Table of Contents

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Executive Summary

The National Association of County and City Health Officials (NACCHO) developed the workbook, entitled *Making Strategic Decisions About Service Delivery: An Action Tool for Assessment and Transitioning*, with support from the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC) and Maternal and Child Health Bureau (MCHB). This workbook may be the first attempt to help local public health agencies (LPHAs) make strategic decisions about the provision of clinical services. Changes in the healthcare environment resulting from Medicaid managed care, cost, and quality concerns, and other factors have raised the question of whether LPHAs should be getting out of the business of clinical service delivery. This workbook guides LPHAs through a stepwise decision-making process derived from assessments of the health agency and the community. The workbook also provides guidance for LPHAs that — based on the results of the assessment process — decide to transition clinical services to community partners.

The workbook provides a historical overview of LPHA service delivery systems, introduces readers to the essential services of public health, describes recent changes in service delivery, and summarizes data on the transitioning of services. The workbook also answers questions about involving partners, designing the planning process, assessing resource needs, conducting a readiness assessment, and managing the process.

The assessment section of the workbook has three components: *Community Assessment, Organizational Assessment,* and *Individual Services Assessment.*

The **Community Assessment** is designed to:
- Explore the community in which the LPHA resides
- Determine the health status of the community, unmet service needs, access to care, availability of other providers, and applicable local, state, and federal policies
- Discern whether the LPHA is in a position to transition services to community partners

The **Organizational Assessment** is designed to:
- Encourage the LPHA to evaluate its capacity, mission, and resources
- Determine if and what services should be transitioned
- Identify stakeholders
- Describe current services
- Assess performance on the 10 essential public health services
- Identify alternatives to service delivery

The **Individual Services Assessment** is designed to:
- Determine services to be considered for transitioning to other providers
- Evaluate financial resources, program resources, and potential providers related to individual services
- Complete a decision tree that asks questions critical to the decision-making process

If, based on these assessments, an LPHA decides to transition services, the workbook includes several subsequent sections on the transitioning process. Each section contains case examples, resources, and references for more information. Because situations and resources vary among communities, the workbook also includes case examples of LPHAs that have opted not to transition services.

The section on **Developing a Work Plan** describes key components that have been identified by local health officials and others who have been involved in a planning process, such as how to:
- Develop a purpose statement
- Identify stakeholders and a transition team
- Develop steps and timetables
- Consider personnel and human resource issues
- Create a communication plan

The section on **Transitioning Models**:
- Provides an overview of transitioning models that LPHAs have implemented
- Outlines criteria for choosing an appropriate model
- Describes the steps in the transitioning process

The section on **Developing Partnerships**:
- Explains how to prepare for an effective collaboration and maintain a strong relationship with other providers
- Presents partnership models and suggestions for potential partners

When LPHAs shift from clinical to population-based services, they often require new sources of funding. The section on **Funding Ideas to Support Population-Based Activities** offers creative ways to find new funding sources as previous revenue sources are lost.

Many persons have a stake in the functioning of an LPHA, from elected officials to community leaders. The section on **Creating Political Will** describes how to develop the awareness and support of key decision-makers and other stakeholders by appealing to them, communicating with them, and involving them in the process.

LPHA staff members are also affected by the transitioning. The section on **Workforce Development**:
- Emphasizes the development of a plan to train staff in the essential services and for working with new partners
- Provides tips on utilizing staff differently as well as locating skilled public health professionals who will be able to help provide population-based services

Labor issues are explored further in the section on **Labor-Management Cooperation**, which discusses union participation and organizational structures that support successful worker participation.

The section on **Contracts Monitoring/ Performance Evaluation**:
- Describes how to prepare a performance evaluation plan
- Explains how to identify and select performance measures
- Reviews data requirements
- Identifies steps for developing a monitoring system for the transitioned services

Finally, the last section on **Technical Assistance Resources**:
- Lists organizations and other resources that can provide technical assistance or information on various areas related to the transitioning process
- Provides available resources on data use, legal issues, federal agencies, managed care, and many other areas

It is our hope that this workbook provides useful information and some structure to a complex process that involves assessment, decision-making, and, sometimes, reorganization. We plan to supplement this workbook with a series of interactive peer-to-peer trainings to reinforce what has been presented here. We also intend to arrange for peer-to-peer technical assistance, Web site activities, and highlighting of best practices through a listserve to provide more guidance and support. Additionally, a supplemental workbook focusing on outcomes measurement will follow this tool as well as an online version of the workbook. Finally, we hope that this project helps you continue to form partnerships with other healthcare providers to increase overall access to services and improve the quality of care.

Introduction from the Chair of the Partnerships Project Workgroup

The birth of the Partnerships Project and this workbook can be attributed to three factors. First, the 1988 Institute of Medicine (IOM) report, *The Future of Public Health*, brought attention to public health service-delivery systems. The authors noted that the shift by many LPHAs to the provision of comprehensive personal clinical services had resulted in decreased attention to public health issues affecting the population as a whole. At the same time, many community/migrant health centers (C/MHCs) and other safety-net providers were seeing decreased patient bases and revenues as a result of Medicaid managed care. The report concluded that contracting clinical services to C/MHCs and other safety-net providers would allow LPHAs to enhance their focus on "core" public health functions and essential services and offer C/MHCs an added source of revenue.

The *1992-1993 National Profile of Local Health Departments*, a report produced by NACCHO, reinforced the IOM's findings. This review of 2,079 LPHAs documented a diminishing capacity to provide population-based services, resulting from increased delivery of clinical services.

Finally, concerned local health officials began simultaneously to approach NACCHO for guidance on these issues. Whereas some LPHAs were already discussing with their partners the possibility of restructuring the service-delivery system in their communities, other LPHAs were not even sure where to begin. The nature of this transition process was not well defined in public health practice. As no tools existed to help LPHAs deal with these complexities, NACCHO management began to consider models for improving the preventive health service system.

In light of these developments, NACCHO initiated contact with the Bureau of Primary Health Care (BPHC) of the Health Resources and Services Administration (HRSA) to discuss a project to help LPHAs make decisions about whether to continue providing clinical services or to transition these services to community partners. In January 1999, NACCHO convened a group of local health officials who had gone through this decision-making process. This group, which was interested in sharing their experiences with others, became the nucleus of NACCHO's Partnerships Project Workgroup. The committee also included state health officials and representatives from primary care associations, primary care offices, federal agencies, health plans, and other public health partners. Learning from the broad experience of each of the committee members was a first step in developing a tool that would not be prescriptive but would be useful to all LPHAs, regardless of their ultimate decision about transitioning of services.

The most popular suggestion among committee members was to develop a user-friendly workbook to assist LPHAs in finding their niche in the continuum of the provision of primary care services. The committee envisioned this workbook not as a "how to" handbook but rather as a guide to the process of decision-making and transitioning based on essential financial, political, and community analyses. The resulting workbook is not meant to replace existing community assessment tools but instead to supplement the information acquired though their use.

Workbook Overview

This workbook will be helpful to local public health agencies (LPHAs) that are pondering any of these questions:

- Is the LPHA duplicating services being provided in the community?
- Is the LPHA providing clinical services at the expense of population-based activities?
- Are there other capable and willing clinical service providers in the community?
- Has the LPHA assessed the community's health needs and priorities?
- Does the LPHA have the community's support to continue providing or to transition services?
- Does the LPHA have the ability to locate funding and other resources to support population-based services?
- What are the community's unmet needs?
- Is the LPHA providing cost-effective services?
- How focused is the LPHA on the 10 essential services of public health?
- How does the community view the LPHA?
- What is the potential to partner with other community organizations?
- What is the staff's capacity to provide clinical and population-based services?

Local health officials are facing the daunting task of deciding where their local public health agencies (LPHAs) fit into the ever-changing healthcare environment. This workbook is designed to assist LPHAs in examining changes in the healthcare environment and determining an appropriate course. The goal is to highlight the issues and questions that can help local health officials and other stakeholders make decisions about the service-delivery system and implement alternative roles and responsibilities while continuing to carry out essential services. The hope is that this workbook will empower health officials to take a convener role in bringing together individuals and organizations from various sectors to address this issue.

