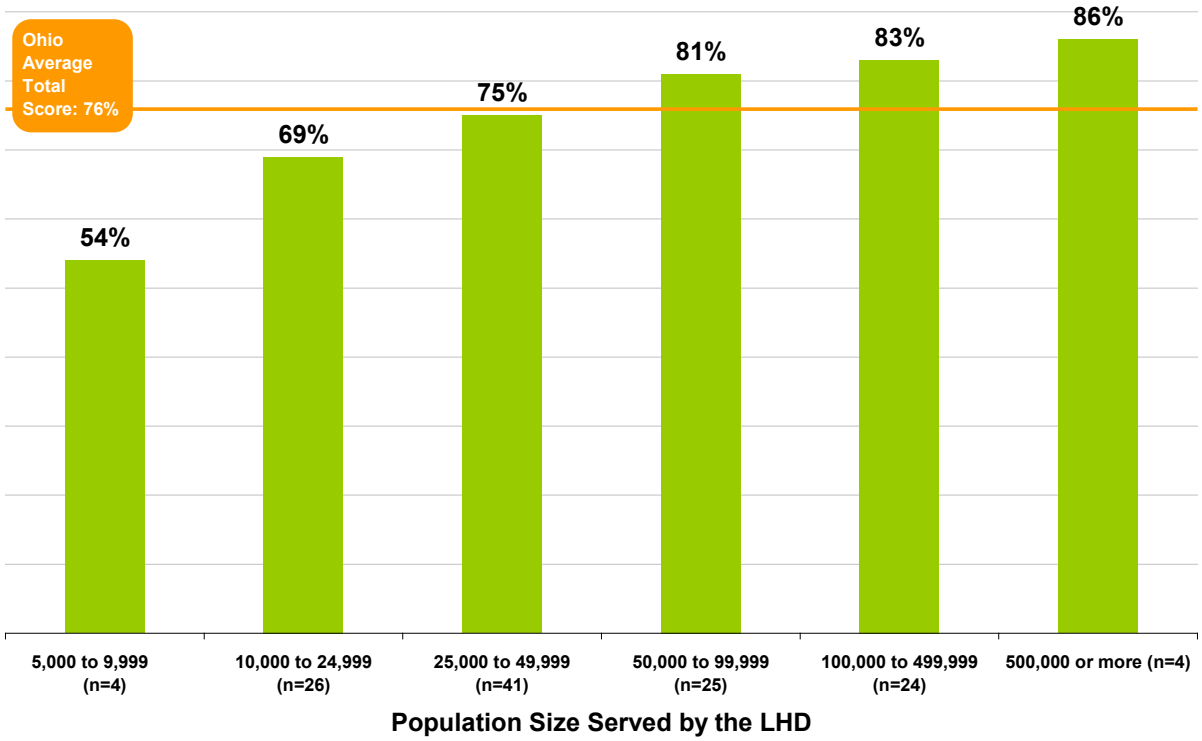
Figure 19. Ohio's 2012 Profile Performance: Total Domain Scores (n=124)



Source: ODH, 2012 Ohio's Profile Performance Database (LHD self-assessment using PHAB measures)

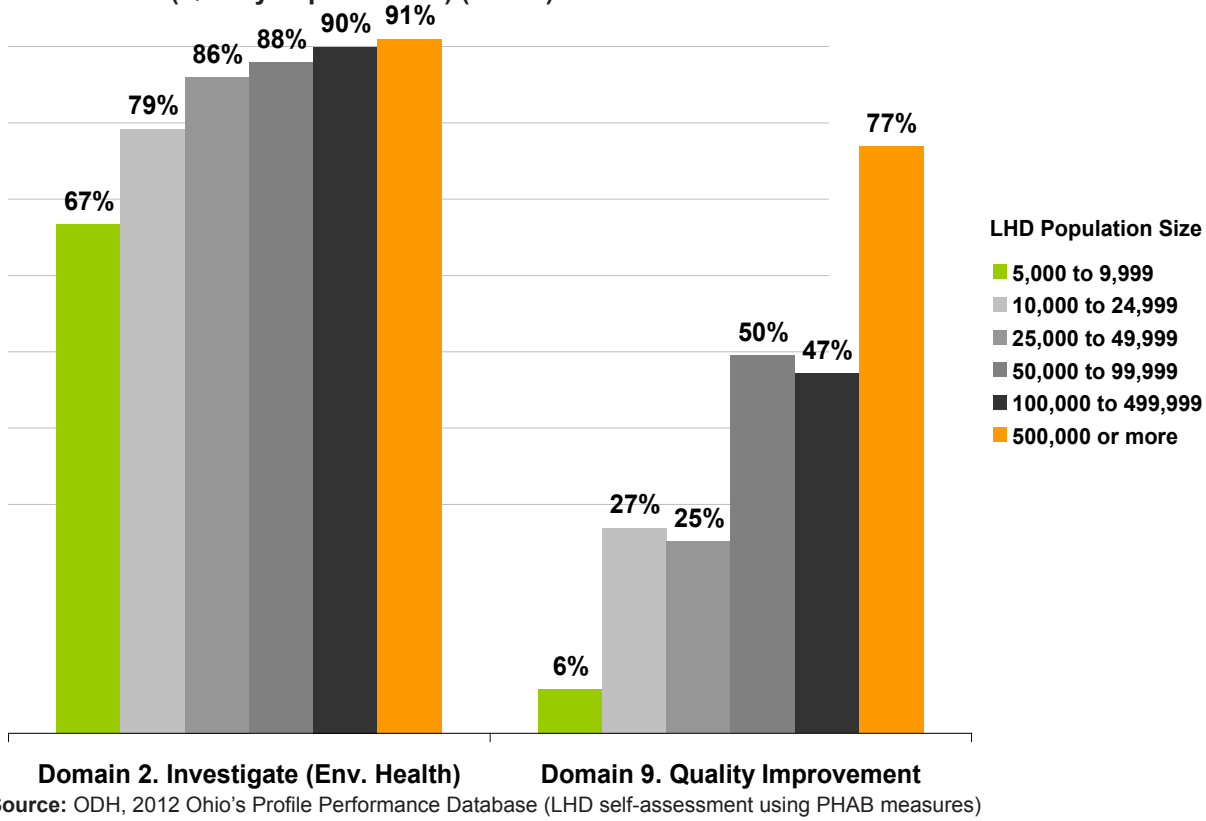
Overall, LHDs serving smaller population sizes received lower overall scores compared to LHDs serving larger population sizes (see Figure 20). These differences were most pronounced for domains related to the Foundational Capabilities. Figure 21 illustrates this difference for two domains. The "Investigate" domain largely refers to Environmental Health and Emergency Preparedness—both Core Public Health Services in the Ohio Minimum Package model. Differences between small and large LHDs are relatively small for this domain, likely due to sustained funding for this capacity. "Quality Improvement," a key Foundational Capability, saw widely differing results by LHD population size, indicating that smaller LHDs may be struggling to fulfill this Foundational Capability.

Figure 20. Average Total Score, by Population Size Served by the LHD (n=124 LHDs)



Source: ODH, 2012 Ohio's Profile Performance Database (LHD self-assessment using PHAB measures)

Figure 21. Total Domain Score, by Population Size Served by the LHD: Domain 2 (Investigate) and Domain 9 (Quality Improvement) (n=124)



Source: ODH, 2012 Ohio's Profile Performance Database (LHD self-assessment using PHAB measures)

Overall, these Profile Performance results indicate that:

- Smaller LHDs appear to have less capacity to meet standards than larger LHDs.
- Performance appears to be stronger for Basic Services-related domains than for some Foundational Capabilities—especially for smaller LHDs.
- All LHDs would likely benefit from assistance in strengthening their Foundational Capabilities and smaller LHDs in particular may need additional resources, infrastructure, and technical assistance to "strengthen the trunk."

Re-defining local public health's role in population health and health care delivery

Strong support for the Foundational Capabilities and clarification of the Core Public Health Services that should be provided by all LHDs should help local public health to assert a stronger role in improving population health and to modernize its involvement with the health care delivery system. The Health Impact Pyramid (Frieden, 2010) provides a useful framework for illustrating the role of local public health as envisioned by the Public Health Futures committee through the lens of population health. (See Part 1 of this report for a description of the Health Impact Pyramid.)

Population health

In the proposed Ohio framework, the Health Impact Pyramid is supported by the Foundational Capabilities. The primary role for LHDs should be focused at the bottom three levels of the pyramid where population impact can be maximized. This role encompasses the following general strategies:

- Assuring a safe and healthy environment (environmental health services)
- Protecting people from disease (communicable disease control)
- Promoting healthy living and preventing health problems (policy, systems, and environmental change), particularly related to:
  - Chronic disease prevention
  - Injury prevention
  - Infant mortality/preterm birth prevention, and
  - Strategies to address social determinants of health.

Local public health needs to maintain its traditional strengths in these areas (e.g., environmental health), while improving its ability to implement evidence-based prevention strategies (e.g., chronic disease). The critical importance of prevention and public health in reducing the burden of chronic disease and health care costs is well documented (Mays and Smith, 2012; Waidmann, TA, et. al., 2011; Trust for America's Health, 2008; The Prevention Institute and The California Endowment, 2007). With enhanced capacity, local public health could leverage significant population health improvements. Providing guidance on how to prioritize public health resources, the national Transforming Public Health project made the following observation:

> "Moving away from direct delivery of services when they can be provided by others in the community more efficiently or effectively, and focusing on systems and policy change with partners in and outside of government to develop and implement population-based health improvement strategies will help spur the change that needs to be achieved. Addressing the social determinants of health and combating the chronic disease challenge is not going to be solved by simply trying to help one person at a time – these are truly population level problems that need to be addressed as such. Governmental public health leaders understand what it takes to improve conditions and peoples' lives and should actively lead in these areas." (RESOLVE, 2012).

The Kane County, Illinois model provides one example of how a local health department restructured itself in response to a budget crisis in order to maximize the value and population health impact of its services. The Kane County Health Department aligned its functions with the PHAB standards and established "policy, systems, and built environment aligned to maximize population wellness" as a desired outcome. As a result, all personal health services were transferred to other providers and job descriptions were reconfigured to reflect the focus on policy and environmental change. (Kuehnert and McConnaughay, 2012). While novel and enlightening, the effectiveness of this model is yet to be determined and may not be a good fit in some communities where LHD direct health care services are a critical piece of the local safety net.