This workbook covers two main topics: assessment and transitioning of services. A subsequent workbook on outcomes measurement will provide tools and resources for measuring the patient and community outcomes of service transition and for ensuring continuity and quality of care.

By completing the exercises in this workbook, LPHAs will be equipped to:

- Act proactively, rather than reactively, in addressing their changing role in the healthcare environment
- Secure funding and redirect the staff resources needed to continue providing population-based services despite the loss of Medicaid revenue
- Engage in a formal decision-making process about service delivery, and come to an informed decision about what is best for the LPHA and the community
- Gain buy-in and support from key stakeholders
- Initiate dialogue and develop partnerships and collaborations with the community and with other components of the local public health system
- Conduct comprehensive community and organizational assessments or update previous assessments
- Learn from the experiences of LPHAs that have already made changes in their service-delivery systems
- Allocate more time and resources to population-based services and the 10 essential services
- Transition services to other healthcare providers while maintaining an assurance role
- Take a leadership role in designing a seamless safety-net system and in ensuring care for uninsured persons
- Increase access to and improve the quality of care

Background

By reading this chapter, you will learn more about:

1. NACCHO's Partnerships Project.
2. History of clinical services delivery in local public health agencies.
3. Primary reasons for transitioning clinical services to other health care providers.
4. Preliminary results of transitioning services.
5. Risks and benefits of transitioning services.
6. Refocusing and redefining public health priorities.

NACCHO's Partnerships Project

In response to changes in the public health system, the National Association of County and City Health Officials (NACCHO), with support from the Health Resources and Service Administration (HRSA), developed the Partnerships Project to help local public health agencies (LPHAs) find their niche in the continuum of healthcare service delivery.

The project's goal is to help LPHAs make strategic decisions about service provision and, in the process, leverage resources and form partnerships to increase access to services and improve the quality of care.

Some LPHAs have decided to transfer clinical services to other healthcare providers, whereas others have decided to maintain or even increase their clinical service delivery system based on community need. When LPHAs cut back on their service delivery system, the responsibility for essential services needs to be transferred to other parts of the healthcare system, such as hospitals, managed-care organizations (MCOs), community health centers, universities, and private providers. This process consists of three steps:

1. **Assessment/Decision-making:** LPHAs need to assess their service delivery system and decide whether they should be providing direct clinical services or if services can/should be provided by other parts of the healthcare system.
2. **Transitioning:** LPHAs that decide to cut back on the provision of direct services need to transition these services to other providers while continuing to fulfill their public health assurance role.
3. **Outcomes Measurement:** LPHAs that transition services need to measure community and patient outcomes over time and assess the impact of the transfer of responsibility.

The Partnerships Project is designed to help LPHAs work through this process. The Project is guided by a workgroup consisting of representatives from state and local public health agencies, federal agencies, primary care offices, primary care associations, MCOs, local policymakers, and local boards of health. Committee members recommend tools to assess the need/capacity of LPHAs to provide direct services, suggest funding sources to support population-based services, and recommend resources to help LPHAs transition services when appropriate.

Given the many factors and questions that need to be considered as LPHAs make decisions about their service delivery systems, the workgroup recommended the development of a tool, in the form of a workbook, to guide LPHAs through the first two steps of assessment/decision-making and transitioning. A workbook on outcomes measurement will follow.

Workbook Development

The workgroup advocated basing the workbook on real-life case studies of LPHAs that have made decisions about their service delivery systems. Four focus groups and ten in-depth interviews with LPHA staff and partners were conducted (Appendices B and C). An informal survey was sent to NACCHO members to identify

additional LPHAs that were involved in the decision-making and/or transitioning processes. Survey responses have been compiled into paragraph descriptions with contact information (Appendix D).

The case studies focus on LPHAs that have partnered with other organizations to illustrate how the transitioning process can initiate interaction among a community's healthcare providers. A few of the case studies describe the experience of LPHAs that, after going through the assessment process, decided to either retain or increase their clinical services. The ideal is for LPHAs to decide what is best and most appropriate for their communities, even if it means continuing to provide clinical services.

Input from the workgroup and the experiences of communities across the country were invaluable to the development of the workbook. Representatives from case study sites candidly expressed not only lessons learned but also mistakes made in the process. Vignettes from LPHAs that have gone through the assessment and transitioning processes are included throughout the workbook.

History of LPHA Service Delivery Systems

The role of LPHAs in the provision of direct clinical services has a long history. That role was expanded in the 1960s, with the advent of federal programs such as Medicaid and Medicare. A few of these programs offered LPHAs financial and technical assistance — and therefore incentives — to provide services in categorical areas such as maternal and child health, immunization, family planning, and prenatal care.

In 1988, the Institute of Medicine (IOM) released *The Future of Public Health*, which addressed the condition of the nation's public health system. The authors highlighted the many gaps and shortfalls in the public health system and its component agencies and, to address these weaknesses, defined the public health mission in more precise terms. The core functions recommended for LPHAs were: assessment, assurance, and policy development (IOM, 1988).

Core Public Health Functions (IOM, 1988)

- **Assessment** to monitor and track local health problems and needs and the resources for dealing with them.
- **Policy development** and leadership that foster local involvement and a sense of ownership, emphasize local needs, and advocate equitable distribution of public resources and complementary private activities commensurate with community needs.
- **Assurance** that quality services, including personal health services, are available and accessible to all persons; that the community receives proper consideration in the allocation of federal, state, and local resources for public health; and that the community is informed about how to obtain public health, including personal health services and to comply with public health requirements.

During the healthcare reform debate of 1994, the Core Public Health Functions Steering Committee, which included representatives from federal agencies and national public health organizations, defined the 10 Essential Public Health Services, which elaborated on the three core functions identified in the IOM report. This new framework was deemed necessary to describe public health to external audiences and constituencies. To realize the potential of population-based services in protecting and improving health, policymakers and the public must have a clear understanding of who is involved in public health, what they do, and the benefits that result from their actions (Lasker et al, 1995). This list of essential services is widely recognized by LPHAs and other public health organizations across the country as the core set of responsibilities for public health agencies.

LPHAs have principal responsibility for carrying out *10 Essential Public Health Services:*

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and safety.
7. Link people to needed personal health services and ensure the provision of health care when otherwise unavailable.
8. Ensure a competent public health and personal healthcare workforce.
9. Evaluate the effectiveness, accessibility, and quality of personal and population-based health services.
10. Conduct research for new insights and innovative solutions to health problems.

The core function of assurance and the seventh essential service imply that LPHAs are responsible for ensuring the adequacy and availability of direct clinical services in the community.

- If clinical services are not provided by other healthcare providers, then they should be offered by the LPHA . Both the core functions and the essential services stress the role of LPHAs in clinical service delivery when there are no other willing, able, or available providers to offer the services.
- Even if LPHAs do not provide clinical services directly, they are still responsible for ensuring that the services offered by other healthcare providers are of good quality and are adequate to meet the public's needs. (See Appendix A for references on core public health functions/essential services.)

Changes in Clinical Service Delivery

With changes in the healthcare environment and healthcare financing, LPHAs are being forced to examine their service delivery systems. The increasing number of uninsured persons poses a unique challenge to LPHAs that have traditionally served as safety net providers. Increases in the number of uninsured also underscore the need for partnerships with community health centers, hospitals, universities, and other providers. In addition, changes in Medicaid policy and the rapid growth of Medicaid managed care (MMC) in many communities over the last several years have had a major impact on the viability of the safety net system.

The advent of MMC and the increase in the number of states that have made the decision to participate in mandatory MMC have significantly affected the provision of direct clinical services by LPHAs (Halverson et al, 1998). Federal and state initiatives to enroll Medicaid beneficiaries in private managed care plans have increased the number of providers willing to treat Medicaid patients (Wall, 1998). All of this has had the following results:

- To avoid competing for services, many LPHAs have decreased their level of clinical services, resulting in a loss of Medicaid revenue.
- Medicaid recipients are more likely to obtain direct clinical services from private providers in their managed care networks than from LPHAs (Bartlett et al, 1996).
- The financial viability of LPHAs often depends on revenues received from the provision of services to Medicaid patients, which continue to decrease under the MMC system.
- It is increasingly difficult for LPHAs to participate in the Medicaid market and use Medicaid revenues to offset the costs of caring for uninsured patients and fund population-based services and other less profitable programs.

The move to managed care also provides LPHAs with new opportunities to redirect resources and develop new strategies for carrying out the 10 essential services. LPHAs that are able to act proactively in seeking new funds or adapting their organizational structures to respond to MMC appear to have greater advantages overall. The potential roles for LPHAs in the delivery of direct clinical services in a managed care environment can vary considerably depending on the LPHA and its community's unique characteristics (Martinez and Closter, 1998).

As Medicaid reimbursement for managed care providers expands and more patients move to the private sector for care, LPHAs have little choice but to move out of direct service provision. However, before LPHAs transition

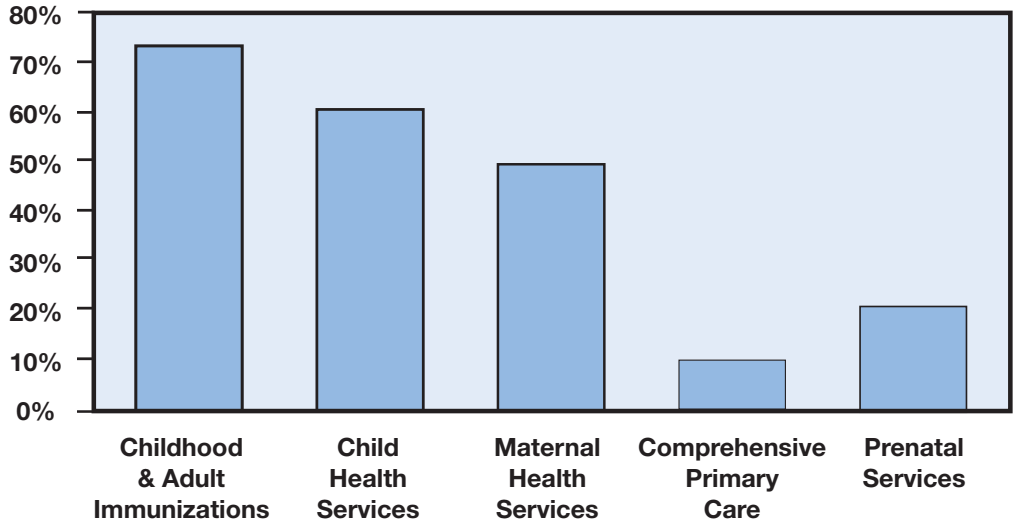
services to other healthcare providers, they must consider the viability of the managed care marketplace. As recently evidenced in many communities, managed care plans are starting to struggle financially and have received much backlash from the media and the public. This has resulted in many communities retreating from managed care and many providers declining to renew contracts with health plans (Center for Studying Health Systems Change, 2001).

Current Situation

According to NACCHO's *Local Public Health Agency Infrastructure Study* (NACCHO, 2001), many LPHAs still provide direct clinical services:

- 74% provide childhood and adult immunizations.
- 61% provide child health services.
- 50% provide maternal health services.
- 9% provide comprehensive primary care.
- 22% provide prenatal care services.

Services Provided by LPHAs:
Data from NACCHO's Infrastructure Study



Although LPHAs are generally still involved in the provision of certain clinical services, many agencies are changing their levels of service provision. Services are being transferred to other healthcare providers, and LPHAs are refocusing on population-based services. To illustrate this trend, a comparison of the most recent infrastructure survey data with those from earlier NACCHO studies shows that the number of LPHAs providing direct clinical services has decreased while the number of LPHAs providing population-based services such as communicable disease control (80%), community assessment (61%), and community outreach and education (70%) has increased (NACCHO, 2001).

Additionally, a 1999 study examined trends in the provision of direct clinical services in 413 urban and nonurban LPHAs between 1995 and 1999 (Shields et al, 1999). The services most affected by the changing healthcare environment were comprehensive primary care services and services offered to women and children. The number of LPHAs providing primary care decreased by 22.9% among urban LPHAs and 17.5% among nonurban LPHAs. Nearly 20% of urban LPHAs and 9.4% of nonurban agencies stopped providing comprehensive primary care services to women. Approximately 20% of urban and 15.5% of nonurban LPHAs eliminated their comprehensive primary care services to children.

The most recent source of data is a University of Pittsburgh Graduate School of Public Health study of more than 300 LPHA directors (Keane et al, 2001). The investigators found that, in most instances, LPHAs transitioned the provision of clinical services to other healthcare providers rather than eliminate the services completely. The study provides data on the extent and forms of privatization of LPHA services, the directors' reasons and political motivations for privatizing services, services they believe should not be privatized, and reported outcomes. The findings reveal that:

- Almost three-quarters (73%) of LPHAs privatized a public health service of some type.
- Of all public health services that were privatized, 57% were contracted to investor-owned, for-profit organizations.
- The most commonly privatized services were direct clinical services, mainly those related to primary care (28% of LPHAs), communicable diseases (27%), and health education (27%).
- In larger jurisdictions, the percentage of direct clinical services being privatized was significantly higher than in smaller areas.

When the LPHA directors were asked about privatization and the role of public health:

- 12% stated that LPHAs should perform only core functions and move entirely out of the provision of direct clinical services.
- 52% stated that LPHAs should always provide direct clinical services in addition to the core functions.
- 35% felt that LPHAs should act as a safety net provider and provide clinical services when there is no one else to do it.

To some public health agencies, moving out of the provision of clinical services means decreased revenue, mainly Medicaid revenue, which has been used to support core functions and subsidize less profitable services. Some directors stated that many physicians in their communities are not taking Medicaid patients and that LPHAs must therefore continue to be safety net providers.

Primary Reasons for Transitioning

These findings raise questions about increases in the number of public health agencies that are getting out of the business of clinical service delivery. In the University of Pittsburgh study (Keane et al, 2001), when directors were asked why they transitioned clinical services, the most common responses were:

- Lack of capacity or expertise to provide the service adequately and effectively
- Cost considerations
- Increasing reimbursement to private providers for performance of direct clinical services
- Opportunities to develop partnerships or collaborations with the community and/or private sector

In 1996-1997, investigators from the Public Health Foundation (PHF) 1) surveyed 11 LPHAs that had privatized one or more services and two LPHAs that had extensively privatized services, and 2) conducted a comprehensive statewide assessment of LPHAs in Maryland (Bechamps et al, 1999). In this study, the catalysts for privatizing LPHA services fell into four general categories, which were similar to those cited in the University of Pittsburgh study:

- Medicaid managed care
- Cost savings and other fiscal concerns
- Opportunity to improve the quality and efficiency of services
- Reorganization of state and local public health agencies

Many of the LPHAs in the PHF study believed that other providers, especially those in the private sector, could provide clinical services more efficiently and often had more capacity to improve the quality of care. Budgetary cuts often resulted in downsizing of government, necessitating privatization of services. However, as in the University of Pittsburgh study, findings indicate that the decision to privatize generally depends on a community's unique characteristics and service delivery system.

The words *transition, partner, collaborate, contract out, privatize, divest*, and *outsource* are all used to describe the process by which services once provided by the LPHA are transferred to other healthcare providers in the community. This workbook will use the term transition. *Transition* has a positive connotation, suggesting that the LPHA maintains the assurance and assessment functions even though another provider delivers the service (Bechamps et al, 1999).

Results of Transitioning

Among the LPHAs that transitioned services in the PHF study, most maintained their assurance function, often through formal contracts. In addition:

- Several LPHAs reported improved quality of care and increased access to clinical services after transitioning.
- As a result of lost Medicaid revenue, most LPHAs began cost shifting and redirecting resources from one program to another.
- Almost all LPHAs indicated that transitioning of services to other providers allowed them to increase the emphasis on the 10 essential services.
- Privatization often strengthened relationships with community providers.