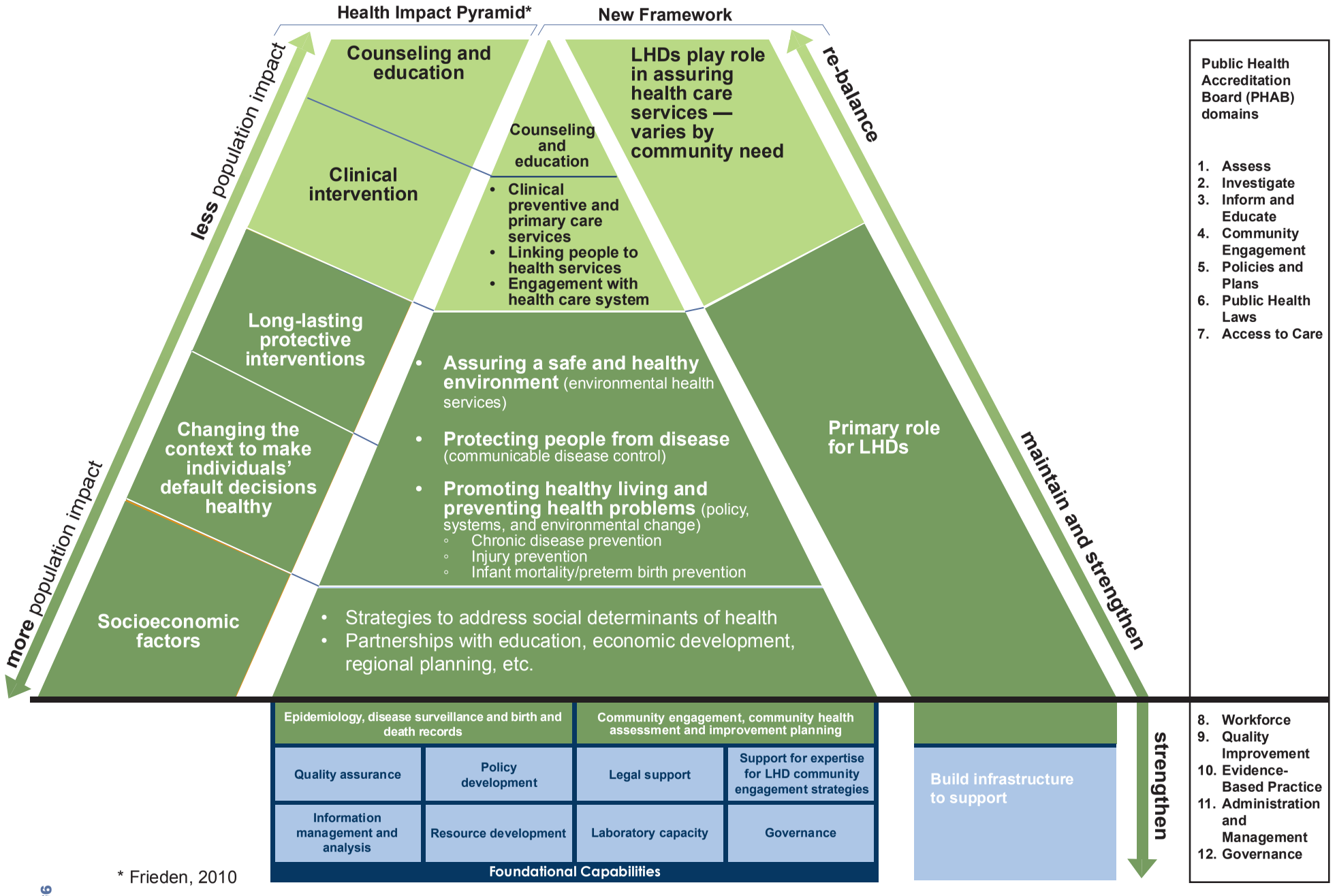
Health care delivery

Clinical preventive services and education/counseling delivered to individuals sit at the top of the Health Impact pyramid. This is an area of public health practice that is currently undergoing significant change and needs to be re-balanced in light of health care reform and the need to maximize the impact of shrinking public health resources. LHD response to these changes should be driven by Community Health Assessment findings. LHDs may need to provide primary care services when they are not sufficiently provided by others. When provided, LHDs need to modernize their approach to billing and reimbursement in order to sustain these services.

In addition to re-assessing their direct provision of primary care, LHDs have a role to play in partnering with the health care system to integrate clinical care and population health. Medical providers can learn from public health expertise in community-based prevention and public health workers can provide critical care coordination, case management, and health care system navigation functions. The 2012 IOM report *Primary Care and Public Health: Exploring Integration to Improve Population Health* provides guidance on this topic. Examples of integration models include the "Accountable Care Community" approach being implemented in Akron by the Austen BioInnovation Institute, the Community-Centered Health Homes model (Prevention Institute, 2011), and Community HUBs (AHRQ, 2010). Research shows that these types of multi-organizational partnerships between public health and other partners can be very effective, although they are difficult to develop and require incentives, changes in organizational culture, and strong commitment from administrators and policymakers (Mays and Scutchfield, 2010).

Figure 22.

Health Impact Pyramid* and Proposed Ohio Local Public Health Framework



* Frieden, 2010

Improving quality and outcomes

Quality improvement is critical for increasing the accountability of the public health system, the effectiveness of public health practices, and ultimately for improving population health outcomes. Unfortunately, current outcome tracking efforts are fragmented and little is actually known about the overall quality of local public health services in Ohio. There are three primary sources of data on LHD performance and quality:

- Ohio's Profile Performance system was first implemented in March 2012 and is likely the most comprehensive source of data about LHD performance. LHDs use this database to report the results of a self-assessment that is based on the PHAB accreditation standards and measures. This assessment is largely focused on capacity and performance, and may provide some indicators of quality. It is not, however, an outcome tracking tool. Self-assessments on the Quality Improvement domain may help LHDs to identify ways they can improve their approaches to program evaluation and continuous quality improvement.
- ODH collects output and outcome results for specific grant programs. There are few common indicators across programs, or even across grantees within programs. The result is a jumble of program evaluation results that reflect the siloed nature of grant funding and do not allow for "apples to apples" comparisons of LHD effectiveness.
- ODH staff conduct on-site surveys for some programs, with an emphasis on mandated environmental health programs. Some LHD stakeholders have questioned the utility of these surveys and it is not clear how they are or can be used to assess the overall quality of the local public health system. In the past, peer review systems were used to conduct these types of assessments at the local level.

Data sources, such as the Robert Wood Johnson-funded County Health Rankings, the Ohio Family Health Survey, and the Behavioral Risk Factor Surveillance System are useful sources for regional and county-level health outcomes. It is difficult, however, to link these outcomes to LHD activities given the broad range of factors that impact health.

Ohio is not alone in struggling to measure public health quality and outcomes. Nationally, public health lags behind medical care and other industries in the development of continuous quality improvement systems (Honore, et. al., 2011; Institute of Medicine, 2010). The drive toward accreditation is designed to accelerate LHD's capacity building in quality improvement and bring attention to the need for

Vision for the Future of Local Public Health in Ohio

The Association of Ohio Health Commissioners (AOHC) envisions a future where all Ohioans are assured basic public health protections, regardless of where they live, and where local public health continues to be a vital leader in improving Ohio's health outcomes. We envision a network of local health departments that:

- Are rooted in strong engagement with local communities;
- Are supported by adequate resources and capabilities that align with community need and public health science; and
- Deliver high quality services, demonstrate accountability and outcomes, and maximize efficiency.

an infrastructure to support public health quality measurement. The following online resources may be helpful to LHDs as they continue with this work:

- *Consensus Statement on Quality in the Public Health System*, Public Health Quality Forum, US Department of Health and Human Services Office of Public Health Science, August 2008
- *For the Public's Health: The Role of Measurement in Action and Accountability*, Institute of Medicine, December 2010
- *Priority areas for improvement of quality in public health*, Public Health Quality Forum, US Department of Health and Human Services Office of Public Health Science, November 2010
- National Network of Public Health Institutes, Accreditation and Performance Improvement programs http://nnphi.org/program-areas/accreditation-and-performance-improvement
- NACCHO Quality Improvement Toolkit http://www.naccho.org/toolbox/program.cfm?id=25&display_name=Quality%20Improvement%20Toolkit
- North Carolina Center for Public Health Quality http://www.ncpublichealthquality.org/ctr/

Recommendations: Local public health capacity, services, and quality

1. All Ohioans, regardless of where they live, should have access to the Core Public Health Services described in the Ohio Minimum Package of Local Public Health Services. (see attached Minimum Package diagram)

2. All local health departments (LHDs) should have access to the skills and resources that make up the Foundational Capabilities in order to effectively support the core services.

3. The Ohio Minimum Package of Local Public Health Services should be used to guide any future changes in funding, governance, capacity building, and quality improvement. (see Structure Analysis diagram)

4. All LHDs should become eligible for accreditation through the Public Health Accreditation Board (PHAB).

5. LHDs that meet Minimum Public Health Package standards should be prioritized for grant funding in their jurisdiction.

6. The biennial LHD Health Improvement Standards reported to the Ohio Department of Health via the Ohio Profile Performance Database should serve as the platform for assessing LHD provision of the Minimum Package. The Profile Performance Database may need to be updated periodically to capture the Core Public Health Services and Foundational Capabilities.

7. The Association of Ohio Health Commissioners (AOHC) supports a review of current laws and regulations to determine where mandates may need to be revised or eliminated and should advocate for elimination of mandates that do not align with the Minimum Package of Public Health Services.

3.3 Structure needed to support the vision

The Public Health Futures Steering Committee agreed that the structure of local public health should be designed to support and sustain the Minimum Package of Public Health Services. The committee's recommendations related to the structure of local public health aim to address two overarching challenges and opportunities. First, the recommendations attempt to strike a balance between local control and statewide standardization. They aim to support continued local community engagement and preserve the amount of funding generated from local sources, while at the same time improving the consistency of performance, quality, and outcomes for all LHDs. Home rule and the heavy reliance on local funding (76% of all LHD revenue) help LHDs to be strongly rooted in their local communities, although this local structure also presents potential barriers to formal cross-jurisdictional sharing (CJS) and consolidation (e.g., city/county officials' concerns about resource allocation, lack of parity in fee structures, wide variability in LHD per-capita expenditures and services provided, etc.). Second, the recommendations use CJS and consolidation as tools for building LHD capacity and improving performance. Transitions to CJS and consolidation must balance local choice with a shift toward more formal and efficient models of collaboration, and must critically assess the feasibility of sustaining 125 LHDs, more than half of which serve fewer than 50,000 residents.

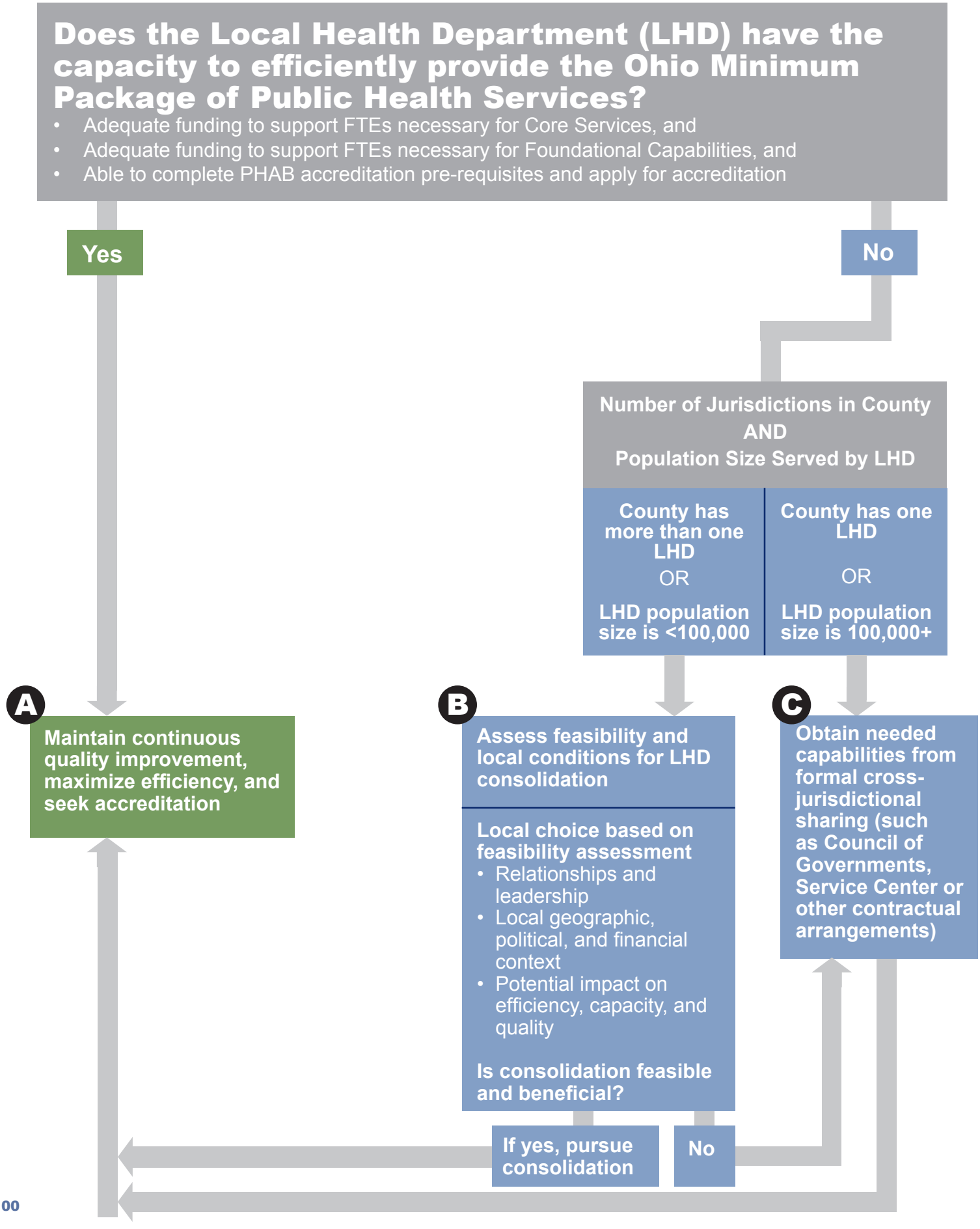
Figure 23 illustrates the committee's recommendations and guidance for how LHDs should make decisions about jurisdictional structure in the future. As depicted in this model, capacity to efficiently provide the Ohio Minimum Package of Public Health Services should be the primary consideration for the future jurisdictional status of a LHD. "Capacity" refers to staff and resources. **LHDs that are not able to provide the Minimum Package should look to consolidation and/or CJS to obtain Foundational Capabilities and provide Core Services**.

The number of jurisdictions in a county and the population size served by the LHD should be the primary considerations for whether or not consolidation should be explored. Research indicates that LHDs serving populations of less than 100,000 are less likely to have the capacity needed to provide essential services (Bhandari, et. al., 2010; Cook, 2012; Mays, et. al, 2006; Minnesota Public Health Research to Action Network, 2011; Santerre, 2009; Suen and Magruder, 2004). It is important to note that public health systems and services research (e.g., research about how to best structure public health systems) is an emerging field. The Steering Committee found that it is difficult to make evidence-informed decisions when the depth and breadth of the available evidence is limited. The positive relationship between population size and LHD performance is one of the only clear research findings that has emerged thus far. Population size should therefore be considered as one factor, but not the only factor, when making decisions about jurisdictional structure.

In the regional meetings, stakeholders expressed minimal interest in multi-county consolidations, and some felt that multi-county consolidations should be "off the table." Voluntary consolidation should therefore be considered by LHDs in counties with more than one LHD and/or by LHDs serving a population of less than 100,000 residents. Ohio has a total of 23 counties with more than one LHD. These 23 counties are home to 37 city health departments, 34 of which serve fewer than 100,000 residents (see Part 1 of the report and Appendix B).

AOHC is not recommending a population-based requirement for consolidation, but rather is recommending that LHDs that meet the criteria specified in the model should conduct a feasibility assessment that takes into consideration the local conditions and potential impacts of consolidation (as listed in the feasibility checklist, page 21). Due to the complexity of the local political and financial environments, forced consolidations that fail to address local conditions and sustainable funding issues may result in unintended consequences (e.g., net loss of local funding) and are not desirable. AOHC is not recommending a set number of LHDs for Ohio at this time. If the recommendations in this report are implemented, however, it is likely that the current trend toward voluntary consolidation and CJS will be accelerated and the total number of LHDs will be reduced.

Figure 23. Local Public Health Structure Analysis



Recommendations: Jurisdictional Structure

8. Decisions about the jurisdictional structure of local public health in Ohio should be based upon LHD ability to efficiently and effectively provide the Minimum Package of Public Health Services. Additional factors that should be considered are:
   a. Number of jurisdictions within a county,
   b. Population size served by the LHD, and
   c. Local geographic, political, and financial conditions. (see Structure Analysis diagram)

9. All LHDs should assess:
   a. Their ability to provide the Minimum Package of Public Health Services,
   b. The potential impact of cross-jurisdictional sharing or consolidation on their ability to provide those services, and,
   c. The feasibility of and local conditions for cross-jurisdictional sharing or consolidation.

10. Most LHDs, regardless of size, may benefit from cross-jurisdictional sharing. However, LHDs serving populations of <100,000 in particular may benefit from pursuing cross-jurisdictional sharing or consolidation to ensure adequate capacity to provide the Minimum Package.

11. LHDs in counties with multiple LHDs should consider the feasibility of voluntary consolidation.

12. Statutory barriers to voluntary multi-jurisdictional consolidation and cross-jurisdictional sharing should be removed, such as allowing for:
   a. Multi-county levy authority, and
   b. Consolidation of non-contiguous cities or counties, and
   c. Addressing other barriers identified in feasibility analyses.

Resources for pursuing consolidation and CJS

Technical assistance, support for feasibility assessments and transition planning, and incentives will help LHDs to consolidate (when appropriate) and/or move toward more formal and efficient models of CJS. The Public Health Futures project developed two tools to guide LHD decision making in these areas. First, the *Checklist for Assessing Feasibility and Local Conditions for Cross-Jurisdictional Sharing (CJS) or Consolidation* (see page 21) provides a list of issues each local community should consider. This list reflects the success factors and barriers identified in the literature review and key informant interviews described in Part 2 of this report. Second, the *Characteristics and Issues to Consider for Potential CJS and Consolidation Models* matrix (see Appendix F) provides a description of three recommended models: 1) ad hoc contracting with a shared services center (similar to Educational Service Centers), 2) Council of Governments (COGs), and 3) Consolidation. HPIO used this as a discussion guide during the regional Public Health Futures meetings and it can serve as a starting place for LHDs as they begin to develop more formal and standardized approaches to CJS.

Additional technical assistance may be available in consultation with academic public health centers across the state.

In order to transition from the current system of informal arrangements and grant-specific service contracts, LHDs will need to address key decisions such as:

- Which CJS model(s) should be used: Council of Governments (COGs), Public Health Service Center (similar to Educational Service Centers), or some other arrangement?
- What number of LHDs should participate in formal CJS arrangements together? For example, should there be five CJS centers to reflect the five AOHC districts, or some other configuration?
- How will formal CJS arrangements be funded and where will they be housed?
- What range of Foundational Capabilities and other services should be provided by the formal CJS arrangements?

The following grant programs and "nuts and bolts" resources identified during the Public Health Futures process may also be useful as LHDs move forward to implement this report's recommendations:

- Center for Sharing Public Health Services. Grant program, learning community, and technical assistance center launched in May 2012. Funded by Robert Wood Johnson Foundation and housed at the Kansas Health Institute. http://www.phsharing.org/
- Ohio Local Government Innovation Fund. Financial assistance for feasibility studies and demonstration projects designed to improve efficiency of local government. http://www.development.ohio.gov/Urban/LGIF.htm
- Attorney General Opinion Number 2012-013, Ohio Attorney General Mike DeWine, May 2012. Legal description of council of governments (COGs). http://ohioattorneygeneral.gov/getattachment/40bd8d50-ff26-42ce-b046-0918926ae5e9/2012-013.aspx
- *Summit County Health District and Akron Health Department Consolidation Feasibility Study*, The Center for Community Solutions, 2010, http://www.scphoh.org/PDFS/PDF-Reports/Final_Merger_Report_021210.pdf
- Kansas regional cooperation model, as described in *Proposal for the implementation of a multi-jurisdictional accreditation process*. Prepared by the Kansas Association of Local Health Departments (http://www.kalhd.org) and the Kansas Health Institute (www.khi.org).
- *Regionalization of Government Services: Lessons Learned and Application for Public Health Service Delivery*, Nancy J. Kaufman for the Robert Wood Johnson Foundation, 2010. http://www.rwjf.org/files/research/rwjfphrregionalizationofgovernmentservices.pdf
- skinnyOhio.org, Ohio Auditor of State, http://skinnyohio.org/
- Shared Services Idea Center, Ohio Auditor of State, http://www.auditor.state.oh.us/sharedservices/default.htm

Checklist for Assessing Feasibility and Local Conditions for Cross-Jurisdictional Sharing (CJS) or Consolidation

Relationships, leadership, and purpose

☐ **History of collaboration.** Do the LHDs have experience collaborating with each other? LHDs with a history of successful collaboration are better positioned to pursue CJS or consolidation.

☐ **Trust, personal relationships, and leadership.** Do the leaders of the LHDs have a strong working relationship? Mutual trust and positive personal relationships between LHD leadership and staff help to support successful collaboration. Strong leadership is critical.

☐ **Clarity of purpose.** Are the LHDs pursuing CJS or consolidation for the same reasons? LHDs should clarify their reasons for pursuing change early on in the planning process (e.g., increased efficiency, improved quality, maintaining services, etc.).

Local geographic, political, and financial context

☐ **Geographic density, dispersion, and size.** What are the potential impacts of CJS or consolidation on the efficiency of transportation logistics for the LHD? What are the potential impacts on the location of services and customer ability to access them?

☐ **Customer service and public visibility.** What is the potential impact on LHD ability to maintain a visible presence in affected communities, and capacity to improve or maintain high-quality customer service?

☐ **Community identity and engagement.** What is the potential impact on LHD ability to engage with community organizations and the public?

☐ **Naturally-occurring regional boundaries.** Do the different communities typically work together or have a regional identity? What are the jurisdictional configurations of related systems in the area? For example, would it be beneficial to align with county-level DJFS agencies or multi-county behavioral health boards, or other regional boundaries used by related systems?

☐ **Demographics.** To what extent are the demographic characteristics of the different communities similar or different? How might this impact the ability of consolidated or collaborating LHDs to provide services?