In the University of Pittsburgh study, many LPHA directors believed that, by transitioning certain services, their agencies could devote more time, effort, and resources to the performance of core functions (Keane et al, 2001).

- Of the directors whose agencies privatized services, 50% claimed privatization had a positive effect on their ability to perform the core public health functions.
- Another 33% either believed that privatization hindered performance of the core functions or were unsure of the effect.
- Only 12% believed that privatization made no difference in the performance of core functions.
- Two-thirds reported no change in staffing after services were privatized.
- 44% of directors reported lower costs or gains in cost-effectiveness after transitioning.

Benefits of Transitioning Services

Some view transitioning of services as a way to encourage market competition and innovation, lower costs, improve effectiveness, enhance quality, and enrich consumer choice (Nelson and Levine, 1999). Proponents of transitioning view large LPHAs as inefficient and hindered by heavy unionization and lack of performance incentives (Bechamps et al, 1999). They believe that private providers often operate in a more flexible environment than government agencies, provide services of higher quality, and are able to be more responsive to consumer needs as a result of the financial incentives associated with competition (Nelson and Levine, 1999).

One of the greatest benefits of transitioning services and forming partnerships with other healthcare providers is the ability to design a seamless safety net system to serve the community's uninsured. Public health has the opportunity to take a leadership role in this process. With greater emphasis on essential services, transitioning often enables LPHAs to concentrate more resources on providing population-based services. Other benefits of transitioning include:

- Organizational flexibility
- Cost efficiency
- Increased choice and opportunity for patients
- Greater accessibility to healthcare providers
- Increased continuity and quality of care

Risks of Transitioning Services

Some people equate transitioning with loss of control, federal restrictions, and lack of interest by the private sector (Nelson and Levine, 1999). They believe that privatization of public services (Center for Policy Alternatives, 2001):

- Is motivated only by the need to reduce the size of government
- Decreases direct accountability to the public
- Reduces government flexibility
- Jeopardizes the quality of services

Philosophical differences may exist between LPHA staff and private partners. Many public health workers may be philosophically opposed to privatization of public health services. Fears of job security, rumors of layoffs, and aversion to change often heighten this opposition.

- Transfer to the private sector can adversely affect women and minority workers because of lower wages, decreased access to health and pension benefits, and a non-union environment (Bernhardt et al, 2000).
- Conflicting organizational cultures may create challenges for the effective management of the transitioned service (Halverson et al, 1997).

Critics of transitioning are concerned about the private sector's accessibility and readiness to deliver services to vulnerable populations and the impact of transitioning on the safety net system (Halverson et al, 1997).

- Many LPHA patients and staff fear that coordinated care and support services are inadequately addressed by MCOs and other private providers.
- A decrease in public responsibility can severely limit LPHAs' involvement in assuring access to services and in monitoring and evaluating quality (Halverson et al, 1997).

> The Public Health Foundation found that, to successfully implement the transitioning of services, LPHAs must "provide strong leadership, monitor services and retain public health agency identity in the community, ensure quality of care, prepare internally prior to initiation of privatization, increase knowledge in corporate skills, build collaborations and understand divergent philosophies" (Bechamps et al, 1999).

Collecting accurate financial and performance data to measure cost and quality is the key to assuring quality and accessibility of care.

- Quality assurance is more easily monitored if LPHAs retain the case management, outreach, and monitoring components of service delivery.
- LPHAs need to be able to monitor their own performance and the performance of private providers in these areas: health outcomes, units of service provided, cost, access, demographics of persons using the services, and consumer satisfaction (Halverson et al, 1997).
- Contracts with private providers should support monitoring by public agencies and include provisions for periodic quality improvement reviews to address health outcomes.
- Transitioning structures that incorporate strong quality management systems, formal accountability systems, and financial risk-sharing arrangements hold the greatest promise for success (Halverson et al, 1997).

Regardless of the healthcare delivery system, LPHAs remain responsible for the health of entire communities and for fulfilling the core public health functions of assessment, assurance, and policy development. Assurance means ensuring that people in the community receive the healthcare services they need and involves three broad roles for local public health (Minnesota Community Health Services Advisory Committee, 1995):

- Encouraging actions by other entities
- Requiring action through regulation
- Providing services directly

LPHAs have the responsibility of assuring that private providers have adequate capacity and expertise to provide services to both uninsured and Medicaid populations. Lack of access to services in the private sector often provides a rationale for public providers to remain in the service delivery business. Having an involved community, a history of partnering with the private sector, a strong community presence, and leadership with a vision of where public health should be headed result in a more successful transition.

Refocusing and Redefining Public Health Priorities

As a result of the factors discussed above, LPHAs are reassessing and redefining their roles and responsibilities in the healthcare system. This process often results in the transitioning of services, mainly the direct delivery of health services, to other providers and refocusing resources to more traditional population-based services. However, based on community needs, other LPHAs may choose to retain or even expand their role in service delivery. LPHAs that have anticipated the changes in the healthcare system and strategically planned how to ensure continued control over services either directly or indirectly appear to be better able to withstand the changes and loss of revenue (Slifkin et al, 2000).

When LPHAs transition clinical services to other healthcare providers, their priorities also change. They become increasingly focused on communities, rather than individuals, and invest more resources in activities related to the 10 essential services. Public health leaders recognize that developing and sustaining healthy communities require concentrating more resources on addressing the social determinants of health. To do so, public health agencies are engaging in various activities. These include (Stout, 2001):

- Adopting a broader definition of health, such as the World Health Organization (WHO) definition, which emphasizes physical, mental and social wellbeing
- Serving the whole community, not only the percentage who are medically underserved
- Redesigning (if necessary) the LPHA so that working in the community is a primary function
- Involving community members in redefining the LPHA's role and learning about priority health concerns (Hatzell et al, 1996). (See Appendix A for references on community involvement and support.)

Five areas of organizational alignment that are critical to preparing LPHAs to work in communities (National Civic League and St. Louis County Department of Health, 2000)

1. **Organizational policy** — Enacting policies that support the value of a community-based approach
2. **Funding strategies** — Eliminating categorical funding and putting some resources in the hands of responsible community organizations and coalitions
3. **Staffing patterns** — Imposing staffing patterns that reflect the high priority given to community work and developing job descriptions that reflect the skills needed to work in communities
4. **Skills building** — Building on the skills of traditional public health staff (e.g., nurses, sanitarians, health educators) who have been working with and in communities for years
5. **Education and communication** — Providing information to all staff about changes in the LPHA and in the broader public health field

- Thinking more broadly about the LPHA's expanded responsibilities and developing new competencies among staff
- Applying systems thinking to the implementation of programming, with a focus on the social determinants of health
- Creating partnerships with social services, criminal justice, mental health, and education systems
- Integrating environmental health thinking and practice into public health programming

Seven organizational competency areas for LPHAs are (Nelson et al, 2001):

1. **Communication** — a dynamic process grounded in respect for diverse voices
2. **Information management** — use of technology to manage the transfer of information to end users
3. **Assessment, planning, and evaluation** — a continuous quality-improvement cycle
4. **Visionary leadership** — collaborative leadership to reach a shared vision
5. **Systems thinking** — future-oriented problem solving and decision-making
6. **Partnerships and collaboration** — optimization of performance through shared resources and accountability
7. **Health promotion and disease prevention**

- Performing epidemiologic research (quantitative and qualitative) to determine prevention strategies
- Generating a sense of commitment among personnel
- Inviting other health services providers and government officials to participate in plans to reorganize
- Acquiring skills to determine community needs, engage partners in strategic planning, maintain sound surveillance systems, and evaluate outcomes based on predetermined measures

The New Metropolitan Public Health Department in Nashville/Davidson County (TN) formulated a 5-year reorganization plan based on the 10 essential services. Their 5-year goals were to: 1) protect the community from communicable and environmental threats, 2) improve the community's health status, 3) refocus on core public health functions, 4) enlist partners to improve the community's health status, and 5) become a nationally recognized model. These goals led the health department in a new direction to focus on:

- Prevention
- Case finding
- Early intervention
- Case management
- Health promotion and protection
- Assessment
- Assurance
- Policy development

A renewed focus on the community requires local government, nonprofit organizations, businesses, citizens, and public health experts to all play roles in performing the essential services. The change in focus to communities and collaboration has also generated a need for new techniques, such as social marketing, to encourage lifestyle changes and media advocacy to transform health policy-making (Novick and Mays, 2001).