☐ **Local funding.** How would CJS or consolidation impact local funding sources, including public health levies if present?

☐ **Local political support.** What kind of local political support is there for CJS or consolidation? What factors are most important to local elected officials? How should local officials be included in the process?

Potential impact on efficiency, capacity, and quality

☐ **Service provision.** Would CJS or consolidation allow for the provision of additional services, or maintaining services with unsustainable funding or capacity? How would CJS or consolidation impact each LHD's ability to provide the Minimum Package of Public Health Services?

☐ **Foundational capabilities.** To what extent would CJS or consolidation impact LHDs capacity for Foundational Capabilities?

☐ **Accreditation and quality.** What is the potential impact on LHD ability to prepare for, seek, and obtain PHAB accreditation? What is the potential impact on LHD ability to assess and improve quality? What is the potential impact on LHD ability to carry out its Community Health Improvement Plan?

☐ **Efficiency.** What are the economies of scale that could be created by CJS or consolidation? Would improvements in efficiency or performance outweigh the costs of collaboration (transaction costs)?

☐ **Personnel.** How would the structure and payment of personnel be impacted by CJS or consolidation? How might labor union participation (if present) impact a consolidation process? Are there any upcoming retirements that may facilitate a leadership transition?

☐ **Health care service reimbursement.** What is the potential impact on LHD ability to obtain reimbursement from health insurance providers for health care services and immunizations?

☐ **Federal and state funding.** What is the potential impact on ability to obtain state or direct federal grants?

3.4. Financing the vision

The 2012 Institute of Medicine (IOM) report, *For the Public's Health*, declares that "The US public health financing structure is broken." Ohio's public health financing system mirrors this national picture and is further challenged by lower per-capita investments in public health compared to most other states (see Part 1 of this report). The fundamental problems with the financing of public health, both nationally and locally, are twofold: "1) insufficient funding for public health, and 2) dysfunction in how the public health infrastructure is funded, organized, and equipped to use its funding" (IOM, 2012, page S-1).

The Public Health Futures Steering Committee recognizes the importance and difficulty of taking on these overarching challenges. The committee's recommendations address the need to build political support for increasing—or at least maintaining—funding for local public health. Secondly, the recommendations identify some initial steps to address the problems caused by the complex, fragmented, and categorical grant-driven funding environment. These problems include:

- Lack of dedicated funding sources for the Foundational Capabilities needed to support effective services (e.g., quality assurance, information management, policy development)
- Lack of dedicated funding sources for CJS and consolidation
- Inability to make long-term investments to improve efficiency and quality due to revenue instability (e.g., competitive grants, local political conditions, changes in funder priorities, etc.), and
- Misalignment between current funding streams and the services that LHDs are mandated and expected to provide based on current public health science and local community need.

While many funding factors are beyond the control of AOHC, the committee attempted to craft finance recommendations that call attention to specific problems that can be addressed at the local and state level. Modernization and simplification of public health funding streams would help to improve accountability for LHDs and for ODH, and would help LHDs to meet the imperative to maximize efficiency within the context of "leaner government." Better alignment between funding categories, State Health Improvement Plan priorities, existing local Community Health Improvement Plan priorities, and the Minimum Package, would help to set a foundation for a pay-for-performance system.

The Steering Committee began the process of developing a cost estimate for the Minimum Package and an AOHC workgroup will continue this important and challenging work. The committee recognizes the critical importance of quantifying the cost of providing the Core Public Health Services supported by adequate Foundational Capacities before proceeding with requests for additional funding to support the Minimum Package.

Recommendations: Financing

13. All LHDs should have adequate funding to maintain the Minimum Package of Public Health Services. AOHC should continue the work of the Public Health Futures Financing Workgroup to identify cost estimates for the Minimum Package (Core Services and Foundational Capabilities) by November 2012.

14. The Ohio Department of Health and LHDs should work together to shift the focus from managing fragmented program silos and funding streams toward improving and coordinating state and local organizational capacity to effectively deliver the Minimum Package.

15. AOHC should advocate for block grants or direct contracts when possible so that communities can implement programs based on Community Health Assessment and Improvement Plan priorities.

16. AOHC should work to assure that local health departments are able to obtain fair reimbursement from public and private payers for eligible services (includes efforts to streamline insurance credentialing).

17. AOHC should explore new mechanisms for improving the stability and sustainability of federal, state, and local funding, such as:
    a. Dedicated percentage of inside millage in lieu of local levies,
    b. Standardized cost methodology to establish fees for programs where no explicit fee-setting authority currently exists,
    c. Increasing Local Health Department Support (“state subsidy”) to LHDs to support Foundational Capabilities,
    d. Excise taxes (e.g., tobacco, sugar-sweetened beverages, medical transactions), and
    e. Integrated health care delivery reimbursement.

3.5 Next steps

The transition to the new model of local public health should occur in an organized, resourced, and transparent manner. AOHC should work with ODH leadership and other state policymakers to develop strategies to implement the Public Health Futures recommendations. Health Commissioners will need to communicate the recommendations to their local boards of health and other local decision makers, and seek their input regarding how to move forward to enact changes. Further exploration of the potential costs and benefits of formal CJS models, as well as local consolidation/CJS feasibility assessments, will help AOHC's membership to move forward with building an infrastructure to support the new vision of local public health in Ohio.

Recommendations: Implementation Strategy

18. AOHC should seek funds to support feasibility assessments, transition planning, and incentives necessary for LHDs to implement the new framework (such as submitting a proposal to the RWJF Center for Sharing Public Health Services grant program).

19. AOHC should convene a meeting with state health policy leaders to formally present and discuss the recommendations of the Public Health Futures final report and to collaboratively plan strategies and action steps to advance forward progress toward the vision for the future.

Endnotes

[i] For more detail regarding requirements of private plan to cover preventive services, see "Focus on Health Reform: Preventive Services Covered by Private Health Plans under the Affordable Care Act," September 2011. The Henry J. Kaiser Family Foundation. http://www.kff.org/healthreform/8219.cfm

[ii] Initial guidance on essential benefits was issued by HHS in December 2011 and indicate that states will have some flexibility in defining essential benefits. Final rules are expected in Spring/Summer 2012. Once essential benefits are defined in Ohio, stakeholders will need to assess the extent of immunization coverage.

[iii] In addition to the coverage gains described above, Title IV, Section 4204, provides authority to states to purchase adult vaccine from manufacturers at the price negotiated by HHS Secretary in federal contracts. (Previously, states could only purchase childhood vaccines on federal contracts.)

[iv] For an overview of the Navigator program, see "Navigators: Guiding People Through the Exchange", June 2011. Community Catalyst. Downloaded at http://www.communitycatalyst.org/doc_store/publications/Navigators_June_2011.pdf

[v] HealthBridge is one of the oldest and largest regional health information exchanges (HIE) in the nation.

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Appendix A. Glossary

Collaboration. In this report, "collaboration" refers to the process of working jointly with others or together, in cooperation, toward a particular end or endeavor.

Consolidation. In this report, "consolidation" refers to Kauffman's definition: "the act of combining into one government body or entity, also known as merger. It can occur through annexation, dissolution, referendum or formal written agreement. State laws govern consolidation of local governments." Kaufman, N. J. *Regionalization of Government Services: Lessons Learned*, July 21, 2010. In Ohio, key statute includes R.C. 3709.07 ("Union").

Cross-jurisdictional Arrangements. In this report, the term "cross-jurisdictional arrangements" means the same as "shared service arrangements." Kauffman refers to Informal Arrangements, Service Contracts, and Inter-local Agreements, as forms of shared service on the continuum. They allow local jurisdictions to share information, equipment, and facilities, and to provide services, or receive them from another local jurisdiction. Kauffman states that "Functional Consolidation - where separate entities are retained but one or more duties normally performed are assigned to employees of another entity by inter-local agreement, is an incomplete form of consolidation." Inter-local agreements are contracts that precisely specify the services, activities, terms and conditions of collaboration. They are based on the principles and concepts of contract law. State laws govern the processes by which local governments form inter-local agreements. In Ohio, key statutes include R.C. 307.15, 307.153, 167.01, 167.08, 305.23, and 9.432.

Government Shared Services Continuum. "Shared services take place under a broad variety of arrangements from informal verbal or 'handshake' arrangements to inter-local joint powers agreements to formal consolidation (merger)" (Kauffman, 2010). This is a useful concept and categorization of the range of activities related to sharing services. This report uses the term in a general sense.

Local Health Districts. Established by ORC Chapter 3709, powers and duties of Boards of Health and Health Commissioners are outlined in ORC Chapter 3707. Each health district is a separate political subdivision, similar to a school district, with an appointed Board of Health. Each district has a Health Commissioner who reports to the Board of Health. There are general health districts (county), city health districts, and combined health districts (county and city). In this report, we refer to "city" and "county" (signifying both general and combined health districts) districts.

Regionalism/Regionalization. In this report, "regionalism/regionalization" refers to shared service or cross-jurisdictional arrangements across county lines. Kauffman's continuum defines regionalization more narrowly, referring only to mergers across county/state lines.

Shared Service Arrangements. Kauffman (2010) cites the following: "governments coming together to deliver services in a combined or collaborative operation (PricewaterhouseCoopers, 2005)." In this report, "shared service arrangements" is a term used to refer to a variety of forms of shared services, but not including "consolidation" and "regionalization" (which Kauffman includes as "shared services" within the continuum).

Appendix B. Ohio Local Health Departments by Population Size Category, 2010 Census

Source: Ohio Department of Health, LHD Census 2010

Health Department	Type	Total Population for Health Jurisdiction
City Health Departments: Small (<50,000)		
Belpre	City	6,441
Oakwood	City	9,202
Shelby	City	9,317
Girard	City	9,958
Galion	City	10,512
Ironton	City	11,129
East Liverpool	City	11,195
Coshocton	City	11,216
Springdale	City	11,223
Ravenna	City	11,724
Salem	City	12,303
Conneaut	City	12,841
Sharonville	City	13,560
Marietta	City	14,085
New Philadelphia	City	17,288
Steubenville	City	18,659
Ashtabula	City	19,124
Norwood	City	19,207
Niles	City	19,266
Portsmouth	City	20,226
Ashland	City	20,362
Piqua	City	20,522
Alliance	City	22,322
Shaker Heights	City	28,448
Kent	City	28,904
Massillon	City	32,149
Findlay	City	41,202
Warren	City	41,557
Middletown	City	48,694
	Count	**29**

City Health Departments: Medium (50,000-99,999)		
Elyria	City	54,533
Hamilton	City	62,477
Youngstown	City	66,982
Canton	City	73,007
Lorain	City	86,678
	Count	**5**

City Health Departments: Large (100,000-499,000)		
Cincinnati	City	296,943
Cleveland	City	396,815
	Count	2