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Introduction to the Decision Tool

Overview of the Decision Tool

This chapter is presented in the form of a decision tool. It is designed to help local public health agencies (LPHAs) make decisions about their service delivery systems by considering a variety of community and organizational issues and factors.

- The decision tool has three components: *Community Assessment, Organizational Assessment*, and *Individual Services Assessment*.
- Each component includes questions and issues to consider when making a decision about service delivery.
- Additional factors may need to be considered, depending on the situation of the LPHA and the community. The decision tool is flexible enough to tailor the process to the community's needs and concerns.

The decision tool can be helpful to LPHAs at any stage of the transitioning process.

- For LPHAs that are beginning the decision-making process and have not yet completed a comprehensive community and/or organizational assessment, completion of the decision tool might be the first step in implementing such a process.
- For those further along in the process, the tool can be used to reassess where the LPHA is and where it is headed.
- Once services are transitioned to other parts of the healthcare system, they are unlikely to be returned to the LPHA. This tool can help reassure the LPHA about the appropriateness of decisions about service provision.
- The decision tool can be used to educate other stakeholders about the choices being made regarding service delivery.
- If the LPHA has been involved in an organizational and/or community assessment process in the last few years, then it is important to apply findings from past assessment processes to this decision tool. Many of the assessment questions may be familiar. This tool can help refresh the planning process and provide more focus on the provision of direct clinical services.
- If key stakeholders have already considered the decision about service delivery and are fairly certain about which services the LPHA should transition, then it might be appropriate to proceed directly to the *Individual Services Assessment*. That section provides a brief overview of the key items to consider and consists of a short decision tree. Once the LPHA completes this abbreviated tool, a decision can be made about whether or not the more comprehensive tool needs to be completed.

First Steps

Before beginning the decision-making process, it is important to engage in the following steps to ensure an informed course of action. The steps are based on those described in the *Mobilizing for Action through Planning and Partnerships (MAPP)* tool (NACCHO, 2001):

1. **Determine the need to make a decision about the service delivery system.**
   The impetus to engage in a decision-making process often derives from one or more of the following factors:
   - The advent of Medicaid managed care (MMC) and an associated decline in patient counts and revenue
   - Cost and other fiscal concerns
   - Reorganization of the LPHA
   - Need to improve the quality and efficiency of services
   - Desire to focus on population-based services
   - Increase in the number of uninsured clients
   - Shortage of providers who are willing to serve Medicaid and uninsured populations

The goal here is to identify the benefits and potential barriers to the decision-making process and consider if the time is right for change. Benefits might include the opportunity to make an informed decision about service delivery based on a variety of factors and the involvement of key stakeholders. Barriers might include resistance from staff, politicians, and others.

2. Decide who should be involved.

LPHA staff should not complete the decision tool in isolation. They should involve key stakeholders both from within and outside the agency. Stakeholders have an investment in the decision about service delivery and the way in which services are transitioned to other healthcare providers. Decision-making about service delivery also provides an opportunity to initiate community involvement in the operation of the LPHA and the entire local public health system. Stakeholders might include policymakers, representatives from partner organizations, and community members.

Once stakeholders are identified, the LPHA will need to select participants with the resources, expertise, and perspectives that will ensure success. Before recruiting any participants, the LPHA should determine the optimal number and define key roles.

- The formation of a decision-making team made up of LPHA management, staff representatives, and a few additional stakeholders is one way of guaranteeing that various perspectives are heard while maintaining a manageable size and structure.
- Another option is to form a larger planning committee to provide additional resources and technical assistance as needed.
- The decision-making team and planning committee might include participants similar to those selected for other assessment processes, such as the *Assessment Protocol for Excellence in Public Health* (APEX*PH*) or MAPP.

Once appropriate stakeholders have been identified, it is critical to assess their expectations, enthusiasm, long-term availability, interest, and time constraints to ensure a continued commitment to the process.

It is possible to include different people at various stages in the decision-making process as necessary. The decision-making team can lead the decision-making process and decide at what point to include other persons with specific expertise. It might also be necessary to involve the broader community through focus groups, meetings, and other mechanisms.

3. Design the planning process.

What will the process entail?

The decision tool provides questions to consider and factors to assess in making an informed decision about service delivery. A more customized process may be appropriate based on the community's needs, concerns, and timeframe. This tool allows for a customized approach, if necessary. For example, if an accelerated process is warranted, the LPHA might proceed directly to the *Individual Services Assessment*. The decision-making process also links to or builds upon previous activities. Many LPHAs may have already collected essential information for decision-making.

How long will it take?

The timing is difficult to predict because of factors such as: expectations and time constraints of participants, participants' prior experience with assessment and transitioning activities, and the availability of technical assistance and supporting information. The LPHA should consider the decision-making process as an ongoing, rather than a one-time effort. It is neither practical nor beneficial to transition all direct clinical services at once. Each service should be addressed separately to determine the most appropriate action.

What results are expected, and how will the LPHA know when they are achieved?

The desired result is an informed decision about whether or not to transfer specific clinical services from the LPHA to another agency or organization. Gaining buy-in and support from key stakeholders and identifying willing and available providers with the capacity to take on the LPHA's service(s) are other signs that the decision-making process is complete.

Who will be responsible for carrying out the decision-making activities?

Although the decision-making team will be responsible for guiding the process, it might be important to seek assistance from outside consultants, the state health department, and/or staff from the LPHA or other organizations who have specific expertise.

4. **Assess resource needs, and secure commitments.**
   Resources needed to complete the decision-making process include: staff time, consultant fees, data collection and information-gathering resources, and meeting space. The budget should also reflect additional factors, such as the timeline, number of participants, and available information and technical assistance. Securing resources from a partner organization is a sign of commitment to the process.

5. **Conduct a readiness assessment.**
   Once the previous steps have been completed, the LPHA is ready to begin the planning process. If one or more elements is not in place or all resources are not available immediately, the LPHA can decide to proceed with caution and address gaps and concerns along the way. The LPHA may also decide to wait until a better time to engage in the process or limit the scope of the undertaking.

6. **Manage the process.**
   This final step includes administrative activities such as clarifying meeting schedules, tasks, and roles. A work plan will be helpful in guiding the process. The work plan will specify whether the LPHA will complete the *Organizational Assessment or Community Assessment* first, or do them at the same time. LPHAs that are further ahead in the decision-making process might complete the *Individual Services Assessment* first. Once the work plan is complete, it is time to begin the decision-making process. Keep in mind the need to incorporate concepts or elements that customize the process to the community's needs.

Format of the Decision Tool

The decision tool has three parts: *Organizational Assessment, Community Assessment, and Individual Services Assessment.* Each section is formatted similarly.

- Definitions, tools/resources, and case studies are highlighted to provide assistance along the way.
- Each series of questions concludes with "Other Items to Consider." These are additional issues that might contribute to a better-informed decision.
- The concluding remarks in each section tie together all of the questions and guide the LPHA in understanding where the answers to the questions might lead in terms of a decision.
- Remember: this is not a survey. Feel free to skip, add, or revise questions as appropriate to the LPHA's situation.

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Community Assessment

Purpose

Assessment is one of public health's three core functions and is highlighted in several of the 10 essential services. This section is designed to help the LPHA conduct a Community Assessment and develop a community profile.