City Health Departments: Very Large(500,000+)		
Columbus	City	800,608
	Count	1

County Health Departments: Small (<50,000)		
Vinton	Co	13,435
Noble	Co	14,645
Monroe	Co	14,679
Morgan	Co	15,054
Harrison	Co	15,741
Paulding	Co	19,495
Wyandot	Co	22,615
Meigs	Co	23,770
Coshocton	Co	25,675
Van Wert	Co	25,700
Carroll	Co	26,794
Henry	Co	28,215
Adams	Co	28,550
Pike	Co	28,709
Fayette	Co	28,919
Hocking	Co	29,365
Hancock	Co	30,475
Gallia	Co	30,934
Hardin	Co	32,170
Ashland	Co	32,831
Jackson	Co	33,225
Crawford	Co	33,290
Putnam	Co	34,499
Morrow	Co	34,827

Perry	Co	36,813
Williams	Co	37,642
Defiance	Co	39,037
Guernsey	Co	40,087
Champaign	Co	40,097
Mercer	Co	40,888
Washington	Co	41,252
Ottawa	Co	41,428
Clinton	Co	42,038
Holmes	Co	42,168
Preble	Co	42,540
Fulton	Co	42,808
Highland	Co	43,591
Madison	Co	44,263
Brown	Co	44,846
Logan	Co	45,746
Auglaize	Co	45,949
Union	Co	49,106
Shelby	Co	49,423
	Count	**43**

County Health Departments: Medium (50,000-99,999)		
Lawrence	Co	51,321
Jefferson	Co	51,637
Darke	Co	52,120
Sandusky	Co	55,679
Pickaway	Co	55,809
Scioto	Co	59,273
Knox	Co	60,905
Seneca	Co	61,453
Huron	Co	62,883
Athens	Co	64,772
Marion	Co	66,501
Ashtabula	Co	69,532
Belmont	Co	69,899
Tuscarawas	Co	75,448
Ross	Co	78,064
Miami	Co	81,766
Erie	Co	83,292
Muskingum	Co	85,231
Columbiana	Co	85,359
Geauga	Co	93,273
	Count	**20**

County Health Departments: Large (100,000-499,999)		
Allen	Co	109,667
Wayne	Co	114,730
Richland	Co	116,049
Fairfield	Co	116,577
Portage	Co	119,504
Wood	Co	124,450
Clark	Co	138,285
Trumbull	Co	139,520
Lorain	Co	154,293
Delaware	Co	155,159
Licking	Co	157,762
Greene	Co	161,152
Mahoning	Co	170,794
Medina	Co	172,118
Clermont	Co	195,451
Warren	Co	210,504
Lake	Co	230,041
Stark	Co	250,192
Butler	Co	257,225
Franklin	Co	422,640
Lucas	Co	441,705
Hamilton	Co	466,508
	Count	**22**

County Health Departments: Very Large (500,000+)		
Montgomery	Co	525,901
Summit	Co	543,072
Cuyahoga	Co	854,975
	Count	**3**

Appendix C. List of key informants and interview guide

Key Informants Interviewed

Local Public Health Group

James M. Adams	Canton City Health Department (Stark County)
Terry Allan	Cuyahoga County Health District
Kathryn C. Boylan	Elyria City Health Department (Lorain County)
Wally Burden	Pike County General Health District
Angela DeRolph	Perry County General Health District
Anne Goon	Henry County General Health District
Timothy Ingram	Hamilton County General Health District
Teresa C. Long	Columbus Public Health (Franklin County)
Kathleen L. Meckstroth	Washington County Health Department
Gene A. Nixon	Summit County Health
Jason Orcena	Union County Health Department
Nancy C. Osborn	Ottawa County Health Department
Dennis R. Propes	Sharonville City Health Department (Hamilton County)
Chris Smith	Portsmouth City Health Department (Scioto County)
Susan A. Tilgner	Franklin County Public Health
Wesley J. Vins	Columbiana County General Health District
Krista Wasowski	Morrow County Health Department
Beth Bickford (Staff)	Executive Director, Association of Ohio Health Commissioners

Statewide Policy Group

Greg Moody	Director, Governor's Office of Health Transformation
Randy Cole	President, Controlling Board and Policy Advisor
Steven R. Wermuth	Chief Operating Officer, Ohio Department of Health
Joe Mazzola	Office of Local Health Department Support, Ohio Department of Health
John Hoornbeek, PhD	Associate Professor, College of Public Health, Director, Center for Public Administration and Public Policy Kent State University
Rex Plouck	Governor's Office of Health Transformation
Bart Anderson	Superintendent, Educational Service Center of Central Ohio

KEY INFORMANT INTERVIEW QUESTIONS

Questions asked of both groups

- Please comment on what you see as the value and role of public health in the future.
- What is your experience and receptiveness toward regional collaboration/shared services issues and comment on the landscape?
- If the Project produced a blueprint that had statewide, regional, and localized elements, what would stop your board from pursuing the solution(s)?

Questions asked of local public health group

- Please share your history/background in public health.
- Please describe some challenges encountered along the way: highlights/lowlights.
- Please comment on local public health delivery system stability issues: direct patient services, funding, politics etc.
- What is your view on accreditation and how would it be useful?
- Describe the level of current activity around local collaboration/consolidation issues/ landscape.
- What is your experience and receptiveness toward regional collaboration/shared services issues and comment on the landscape?
- This Project's Results: what coming out of this would be most helpful to you and the communities you serve?
- Policy Development: What does this mean and what would make sense to you in terms of the focus of this project?
- Access to specialized expertise: What does this mean, and what would make sense to you?
- Electronic Health Records: comment on relevance, capacity vis a vis your organization.
- Name some key partners locally; any sharing discussions occurring?
- Comment on the state level environment and its impact locally.
- If Project produced a blueprint that had statewide, regional, and localized elements, what would stop your board from pursuing the solution(s)?
- Please comment on what you see as the value and role of public health in the future.

Questions asked of statewide policy group only

- Opportunities and barriers to sharing/consolidating - how can you help?
- Discuss information technology, performance measurement, focus of locally delivered services

Appendix D. Mandated and Permitted Services and Governance/Administrative Provisions in the Ohio Revised Code (ORC) and Ohio Administrative Code (OAC)

Appendix D Table 1. Mandated Services and Governance/Administrative Provisions

Ohio Revised Code (ORC)	
Department of Health	Summary
3701.02	Department of Health (DOH) consists of a *director of health* and a *public health council*
3701.021	Public health council shall adopt rules as are necessary to carry out required functions/duties not limited to but including: *Standards for the provision of service coordination by the department of health and city and general health districts*
3701.023 "Medically handicapped children program"	DOH shall review applications for eligibility for the program for medically handicapped children that are submitted to the department by city and general health districts and shall evaluate applications for authorization to provide treatment services, service coordination, and related goods to children deemed eligible for the medically handicapped children program.
3701.024 "Medically handicapped children program"	DOH shall determine the amount each county shall provide annually for the program for medically handicapped children and may allow each county to retain up to ten per cent of the amount determined to provide funds to *city or general health districts* of the county with which the districts shall provide service coordination, public health nursing, or transportation services for medically handicapped children. City or general health districts shall use the amounts retained to conduct outreach activities to increase participation in the program for medically handicapped children.
3701.13	Whenever possible, the DOH shall work in cooperation with the *health commissioner of a general or city health district*. The DOH may make and enforce orders in local matters when an emergency exists, or when the board of health of a general or city health district has neglected or refused to act with sufficient promptness or efficiency, or when such board has not been established. In such cases the necessary expense incurred shall be paid by the general health district or city for which the services are rendered.
3701.14	When called upon by the state or local governments, or the board of health of a *general or city health district*, the director of health shall promptly investigate and report upon the water supply, sewerage, disposal of excreta of any locality, and the heating, plumbing, and ventilation of a public building.
3701.24	In each county the director shall designate the *health commissioner of a health district* in the county to receive reports regarding every case of AIDS, every AIDS-related condition, and every confirmed positive HIV test reported to the DOH.
3701.29	DOH shall make provision for annual conferences of *district health commissioners* for the consideration of the cause and prevention of dangerous communicable diseases and other measures to protect and improve the public health.
3701.342 "minimum and optimum achievable standards for boards of health and local health departments"	After consultation with the public health standards task force, the public health council shall adopt rules establishing minimum standards and optimum achievable standards for *boards of health and local health departments*. The minimum standards shall assure that boards of health and local health departments provide for: Analysis and prevention of communicable disease; Analysis of the causes of, and appropriate treatment for, the leading causes of morbidity and mortality; The administration and management of the local health department; Access to primary health care by medically underserved individuals; Environmental health management programs; Health promotion services designed to encourage individual and community wellness. The public health council shall adopt rules establishing a formula for *distribution of state health district subsidy funds to boards of health and local health departments*. The formula shall provide no subsidy funds to a board or department unless it meets minimum standards and shall provide higher funding levels for boards and districts that meet optimum achievable standards.
3701.344 "private water systems"	Unless otherwise provided, *boards of health of city or general health districts* shall be given the exclusive power to establish fees for administering and enforcing rules regarding private water systems. If the director of health determines that a board of health of a city or general health district is unable to administer and enforce a private water system program in the district, the director shall administer and enforce such a program in the district and establish fees for such administration and enforcement.

	Boards of health of city or general health districts shall be given the exclusive power to determine the number of inspections necessary for determining the safe drinking characteristics of a private water system. *Boards of health of city or general health districts* shall have the option of determining whether bacteriological examinations shall be performed at approved laboratories of the state or at approved private laboratories.
3701.35	Every rule the public health council adopts shall state the date on which it takes effect, and a copy thereof, signed by the secretary of the council, shall be filed in the office of the secretary of state, and a copy thereof shall be sent by the director of health to each *board of health of a general or a city health district*, health officer, or person performing the duties of health officer, within the state.
3701.50	The *health commissioner of the city or general health district*, wherein any person required to be tested for syphilis and gonorrhea resides, may waive the requirements of such sections if the commissioner is satisfied by written affidavit or other written proof that the tests required are contrary to the tenets or practices of the religious creed of which the person is an adherent, and that the public health and welfare would not be injuriously affected by such waiver.
3701.53 "Duties of Health Commissioner"	The health commissioner of a city or general health district shall: Investigate each case of inflammation of eyes of the newborn or gonorrheal ophthalmia as filed with him and any other such case that comes to his attention; Report all cases of inflammation of the eyes of the newborn or gonorrheal ophthalmia, and the result of all such investigation, as the department of health directs; Conform to such other rules and regulations as the department promulgates for his further guidance; Determine the nature of the inflammation of the eyes in any case reported to him, and refer immediately to the Ohio commission for the blind, any inflammation of the eyes, for such treatment as the commission deems necessary.
3701.56; 3701.57	*Boards of health of a general or city health district*, health authorities and officials, officers of state institutions, police officers, sheriffs, constables, and other officers and employees of the state or any county, city, or township, shall enforce quarantine and isolation orders, and the rules the department of health adopts. The director of health, the board of health of a general or city health district, or any person charged with enforcing the rules of the department of health, may petition the court of common pleas for injunctive or other appropriate relief requiring any person violating a rule adopted by the public health council or any order issued by the director of health to comply with such rule or order.
County Health Department or Agency	
301.24	Electors of any county may establish, by charter provision, a county department or agency for the administration of public health services. The authorities provided in accordance with the county charter shall exercise all the powers and perform all the duties which are vested in or imposed upon the authorities of city or general health districts. All health districts shall be abolished within the county, and the county shall succeed to the property, rights, and obligations of such districts. DOH shall have the same powers with respect to a county health department or agency as it possesses with reference to a general health district. A county health department or agency may participate in any state grants for the expenses of local health administration on the same basis and degree as a general health district.
307.621	A board of county commissioners shall appoint a health commissioner of the board of health of a city or general health district that is entirely or partially located in the county in which the board of county commissioners is located to establish a child fatality review board to review the deaths of children under eighteen years of age.
Boards of Health	
3707.01 "abatement of nuisances"	The board of health of a city or general health district shall abate and remove all nuisances within its jurisdiction. The board *may* regulate the location, construction, and repair of water closets, privies, cesspools, sinks, plumbing, and drains. The board *may* regulate the location, construction, and repair of yards, pens, and stables, and the use, emptying, and cleaning of such yards, pens, and stables and of water closets, privies, cesspools, sinks, plumbing, drains, or other places where offensive or dangerous substances or liquids are or may accumulate.
3707.26	Semiannually, and more often, if judged necessary, the board of health of a city or general health district shall inspect the sanitary condition of all schools and school buildings within its jurisdiction, and may disinfect any school building.
3707.30	Hospital buildings shall be under the care and control of the board of health of the city or general health district in which such buildings are located.
3734.042	Upon receiving a written complaint of the presence of vectors at a scrap tire collection, storage, monocell, monofill, or recovery facility, the board of health of the health district having jurisdiction *promptly shall conduct an inspection of the facility* named in the complaint.
3734.05	Except as provided in divisions (A)(4), (8), and (9) of this section, no person shall operate or maintain a solid waste facility without a license issued under this division by the board of health of the health district in which the facility is located or by the director of environmental protection when the health district in which the facility is located is not on the approved list under section 3734.08 of the Revised Code.