- The *Community Assessment* is not intended to replace a more comprehensive assessment, such as the *Planned Approach to Community Health (PATCH)*, *Assessment Protocol for Excellence in Public Health (APEXPH)*, or *Mobilizing for Action through Planning and Partnerships (MAPP)*, but rather to be part of a comprehensive process to inform the decision about service delivery.
- The *Community Assessment* tool was developed in consultation with local health officials and others who identified the most important information to consider when making a decision about service delivery.
- Responses to questions about health status, access to services, community perceptions, and availability of providers will be used to derive a community profile.
- Responses to questions about the impact of managed care on the healthcare system, the role of the state health department, and the relationship of the LPHA to policymakers will be used to assess the community's political environment.
- The decision-making team should be aware of other community development processes that are occurring concurrently with the assessment. The LPHA might be able to build on these processes.

Timeline

- The timeline will depend on the LPHA's experience with community assessment and the team members' experience, time constraints, and areas of expertise. LPHAs that have not yet engaged in a community assessment will require more time and commitment.
- The desire to make a decision about service provision often provides the impetus to conduct a more comprehensive assessment.

- Given that a community's demographics, health status, and political situation are dynamic, information should be updated periodically.

Participants

The decision-making team should take the lead in the process. However, additional persons who have access to data, expertise in data collection and analysis, and/or experience in policymaking should be included at some point, either as members of the larger planning group or as consultants. Representatives from the community should be included in deliberations as well.

Other healthcare providers in the community should be consulted about questions related to the availability of providers and the impact of managed care. This is an excellent way to learn about resources and data that are available in the community, which might be used to assess health status, access to care, availability of providers, and community perceptions. Since the availability of other providers in the community is one of the most significant items to consider in the decision about service provision, it is crucial to learn who they are, the services they provide, and the populations they serve.

Components

The *Community Assessment* can be completed before, after, or concurrently with the *Organizational Assessment.* Although conducting two assessments simultaneously might seem difficult, each requires different expertise and resources. The *Community Assessment* is likely to include external stakeholders, whereas the *Organizational Assessment* will require significant time and resources from LPHA staff.

The *Community Assessment* consists of six subsections, each of which comprises a different part of the community profile:

1. Community Health Status
   Health indicators, unmet health needs, and access to services.
2. Community Perceptions about the Healthcare System
   Community members' views of the healthcare delivery system and perceived roles and responsibilities of the LPHA.
3. Availability of Providers
   Identification of healthcare providers with a significant community presence, the services they provide, and their client populations.
4. Managed Care
   Impact of Medicaid managed care on the LPHA's ability to provide population-based and direct clinical services.
5. Local, State and Federal Policy
   Relationship of the LPHA to the state health department and the influence of the state health department on decisions about service delivery.
6. Relationship to Policymakers
   Relationship of the LPHA to local and state policymakers, including the local board of health.

Community Health Status

Public health agencies monitor health status in their jurisdictions to identify community health problems, determine unmet needs, and assess community members' access to health services. An assessment of community health status enables an LPHA to determine priorities among health issues, monitor population-based health status, identify community resources and assets, and make decisions about resource allocations.

> The assets of a community are "contributions made by individuals, citizen associations and local institutions that individually and/or collectively build the community's capacity to assure the health, well-being and quality of life of the community and all its members" (CDC and NACCHO, 2001).

By analyzing health outcomes, the LPHA and others can determine trends in health status indicators and thus track improvements in health status over time. An assessment of community health status provides the LPHA with baseline data that are needed to measure the outcomes of any changes in service delivery (NACCHO, 2000). To assess the impact of a transition in public health services and determine if the community's needs have changed, if they are being met, and where needs persist, LPHAs will want to have baseline data with which to compare the outcome data that will be collected.

An analysis of health outcomes can also identify pockets of need and disparities in health status based on gender, race or ethnicity, education or income, disability, geography, or sexual orientation. The elimination of health disparities will necessitate the improved collection and use of standardized data to identify and address disparities among select population groups (DHHS, 2000).

The MAPP tool encourages communities to engage in a "community health status assessment" — a comprehensive compilation of measures that describe health status at the community level and resources available to address priority health needs (NACCHO, 2000). The National Public Health Performance Standards program also supports the assessment of health status through the development of a community health profile.

Mobilizing for Action through Planning and Partnerships (MAPP)
MAPP is a strategic approach to community health improvement. The MAPP tool helps communities improve health and quality of life through community-wide strategic planning. It helps communities achieve optimal health by identifying and using their resources wisely, considering their unique circumstances and needs, and forming effective partnerships for strategic action. The MAPP tool was developed by NACCHO in cooperation with CDC. A workgroup comprised of local health officials, CDC representatives, community representatives, and academicians developed MAPP between 1997 and 2000. The MAPP tool is available on NACCHO's website: www.naccho.org.

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The MAPP community health status assessment includes core indicators (data elements) for 11 categories:

- Demographic characteristics
- Socioeconomic characteristics
- Health resource availability
- Quality of life
- Behavioral risk factors
- Environmental health indicators
- Social and mental health
- Maternal and child health
- Death, illness, and injury
- Infectious disease
- Sentinel events

Communities may also select other locally appropriate indicators (see MAPP for discussion of indicators).

National Public Health Performance Standards Program (NPHPSP)

NPHPSP is a collaborative effort of NACCHO, CDC, American Public Health Association (APHA), Association of State and Territorial Health Officials (ASTHO), National Association of Local Boards of Health (NALBOH), and Public Health Foundation (PHF). NPHPSP includes performance standards to measure public health practice at the state and local levels. For the local level, measures are designed to assess activities of the local public health system, which includes all public, private, and voluntary entities, as well as individuals and informal associations that contribute to the delivery of public health services in a jurisdiction. The latest draft is available at: www.phppo.cdc.gov/nphpsp

If the LPHA has already developed a community health profile, the team should review it before proceeding to see if it needs to be updated or revised. If the LPHA has not yet developed a community health profile, the team should refer to available tools and resources. Completing this section is not an alternative to conducting a complete community assessment. It is only to prompt a consideration of the most important data and issues to consider when making decisions about the service delivery system.

- See MAPP (www.naccho.org) for a tip sheet on data issues in jurisdictions with small populations.
- See Appendix A for references on data sources.

Data Sources

Community Health Status Indicators

In response to the need for easy-to-use, county-level health information, HRSA, ASTHO, NACCHO, and the Public Health Foundation (PHF) developed county health profiles. States and counties can use the indicators as a baseline for benchmarking *Healthy People 2010* activities, comparing one county to others and to the nation, and characterizing a county's overall health. The HRSA Web site www.communityhealth.hrsa.gov includes the health status reports and information on their interpretation and use.

Healthy People 2010

Healthy People 2010 is a health promotion and disease prevention agenda for the nation. It is designed to serve as a roadmap for improving the U.S. population's health during the first decade of the 21st century (DHHS, 2000). *Healthy People 2010* represents the expertise of the Healthy People Consortium, an alliance of more than 350 national organizations and 250 state public health, mental health, substance abuse, and environmental agencies. The leading health indicators identified in *Healthy People 2010* reflect the nation's major public health concerns and were chosen based on "their ability to motivate action, the availability of data to measure their progress, and their relevance as broad public health issues." The ten leading indicators are: physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to healthcare. For more information, visit www.health.gov.

Community definition and previous assessments

Community is "the aggregate of persons with common characteristics such as geographic, professional, cultural, racial, religious or socio-economic similarities; communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes or other common bonds" (NACCHO, 2000).

1. **Define the community(ies) served by the LPHA.** This definition will affect the answers to the subsequent questions. Remember that a health jurisdiction may comprise multiple communities. Include all of the communities in the LPHA's jurisdiction.