3734.06	Creates a special fund in health districts used solely to administer and enforce the solid waste provisions of ORC chapter 3734. Creates a special infectious waste fund in each health district used solely to administer and enforce the infectious waste provisions of ORC chapter 3734.
Health Districts	

3709.01	State is divided into health districts:
	- City constitutes a *"city health district"*
	  ○ Two or more contiguous city health districts may unite to form a single city health district (affirmed by majority vote of legislative authority of each city or by electorate petition/election)
	- Townships and villages in each county are combined into a *"general health district"*
	  ○ Two or more contiguous general health districts, not to exceed five may unite to form a single general health district (affirmed by majority vote of the district advisory council)
	- *Combined health district* is a union of a general health district and one or more city health districts

Authority	
3709.03-.04 "general health district"	A *district advisory council* is created in each general health district. Council members include: president of the board of county commissioners, chief executive of each municipal corporation not constituting a city health district, president of the board of township trustees of each township or a selected representative from each of these entities. *Reference to a larger number of council members but not sure how they are appointed.* Council shall: 1. appoint four members of the BOH 2. receive and consider annual reports from the BOH 3. make recommendations to the BOH or DOH in re: matters for the betterment of health and sanitation w/in the district or for needed legislation If a district advisory council fails to select a BOH, the director of health with the consent of the *public health council* may appoint a board of health.
3709.02-.03; 3709.11 "general health district and Board of Health"	General health districts shall have a *board of health* (BOH) consisting of five members. Four members are appointed by the *district advisory counsel* and one is appointed by the *health district licensing council*. One member must be a physician; BOH shall appoint a *health commissioner* (term not to exceed five years). Commissioner shall be the executive officer of the board and carry out all orders of the board and the DOH (enforcement of sanitary laws and regulations in the district). If commissioner is not a physician, then BOH shall appoint a licensed physician as medical director to provide medical direction.
3709.05-06 "city health district"	*Legislative authority* of each city constituting a city health district shall establish a BOH. BOH shall have four members appointed by the *mayor* and confirmed by the *legislative authority* and one member appointed by the *health district licensing council*. If city fails to establish a BOH, the director of health, with approval of the public health council, may appoint a health commissioner for the city.
3709.14 "city health district and Board of Health"	In any city health district, BOH shall appoint a *health commissioner*.
3709.07 "combined city and general health district"	Chair of the district advisory council and the chief executive of each city shall enter into a contract for the administration of health affairs in the combined district. Contract may provide that the administration of the combined district shall be taken over by either the board of health or health department of one of the cities, by the board of health of the general health district, or by a combined board of health and agreed upon entity shall have all powers and duties required of the board of health of a general health district. The district advisory council of the combined general health district shall consist of: - the members of the district advisory council of the original general health district and - the chief executive of each city constituting a city health district, each member having one vote.
3709.41 "Health District Licensing	A health district licensing council is created in each general and city health district. Council is to be appointed by the entity that has responsibility for appointing the board of health in the health district. The members of the council shall consist of one representative of each business activity for which the board of health operates a licensing program.

Council"	
121.37	Each board of county commissioners shall establish a county family and children first council which includes the health commissioner, or commissioner's designee, of the board of health of each city and general health district in the county.
Regional Council of Governments	
167.02 "membership"	Membership in the regional council shall be the counties, municipal corporations, townships, special districts, school districts, and other political subdivisions entering into the agreement establishing the council or admitted to membership subsequently pursuant to the agreement establishing the council or the bylaws of the council. Representation on the council may be in the manner as provided in the agreement establishing the council.
Duties of BOH	
3709.14	Shall appoint a health commissioner
3709.16	Shall determine duties and fix salaries of its employees
3709.19	Shall keep a complete and accurate record of diseases reported to the health commissioner
3709.22	Shall study and record the prevalence of disease within its district and provide for the prompt diagnosis and control of communicable diseases.
3709.25	Shall provide for the free distribution of antitoxin for the treatment of cases of diphtheria and shall establish sufficient distributing stations to render such antitoxin readily available in all parts of the district.
	Shall annually adopt an itemized appropriation measure.
3709.36	Shall exercise all the powers and perform all the duties formerly conferred and imposed by law upon the board of health of a municipal corporation.
121.36 "home care services"	City and general health districts must comply with ORC 121. 26 when entering into a contract for the provision of home care services to home care dependent adults that are paid for in whole or in part by federal, state, or local funds.
Ohio Administrative Code (OAC)	
3701-36-03 "minimum standards for health district"	Each health district must meet the following minimum standards to receive any state subsidy funds: (1) Submission of a state health district subsidy fund application to the department due March first of each year; (2) Completion and submission of the department's on-line report which incorporates the PHAB standards on March first of every even numbered year; (3) Completion and submission of the United States centers for disease control and prevention public health performance standards report and submission of a copy to the department at least once, on a rolling basis, every five years, or on an interval of greater than five years as determined by the director; (4) Submission of a completed annual financial report to the department by March first of each year; (5) Be represented by the health commissioner or the health commissioner's designee at each conference provided by the Ohio DOH; (6) Provide administrative leadership by: Employing a health commissioner; Employing a registered nurse as nursing director; Employing a registered sanitarian as environmental health director; and employing a medical director; (7) provision of services for health education; and (8) expenditure of a minimum of three dollars per capita in local funds for public health services per year.
3701-36-01 "Definition of optimal achievable standards"	Optimal achievable standards is a concept for distributing subsidy funds beyond those awarded for achieving minimum standards. These *standards will be defined by the director on an annual basis when sufficient funds are allocated by the legislature*.
3701-36-04	Each local health department shall provide programs in such a manner as to protect and promote the public's health for the communities each board of health serves. Each local health department shall complete and submit a report to show compliance thereof.
3701-36-10 "payment of health district	No health district shall be eligible for or be paid a state subsidy unless: (1) The health district has been provided local funds for public health services, as determined by the health commissioner and board of health, totaling at least three dollars per capita, according to the most recent federal decennial census or the United States census bureau's most recent population estimate, however, the director may grant an exception to the requirements of this paragraph when it is shown

subsidies"	to his satisfaction that unusually severe economic conditions prevent the health district from receiving adequate tax revenues. (2) The certification of funds expended by the health district is endorsed by the director. (3) The health district has submitted, by the time requested, all data, reports, and other information concerning services and costs associated with state subsidy distribution required by the director of health. (4) The health district has not decreased local funds in the local health department budget in anticipation of using state subsidy funds to provide services normally supported by local revenues. (5) The local health department is in compliance with the minimum standards set out in the OAC. Each health district meeting the improvement minimum standards and which is otherwise eligible for a state subsidy shall be paid the subsidy to be computed as follows: (1) Health districts that are in compliance with the minimum standards may be paid a pro rata amount not to total more than fifty cents on a per capita basis according to the most recent federal decennial census or the United States census bureau's most recent population estimate. (2) If the amount appropriated by the general assembly in any fiscal year for state health district subsidy exceeds fifty cents per capita for health districts that qualify for any subsidy under this rule, health districts that are in compliance with one or more of the *optimal achievable standards (see 3701.342)* contained in this chapter of the Administrative Code may be paid an additional subsidy amount for each optimal achievable standard met, on a per capita basis according to the most recent United States census bureau's population figures, as determined by the director. In addition to compliance with one or more of the optimal achievable standards, a health district must comply with all minimum standards to qualify for an additional subsidy.
3701-36-11 "Certification of compliance and financial disclosure"	To apply for state subsidy payments, the president of each board of health and the health commissioner of each local health department shall submit to the director on forms provided by the director and shall be submitted no later than the first day of March of each year, the following: (1) An annual application for state subsidy. The application shall include a certification of the extent of the local health department's compliance with the improvement standards established by rules 3701-36-03 and 3701-36-04 of the Administrative Code; (2) An annual subsidy compliance statement; and (3) Submission of the department's on-line report on improvement standards and the centers for disease control and prevention national performance standards survey. (B) The president of each board of health providing health services in one or more health districts and the chief executive officer of each local health department providing services in one or more health districts shall, on or before the first day of March of each year, submit to the director on forms provided by the director an annual financial report for the preceding calendar year, describing amounts expended which qualify for state health district subsidy funds. This report shall be certified by the health commissioner and the auditor of the health district.
3701-36-12 "assessing compliance"	The director may evaluate the extent to which local health departments comply with the minimum and optimal achievable standards established by Chapter 3701-36 of the Administrative Code by means of the review process provided in this rule. Each local health department which has certified that it is in compliance with minimum or optimal achievable standards may be evaluated as frequently as the director deems necessary.

Appendix D Table 2. Permitted Services and Governance/Administrative Provisions

Ohio Revised Code (ORC)	
Department of Health	Summary
3701.03; 3701.04	Director of Health shall perform duties incident to the position as CEO of the DOH. Director shall administer the laws relating to health and sanitation and the rules of the DOH. Director may enter into agreements to sell services offered by the department of health to boards of health of city and general health districts and to other departments, agencies, and institutions of this state, other states, or the United States.
3701.10	Director of health may require any district health commissioner to attend, immediately after his appointment, a school of instruction to be conducted by the department of health at Columbus.
3701.13	Whenever possible, the DOH shall work in cooperation with the *health commissioner of a general or city health district*. The DOH may make and enforce orders in local matters when an emergency exists, or when the board of health of a general or city health district has neglected or refused to act with sufficient promptness or efficiency, or when such board has not been established. In such cases the necessary expense incurred shall be paid by the general health district or city for which the services are rendered.
3701.35	Every rule the public health council adopts shall state the date on which it takes effect, and a copy thereof, signed by the secretary of the council, shall be filed in the office of the secretary of state, and a copy thereof shall be sent by the director of health to each *board of health of a general or a city health district*, health officer, or person performing the duties of health officer, within the state.
3701.56; 3701.57	*Boards of health of a general or city health district*, health authorities and officials, officers of state institutions, police officers, sheriffs, constables, and other officers and employees of the state or any county, city, or township, shall enforce quarantine and isolation orders, and the rules the department of health adopts. The director of health, the board of health of a general or city health district, or any person charged with enforcing the rules of the department of health, may petition the court of common pleas for injunctive or other appropriate relief requiring any person violating a rule adopted by the public health council or any order issued by the director of health to comply with such rule or order.
County Health Department or Agency	
301.24	Electors of any county may establish, by charter provision, a county department or agency for the administration of public health services. The authorities provided in accordance with the county charter shall exercise all the powers and perform all the duties which are vested in or imposed upon the authorities of city or general health districts. All health districts shall be abolished within the county, and the county shall succeed to the property, rights, and obligations of such districts. DOH shall have the same powers with respect to a county health department or agency as it possesses with reference to a general health district. A county health department or agency may participate in any state grants for the expenses of local health administration on the same basis and degree as a general health district.
307.806 "County microfilming board"	The county microfilming board may enter into a contract with the legislative authorities of any municipal corporation, township, port authority, water or sewer district, school district, library district, county law library association, health district, park district, soil and water conservation district, conservancy district, other taxing district, regional council, county land reutilization corporation, or with the board of county commissioners or the microfilming board of any other county, or with any other federal or state governmental agency, and such authorities may enter into contracts with the county microfilming board, to provide microfilming or image processing services to any of them.
307.846 "County automatic data processing board"	The county automatic data processing board may enter into a contract with the legislative authorities of any municipal corporation, township, port authority, water or sewer district, school district, library district, county law library association, health district, park district, soil and water conservation district, conservancy district, other taxing district, regional council, county land reutilization corporation, or with the board of county commissioners or the automatic data processing board of any other county, or with any other federal or state governmental agency, and such authorities or entities may enter into contracts with the county automatic data processing board, to provide automatic or electronic data processing or record-keeping services to any of them.
311.29 "Sheriff"	Sheriff may enter into contracts with any municipal corporation, township, township police district, joint police district, metropolitan housing authority, port authority, water or sewer district, school district, library district, health district, park district, soil and water conservation district, water conservancy district, or other taxing district or with the board of county commissioners of any contiguous county with the concurrence of the sheriff of the other county, and such subdivisions, authorities,

	and counties may enter into agreements with the sheriff pursuant to which the sheriff undertakes and is authorized by the contracting subdivision, authority, or county to perform any police function, exercise any police power, or render any police service in behalf of the contracting subdivision, authority, or county, or its legislative authority, that the subdivision, authority, or county, or its legislative authority, may perform, exercise, or render.
307.15 "Board of County Commissioners"	The board of county commissioners *may enter* into an agreement with the legislative authority of a health district or with the board of health, and such legislative authorities may enter into agreements with the board of county commissioners, whereby the board undertakes, and is authorized by the contracting subdivision, to exercise any power, perform any function, or render any service, on behalf of the contracting subdivision or its legislative authority, that such subdivision or legislative authority may exercise, perform, or render.
307.153 "Agreements with board of health"	A board of health of a city or general health district may enter into an agreement with the board of county commissioners of the county in which the health district is totally or partially located, and the board of county commissioners may enter into an agreement with the board of health, whereby the board of health undertakes to exercise any power, perform any function, or render any service, in behalf of the county commissioners, which the board of county commissioners may exercise, perform, or render.
3707.01 "abatement of nuisances"	The board of health of a city or general health district **shall** abate and remove all nuisances within its jurisdiction. The board *may* regulate the location, construction, and repair of water closets, privies, cesspools, sinks, plumbing, and drains. The board *may* regulate the location, construction, and repair of yards, pens, and stables, and the use, emptying, and cleaning of such yards, pens, and stables and of water closets, privies, cesspools, sinks, plumbing, drains, or other places where offensive or dangerous substances or liquids are or may accumulate.
3707.02; 3707.021	When an order of the board of health of a city or general health district is neglected or disregarded, the board *may* elect to cause the arrest and prosecution of all persons offending, petition the court for an injunction, or perform, by its officers and employees, what the offending parties should have done.
3707.04	In response to an epidemic or threat thereof, the BOH *may* impose a quarantine on vessels, railroads, or other public or private vehicles conveying persons, baggage, or freight, or used for such purpose.
3707.12	The board of health of a city or general health district may destroy any infected clothing, bedding, or other article that cannot be made safe by disinfection, and shall furnish to the owner of the articles a receipt.
3707.27	The board of health of a city or general health district *may* take measures, supply agents, and afford inducements and facilities for gratuitous vaccination, or may make reasonable charges for such vaccination.
3707.55	A board of health of a general health district *may* acquire, convey, lease, or enter into a contract to purchase, lease, or sell real property for the district's purposes, and may enter into loan agreements, including mortgages, for the acquisition of such property.
Health Districts	

3709.01	State is divided into health districts:
	- City constitutes a *"city health district"*
	  ○ Two or more contiguous city health districts may unite to form a single city health district (affirmed by majority vote of legislative authority of each city or by electorate petition/election)
	- Townships and villages in each county are combined into a *"general health district"*
	  ○ Two or more contiguous general health districts, not to exceed five may unite to form a single general health district (affirmed by majority vote of the district advisory council)
	- *Combined health district* is a union of a general health district and one or more city health districts

Authority	
3709.03-.04 "general health district"	A *district advisory council* is created in each general health district. Council members include: president of the board of county commissioners, chief executive of each municipal corporation not constituting a city health district, president of the board of township trustees of each township or a selected representative from each of these entities. *Reference to a larger number of council members but not sure how they are appointed.* Council shall: 4. appoint four members of the BOH 5. receive and consider annual reports from the BOH 6. make recommendations to the BOH or DOH in re: matters for the betterment of health and sanitation w/in the district or for needed legislation If a district advisory council fails to select a BOH, the director of health with the consent of the *public health council* may appoint a board of health.

3709.05-06 "city health district"	*Legislative authority* of each city constituting a city health district shall establish a BOH. BOH shall have four members appointed by the *mayor* and confirmed by the *legislative authority* and one member appointed by the *health district licensing council*. If city fails to establish a BOH, the director of health, with approval of the public health council, may appoint a health commissioner for the city.
3709.07 "combined city and general health district"	Chair of the district advisory council and the chief executive of each city shall enter into a contract for the administration of health affairs in the combined district. Contract may provide that the administration of the combined district shall be taken over by either the board of health or health department of one of the cities, by the board of health of the general health district, or by a combined board of health and agreed upon entity shall have all powers and duties required of the board of health of a general health district. The district advisory council of the combined general health district shall consist of: - the members of the district advisory council of the original general health district and - the chief executive of each city constituting a city health district, each member having one vote.
Regional Council of Governments	
167.01 "formation"	Governing bodies of any two or more counties, municipal corporations, townships, special districts, school districts, or other political subdivisions may enter into an agreement with each other, or with the governing bodies of any counties, municipal corporations, townships, special districts, school districts or other political subdivisions of any other state to the extent that laws of such other state permit, for establishment of a regional council consisting of such political subdivisions.
167.03 "powers"	The council has power to: (1) Study such area governmental problems common to two or more members of the council as it deems appropriate, including but not limited to matters affecting health, safety, welfare, education, economic conditions, and regional development; (2) Promote cooperative arrangements and coordinate action among its members, and between its members and other agencies of local or state governments, whether or not within Ohio, and the federal government; (3) Make recommendations for review and action to the members and other public agencies that perform functions within the region; (4) Promote cooperative agreements and contracts among its members or other governmental agencies and private persons, corporations, or agencies; (5) Perform planning directly by personnel of the council, or under contracts between the council and other public or private planning agencies. The council may: (1) Review, evaluate, comment upon, and make recommendations, relative to the planning and programming, and the location, financing, and scheduling of public facility projects within the region and affecting the development of the area; (2) Act as an areawide agency to perform comprehensive planning for the programming, locating, financing, and scheduling of public facility projects within the region and affecting the development of the area and for other proposed land development or uses, which projects or uses have public metropolitan wide or interjurisdictional significance; (3) Act as an agency for coordinating, based on metropolitan wide comprehensive planning and programming, local public policies, and activities affecting the development of the region or area. The council may, by appropriate action of the governing bodies of the members, perform such other functions and duties as are performed or capable of performance by the members and necessary or desirable for dealing with problems of mutual concern. The *authority granted to the council by this section or in any agreement by the members thereof shall not displace any existing municipal, county, regional, or other planning commission or planning agency* in the exercise of its statutory powers.
167.08 "contracts for service"	Appropriate officials, authorities, boards, or bodies of counties, municipal corporations, townships, special districts, school districts, or other political subdivisions may contract with any council to receive any service from such council or to provide any service to such council. Such contracts may also authorize the council to perform any function or render any service in behalf of such counties, municipal corporations, townships, special districts, school districts, or other political

	subdivisions, which such counties, municipal corporations, townships, special districts, school districts, or other political subdivisions may perform or render.
Powers of BOH	
3709.14-15	May appoint public medical health staff (including physicians) and persons for sanitary duty.
3709.09	May, by rule, establish a uniform system of fees to pay the costs of any services provided by the board.
3709.15	May provide nursing care and other therapeutic and supportive care services to maintain an ill or infirm person in a place of residence used as such person's home or elsewhere OR contract with any individual or a public or private agency to furnish services.
3709.16	May procure and pay all or any part of the cost of group life, hospitalization, surgical, major medical, sickness and accident insurance, or a combination of any of the foregoing types of insurance or coverage, for the health commissioner, the employees of the health district, and their immediate dependents.
3709.161	May procure a policy or policies of insurance insuring the members of the board, the health commissioner, and the employees of the board against liability.
3709.18	May provide infant welfare stations, prenatal clinics, and other measures for the protection of children as are necessary. May also provide for the prevention and treatment of trachoma and establish clinics or detention hospitals and provide the necessary medical and nursing services.
3709.20-21	May make orders and regulations necessary for its own government, for the public health, the prevention or restriction of disease, and the prevention, abatement, or suppression of nuisances.
3709.22	May also provide for the medical and dental supervision of school children, for the free treatment of cases of venereal diseases, for the inspection of schools, public institutions, jails, workhouses, children's homes, infirmaries, and county homes, and other charitable, benevolent, and correctional institutions. May also provide for the inspection of dairies, stores, restaurants, hotels, and other places where food is manufactured, handled, stored, sold, or offered for sale, and for the medical inspection of persons employed therein. May also provide for the inspection and abatement of nuisances dangerous to public health or comfort, and may take such steps as are necessary to protect the public health and to prevent disease.
3709.23	May provide for laboratory work.
3709.24	May provide for the free treatment and quarantine of carriers of cases of gonorrhea, syphilis, and chancroid. May establish and maintain one or more clinics for such purpose and may provide for the necessary medical and nursing service.
3709.26	May make frequent inspection of all county homes, children's homes, workhouses, jails, or other charitable, benevolent, or correctional institutions in the district, including physical examination of the inmates whenever necessary, and may make laboratory examinations of inmates as requested by authorized jurisdiction.
3709.27	May establish detention hospitals for cases of communicable diseases and provide for the support and maintenance thereof
3709.281	May enter into an agreement with the legislative authority of a municipality of the locus of the health district
3709.282	May participate in, receive or give financial and other assistance, and cooperate with other agencies or organizations, either private or governmental, in establishing and operating any federal program enacted prior to or after November 6, 1969.
Ohio Administrative Code (OAC)	
3701-36-01 "Definition of optimal achievable standards"	Optimal achievable standards is a concept for distributing subsidy funds beyond those awarded for achieving minimum standards. These *standards will be defined by the director on an annual basis when sufficient funds are allocated by the legislature*.