   _____

   _____

   _____

2. **Within the last 5 years, has the LPHA or any other organization in the jurisdiction conducted an assessment of the community's health status**? This may include PATCH (see below), *APEXPH* Part II (see below), MAPP's community health status assessment, a standardized state process, or a process unique to the LPHA.
   - ❑ Yes
   - ❑ No

Community Health Assessment Tools

Planned Approach to Community Health (PATCH)
The PATCH model, developed by the CDC and partners, helps states and localities identify and address health priorities and develop, implement, and evaluate community health plans and interventions. www.cdc.gov/nccdphp/patch/

Assessment Protocol for Excellence in Public Health (*APEXPH*)
APEX*PH*, a collaborative effort between CDC and NACCHO, is one of the most comprehensive public health assessment and planning processes. APEX*PH* was developed to be used voluntarily by local health officials to assess the organization and management of LPHAs, provide a framework for working with community members and other organizations in assessing the community's health status, and establish the LPHA's leadership role in the community. www.naccho.org

APEX*PH* Part II, the community assessment component, includes eight steps:
- Prepare for the community process
- Collect and analyze health data
- Form a community health committee
- Identify community health problems
- Prioritize community health problems
- Analyze community health problems
- Inventory community health resources
- Develop a community health plan

***If yes*, did the assessment include one or more of the following?**
____ Identification of health risks and determination of health-service needs
____ Information on access to services
____ Vital statistics and health status of groups at highest risk
____ Identification of community assets and resources that support the local public health system in promoting health and improving the quality of life
____ Other: _____

What were identified as the five priority community health problems that the public health system needs to address?

A community health problem is "a situation or condition of people, which is considered undesirable, is likely to exist in the future, and is measured as death, disease or disability" (NACCHO, 1991).

1. _____
2. _____
3. _____
4. _____
5. _____

The Lake County (IL) Health Department conducted the Illinois Plan for Local Assessment of Need (IPLAN), a derivative of APEX*PH*. The community identified access as a problem, which prompted the health department to look more closely at its jurisdiction. This assessment identified a major change in the county's demographics — an increase in the Hispanic population, many of whom were uninsured and underinsured. Although the county's incidence rates for most diseases were among the lowest in the state, these new pockets of poverty were resulting in tremendous disparities in health status. At the same time, doctors were refusing to accept low-income clients; of the more than 1,000 doctors in the county, virtually none were accepting Medicaid. Based on this information, the health department decided to increase, rather than divest, its services by starting a community health center to increase access to care for the most vulnerable.

Unmet service needs

Unmet service needs are "services that are not adequately being provided in the community based on either lack of quality or not enough services to cover the entire population" (CDC and NACCHO, 2001).

1. **Complete the table on the following page to describe the community's unmet service needs.** Stress the needs that are essential to maintaining the health of the community. Include all direct clinical services and population-based services.

   Direct clinical services: Services provided to individuals rather than communities. These include primary care, clinical preventive services, specialty care, hospital care, emergency care, and rehabilitative care.

   Primary care is "the provision of integrated, accessible health care services by clinicians, who are accountable for addressing a large majority of health care needs, developing a sustained partnership with parties, and practicing in the context of family and community" (IOM, 1996).

   Clinical preventive services are "common screening tests, immunizations, risk assessment, counseling about health risk behaviors, and other preventive services routinely delivered in the clinical setting for the primary prevention of disease or for the early detection of disease in persons with no symptoms of the illness" (DHHS, 2000).

   Community preventive services/population-based services: Health-related services not delivered in a one-to-one clinical setting. These include monitoring population health status, investigating and diagnosing community health problems, educating the community about health-related issues, mobilizing partnerships to identify and solve health problems, developing health-related policies, and enforcing laws and regulations that protect health and safety (Bartlett et al, 1996; NACCHO, 2000).

List the five most significant unmet service needs in the community. Include both direct clinical services and population-based services.	Is the LPHA providing this service?	Are other organizations in the community providing this service?	Is the problem a lack of quality or of quantity of services?	Note any plans of the LPHA or the community to address these unmet service needs.
	Yes No	Yes No Unknown	___Lack of quality ___Not enough services ___Other:_____	
	Yes No	Yes No Unknown	___Lack of quality ___Not enough services ___Other:_____	
	Yes No	Yes No Unknown	___Lack of quality ___Not enough services ___Other:_____	
	Yes No	Yes No Unknown	___Lack of quality ___Not enough services ___Other:_____	
	Yes No	Yes No Unknown	___Lack of quality ___Not enough services ___Other:_____	

Guidelines

The Task Force on Community Preventive Services, a 15-member panel of non-federal experts in population-based health convened by the Department of Health and Human Services, is developing a *Guide to Community Preventive Services*. The Guide will "present rigorously reviewed evidence on the effectiveness and cost-effectiveness of interventions that are designed to prevent disease and injury and improve health in groups of people." www.thecommunityguide.org

The U.S. Preventive Services Task Force prepared the *Guide to Clinical Preventive Services*, which presents rigorously reviewed evidence regarding the importance of clinical interventions to prevent illness and other health conditions and summarizes clinical research on the effectiveness of various preventive services. www.odphp.osophs.dhhs.gov/pubs/guidecps/

Other items to consider

- If any services are limited or non-existent, how many persons are affected?
- Are the new or existing unmet needs prioritized?

Conclusions

- By identifying unmet service needs, the LPHA and the community can determine the needs that are not being adequately addressed. This is important for identifying gaps in the public health system.
- When making decisions about service delivery, the LPHA must consider unmet service needs and determine ways to address them — if not by the LPHA than by other parts of the healthcare system.
- Through a community health status assessment, the LPHA may determine that population-based needs are more pressing than direct service needs or vica versa. As a result, the LPHA may decide that one or more direct clinical services should be transitioned to other providers or should be continued or expanded.

Access to care

> Access is: "the timely use of personal health services to achieve the best possible health outcomes. Includes both the use and effectiveness of health services and the physical accessibility of facilities" (IOM, 1993).

1. **If information is available on the community's access to services, provide the information below. If the information is not available, refer to the appropriate resources, as indicated.**

   Number of uninsured persons _____
   Community Health Status Indicators report, www.communityhealth.hrsa.gov

   Number of Medicare beneficiaries _____
   www.hcfa.gov/stats/

   Number of Medicaid beneficiaries _____
   State Medicaid office

   Number of primary care physicians per 100,000 population _____
   American Medical Association physician master file; state primary care office (see Appendix E).

   Number of dentists per 100,000 population _____
   American Dental Association; state and county demography report

   Number of community/migrant health centers _____
   Bureau of Primary Health Care, www.bphc.hrsa.gov

   Number of health professional shortage areas (urban and rural geographic areas, population groups, and facilities with shortages of health professionals) _____
   www.bphc.hrsa.gov/databases/newhpsa/newhpsa.cfm; state primary care office (see Appendix E).

2. **Is the LPHA the jurisdiction's major or only safety net provider?**
   - ❑ Yes
   - ❑ No

> Safety net providers are: "providers that deliver a significant level of health care to uninsured, Medicaid and other vulnerable patients regardless of patient's ability to pay for services" (IOM, 2000).

3. Based on the above information, rate the community's overall access to healthcare.

Poor		Good		Excellent
1	2	3	4	5

4. What are the financial, structural, and personal barriers to accessing care? Consider the five most significant barriers in the community (CDC and NACCHO, 2001; DHHS, 2000).

> Patient barriers, are mental, physical or psychosocial conditions that prevent an individual from accessing needed healthcare services (HRSA, 2000).

- ❑ Attitudes or biases
- ❑ Cultural or spiritual differences
- ❑ Physical disability
- ❑ Mental/behavioral disorder
- ❑ Sexual orientation
- ❑ Language
- ❑ Not knowing how/when to seek care
- ❑ Confidentiality concerns
- ❑ Discrimination concerns
- ❑ Transportation
- ❑ Child care
- ❑ Health insurance
- ❑ Financial resources
- ❑ Lack of provider/specialist
- ❑ Lack of healthcare facility
- ❑ Hours of operation
- ❑ Geographic convenience
- ❑ Other _____

The Monterey County (CA) Health Department's clients have an array of challenging medical and social problems. Many are immigrants with limited English skills and high levels of illiteracy. Others have received inadequate or no preventive healthcare, and most have chronic health conditions that require intensive case management and specialty referral. A fear of discovery by the Immigration and Naturalization Service inhibits clients' willingness to complete the paperwork required by state healthcare programs. Many patients are without telephones and have migratory employment. Transportation poses another significant hurdle, especially since the county lacks an efficient mass transit system.