Note: Some statutes include both mandated and permitted provisions and are therefore included in both tables.

Appendix E. Crosswalk between PHAB standards and the Ohio Minimum Package of Local Public Health Services

There are many overlaps between PHAB domains and the Minimum Package categories. This crosswalk displays the *primary* areas of alignment.

PHAB Domain	Core Public Health Services	Other Public Health Services	Foundational Capabilities
1. Assess	▪ Epidemiology ▪ Access to birth and death records		▪ Information management and analysis ▪ Community health assessment (Support and expertise for LHD community engagement strategies)
2. Investigate	▪ Environmental health services ▪ Communicable disease control ▪ Emergency preparedness	Non-mandated environmental health services	Laboratory capacity (environmental)
3. Inform and Educate	▪ Health promotion and prevention ▪ Community engagement	Specific maternal and child health programs	
4. Community Engagement	▪ Community engagement ▪ Health promotion and prevention		Support and expertise for community engagement strategies
5. Policies and Plans	▪ Health promotion and prevention ▪ Emergency preparedness		▪ Policy development ▪ Community health improvement planning (Support and expertise for LHD community engagement strategies)
6. Public Health Laws	Environmental health services		Legal support
7. Access to Care	Linking people to health services	▪ Clinical preventive and primary care services ▪ Specific maternal and child health programs	Laboratory capacity (clinical)
8. Workforce			Resource development
9. Quality Improvement			▪ Quality assurance ▪ Information management and analysis
10. Evidence Based Practice			▪ Quality assurance ▪ Information management and analysis
11. Administration & Management			Resource development
12. Governance			Governance

Appendix F. Characteristics and Issues to Consider for Potential Cross-Jurisdictional Sharing and Consolidation Models

Discussion guide prepared for Public Health Futures regional district meetings, April 2012

Appendix F Table 1: Basic description, structure, and authority

	Model 1	Model 2	Model 3
	Ad Hoc contracting with a shared services center	Council of Governments (COGs)	Consolidation
Potential variations	1A. Build on existing Educational Service Centers (ESCs) 1B. Develop Public Health Service Centers (PHSCs)	2A. Geographic 2B. Service-specific 2C. Hybrid	3A. Based on county boundaries 3B. Based on population size criteria
1. Example	Educational Service Centers (ESCs) – both backroom (traditional shared services) and OCALI model (specialized expertise services)	DD Regional Council of Governments (COGs); Three C Recovery and Health Care Network	Summit-Akron health department union
2. Basic description of the structure	This is the model most similar to the current state in that each LHD decides what to contract for and negotiates and administers its own contracts. The difference is that LHDs are contracting with a service center, rather than (or in addition to) each other.	LHDs create and govern ("own") the COG. Opportunity to agree to standardized business processes and services. COGs could provide back office functions and/or expertise. COGs can serve as a Multi-Jurisdictional Applicant (MJA) for PHAB accreditation.	Union (merger) of city and county LHDs and/or union of multiple county LHDs
3. How is it different from what we are doing now?	Not much – more organized and formalized, possibly more efficient shared service arrangements.	Depends on scope. From mostly an alternative to service contracts and current collaborations to very deliberate re-organization, funding, staffing of activities aligned with PHAB, balanced with truly local needs/funding (See Table 4)	Would lead to fewer LHDs and larger LHDs.
4. Implications for accreditation	Each LHD would need to apply for accreditation separately.	More efficient because COG could serve as Multi-Jurisdictional Applicant (MJA)	Each LHD would need to apply for accreditation separately.
5. How many LHDs would there be?	Could retain 125	Could retain 125 LBOHs – but operations of LHDs would change significantly	88 if based on county boundaries; 28 to 124 if based on population size criteria

Table 1 continued	Model 1	Model 2	Model 3
6. How does it affect current autonomy of LHDs?	It doesn't, to the extent they really have local autonomy vs. "theoretical" autonomy	Could argue it strengthens it by improving capacity to focus on truly local functions; can retain rule-making/enforcement powers at LBOH	Autonomy only in merged entity
7. Which functions would be done by the shared body vs. what is done by the LHD?	See Table 4	See Table 4	NA
8. How much up-front investment would it take to start it?	Need more information	Need more information	Need more information
9. What laws or regulations would need to be changed?	Depends	Depends	Apportionment (governance) and local taxing authority issue must be addressed
10. What details or features would need to be decided?	See Table 4	See Table 4	See Table 4

Appendix F Table 2. Considerations based on "clarity of purpose" reasons for developing a new framework

Questions:
a. Does the model address the priority area? If yes, to what extent does the model address this priority area?
b. To what extent does the model help to make the priority a reality?

Reasons for developing a new framework (in priority order*)	Ad Hoc contracting with a shared services center	Councils of Government (COGs)	Consolidation
	Model 1	Model 2	Model 3
1. Improve the stability and sustainability of revenue for LHDs.	Low	Depends	Depends
2. Improve alignment between funding streams, mandated services, and the essential public health services. (Simplify funding streams, stop "robbing Peter to pay Paul," and adequately fund mandated and expected services.)	Low	Moderate to high	Moderate to high in some counties
3. Improve the quality of LHD services and improve health outcomes in local communities.	Low	Moderate to high	Moderate to high, depends
4. Clarify the role of local public health in Ohio, including greater clarity on services that should be provided by LHDs versus the broader health care system.	Depends	Depends	Depends
5. Retain local control, authority, and flexibility.	High	Moderate to high – depends on how govern the COG	Lower for some LHDs, unchanged for others?
6. Retain and/or build upon current collaborative arrangements.	High – If current arrangement beneficial	High	Depends on local issues/relationships
7. Specify a minimum standard range of services and ensure that LHDs have the capacity to provide those services.	Depends	Moderate	Depends

Table 2 continued	Model 1	Model 2	Model 3
8. Prevent the state from imposing a new structure on local public health by proactively proposing our own approach. Satisfy pressure from state policymakers to "do something" to become more efficient.	Low	Moderate to high	Moderate to high – depends
9. Reduce costs. Improve the efficiency of LHDs within the context of "leaner government."	Moderate, depends on scope and willingness to use and consider transaction costs	Moderate to high	Moderate to high – depends
10. Reduce disparities in capacity and funding across LHDs.	Low to moderate on capacity; low on disparities	Moderate to high – depends	Moderate to high – depends

*Priority order based on vote of AOHC membership at March 30, 2012 all-member meeting. Number one is top priority.

Appendix F Table 3. Other considerations

	Ad Hoc contracting with a shared services center	Council of Governments (COGs)	Consolidation
	Model 1	Model 2	Model 3
1. Ability to achieve Minimum Efficient Scale and Determinants of LHD Performance (approximates that ideal population size to maximize efficiency and effectiveness is 100,000 to 500,000 residents)	N/A	Moderate to high	High, if model sets 100,000 as minimum population size
2. Ability to meet PHAB standards (accreditation)	Depends	Higher due to ability to apply as MJA (depends on eligibility)	Depends
3. Ability to provide services toward base of Health Impact Pyramid	Depends	Potentially higher if larger population size	Potentially higher if larger population size
4. Ability for LHDs to serve "convener and planner" role	Depends	Depends	Depends
5. Ability to LHDs to provide preparedness and emergency response services	Depends	Depends	Depends
6. Ability to retain current local funding	Moderate	Moderate	Depends
7. Ability to improve LHD ability to leverage local funds	Moderate	Moderate	Depends
8. Ability to improve LHD ability to leverage state funds	Low	Moderate	Moderate
9. Ability to improve LHD ability to leverage federal funds	Low	Potentially higher if larger population size	Potentially higher if larger population size

Appendix F Table 4. Potential services that could be provided by a COG, by PHAB domain

PHAB Domain	Services that may be more efficiently provided by the COG	Services that may be more effective if retained by the LHD
Assess	▪ Community health assessment technical assistance and data management ▪ Surveillance data management IT ▪ Data analysis expertise	▪ Community health assessment facilitation, partnership with other organizations and sectors, and use of findings ▪ Some surveillance and reporting functions
Investigate	▪ Epi expertise ▪ Laboratory (24/7 services)	▪ Inspections ▪ Health hazard mitigation ▪ Partnerships with other sectors and organizations
Inform and Educate	▪ Health education and communications technical assistance and expertise ▪ Marketing and branding support ▪ Website IT ▪ Grant writing and grant management support	▪ Health education implementation ▪ Feedback from target audiences, program/message modification for local needs and conditions (including cultural and linguistic appropriateness)
Community Engagement	Technical assistance	Leadership and participation in local coalitions and collaborative groups (including Children and Family First Councils)
Policies and Plans	▪ Policy development technical assistance ▪ Community Health Improvement Plan technical assistance ▪ Program evaluation technical assistance	▪ Monitor local issues and policies ▪ Educate local policymakers about public health issues ▪ Community Health Improvement Plan facilitation and implementation ▪ Emergency Operations planning
Public Health Laws	▪ Legal expertise ▪ Inspection compliance tracking data management IT	▪ Educate local community about public health laws ▪ Inspection and enforcement
Access to Care	▪ EHR and billing expertise and IT ▪ Connections to broader health care system ▪ Grant writing and grant management support	▪ Assessment of local access to care issues and identification local resources, gaps, and needs ▪ Care coordination services ▪ Provision of primary care services, screening/testing, home health, BCMH, HMG, WIC, immunizations, etc.
Workforce	▪ Human resources support ▪ Training, certification	LHD staff
Quality Improvement	▪ Program evaluation, Performance management, and quality improvement services ▪ Performance management IT and evaluation data management ▪ Accreditation coordinator	
Evidence Based Practice	▪ Identification of evidence-based practices	Implementation of evidence-based practices

	▪ Training or technical assistance on evidence-based practices ▪ Research design, data collection, and analysis; human subjects protections	
Administration & Management	▪ Policy development ▪ Contract negotiations and purchasing ▪ Human resources support ▪ Grants management support ▪ IT ▪ Insurance ▪ Fiscal support	
Governance		LBOH owns and governs the COG

Note: Any of the services listed above could also be provided by a Public Health Shared Service Center on an ad hoc basis (Model 1B).

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