Other items to consider

- Which populations (e.g., children; homeless persons; persons who encounter barriers due to lack of education, low income, language problems, cultural differences, race and ethnicity; persons with physical or mental disabilities; persons lacking health insurance) do the barriers affect?
- What must be done to minimize barriers and ensure access to care for these populations?
- Does the LPHA have any plans to minimize barriers to accessing care?

Conclusions

- Equal access to healthcare for all populations is a significant goal for a community. Increasing access requires efforts by the LPHA and other organization/entities that comprise the local public health system.
- In addition to the patient barriers listed above, provider and system-of-care barriers also exist. Provider barriers include lack of time and training for health professionals. System barriers include lack of resources or lack of coverage, inadequate reimbursement for services, and lack of systems to track quality of care.
- Frequent measures of access are: the proportion of persons with health insurance and the proportion of persons with a usual source of care. A usual source of care has been correlated with improved access to preventive services and follow-up care (DHHS, 2000). However, health insurance does not guarantee that healthcare will be accessible, affordable, and of good quality.
- To reduce or eliminate disparities in access to care, the local public health system needs to aggressively tackle the root causes or the social determinants of health. The hope is that achieving access to quality care is one step in achieving *Healthy People 2010* goals, eliminating disparities in health status, and increasing quality of life.
- Access to care becomes more limited when the LPHA is the only safety net provider and Medicaid clients and uninsured, underinsured, and other low-income persons have little choice in where to go for care. If this is the case, the LPHA has a responsibility to continue to provide services to low-income populations or to locate other providers who might be willing and able to serve them.
- The number of providers offering certain services in the community is one of the most important items to assess as LPHAs make decisions about whether to continue the delivery of direct clinical services.

Community support consists of participation in the design and provision of services, advocacy for expanded services, participation at board meetings, support for services that are threatened to be curtailed or eliminated, and other activities demonstrating that the community values a healthy community and an effective local public health system (NACCHO, 2000).

1. **Are routine mechanisms (1-2 years) in place to gather feedback from community members on their perceptions of the healthcare system** (University of Washington, 1996)?
   - ❑ Yes
   - ❑ No

   ***If yes*, what mechanisms are used to gather this feedback?**
   - ❑ Surveys/questionnaires via telephone, mail, or in person
   - ❑ Point-of-service evaluation forms
   - ❑ Interviews
   - ❑ Focus groups
   - ❑ Annual surveys
   - ❑ Consumer groups
   - ❑ Local health councils
   - ❑ Other: _____

   Are these feedback mechanisms conducted in other languages?
   - ❑ Yes
   - ❑ No

   What were the findings? What do community members have to say about the healthcare system?

   _____

   _____

   _____

   _____

What does the community view as the LPHA's roles and responsibilities?	Is the LPHA currently addressing these roles and responsibilities?	
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No

If the LPHA has no current information on the community's perceptions of the healthcare system and the LPHA's roles and responsibilities, it is important to facilitate a community dialogue to obtain this information (University of Washington, 1996). This can be done via focus groups, community councils, surveys, town meetings, etc.

Other items to consider

- What proportion of persons are satisfied with the community's quality of life?
- What proportion of adults are satisfied with the community's healthcare system?

- Is health status information provided to the community?
- What is the LPHA's image in the community (Reid et al, 1998)?

One of the community health centers operated by the Jefferson County (AL) Department of Health decided to hear from the community about ways to be more efficient and user-friendly. Initial input was obtained through a town meeting and a marketing survey. The health department also convened a community advisory council comprised of persons who had used the health department's services. The council's concerns centered on issues in the health center catchment area and community education on public health and morbidity issues. The council is now active in and concerned about their community's healthcare. Focus groups were used to explore specific concerns that emerged from the council's meetings. Information from the focus groups was used to redesign maternal and child health services.

Steps for Community Engagement

Gather Information

- Before starting a community engagement effort, be clear about the purposes/goals and target populations/communities (CDC, 1997). Understand that the message may need to be tailored to specific audiences.
- Become knowledgeable about the community. Learn about economic conditions, political structures, demographic trends, history, and the image of the LPHA (CDC, 1997).
- Learn about constituents' characteristics/assets and factors that might encourage their involvement. Identify potential areas of conflict by becoming familiar with their beliefs, values, missions, goals, and history of working with others. Establish strategies to guide the agency's interaction with constituents (Hatcher and Nicola, 2001).
- Develop an inventory of community associations and local organizations (NCL, 2000).
- Encourage the LPHA leadership to support policies that encourage a community-based approach to public health (NCL, 2000).

Build Relationships and Develop Trust

- Go into the community, establish relationships, and build trust. Keep an open mind. Through dialogue with the community, learn about people's concerns and priorities, and discover what activities are currently taking place. Community dialogue can also reveal which various groups interact and whether any networks or coalitions exist (CDC, 1997).
- Visit county residents outside the agency. Speak to community groups, and share data about the community's health status to encourage involvement and interest (Wiesner, 1997).
- Reach out to all organizations that have a stake in any decision the LPHA makes (e.g., service providers, educational groups, community organizations, churches). Plan community forums, lunches, and meetings, and allow time for discussion. Visit organizations, and seek opportunities for collaboration.
- Overcome any mistrust and skepticism. A history of mistrust in a community may be difficult to overcome, but no effort can move forward until these issues are addressed. Open communication and time are essential to overcoming obstacles.

continued

Engage the Community

- Work with and seek commitments from formal and informal community leaders. People in the community are more inclined to be supportive if high-level leaders are involved.
- At an early stage, involve key professionals who work in the community and already have credibility and community trust. They are likely to be an invaluable source of information about interest groups and the dynamics among various constituencies.
- Support the development of community advisory boards, planning groups, and coalitions as advisors during the LPHA's reorganization. Formal and informal networks will help to establish and maintain relationships, communication channels, and the ability to leverage resources among constituent groups (Hatcher and Nicola, 2001).
- Recognize and respect community diversity.
- Include persons who are not of like mind. Differences in perception strengthen the effort. Diverse individuals come to the table with new ideas that open up the dialogue for a truly collaborative effort. However, it is important to identify those who may become obstacles.
- Engage disenfranchised populations that traditionally may not be involved in community dialogue. Confront feelings of mistrust and existing cultural differences.
- Identify and mobilize community assets, and develop capacities and resources for community health decisions and actions.

Conclusions

- Through constituency building, LPHAs are working to "establish relationships among the public health agency and the public it serves, the governing body it represents and other health-related organizations in the community" (Hatcher and Nicola, 2001).
- The LPHA's activities and structure affect the entire community. When an LPHA is making a decision about transitioning, it is logical to seek community members' input.
- LPHAs can take a leadership role in garnering community support and bringing together a variety of organizations.
- Community members are key stakeholders in determining what the LPHA's roles and responsibilities should be, especially as the LPHA begins to change its focus. Gathering information on community perceptions is critical before making any changes in service delivery.
- To help ensure the development and implementation of workable strategies, it is important to assess the community's needs and wants on a relatively frequent basis — especially as changes in the service delivery system begin to happen. Many LPHAs acquire support by including the community through every stage of the process, beginning with a community needs assessment.
- If the LPHA establishes relationships with the public it serves, increased communication may help decrease anxiety and facilitate the decision-making process.
- Social marketing is an important activity for LPHAs. Creating or sustaining a positive image in the community has strong implications for the scope and type of activities it can engage in. (See Appendix A for references on marketing public health.)

Availability of Providers

1. Complete the following table on primary healthcare providers (Bartlett et al, 1996).

A primary healthcare provider is a physician or other practitioner (e.g., nurse practitioner, physician assistant, certified nurse midwife) who provides medical, dental, and/or preventive health services. A primary healthcare provider can practice in a variety of settings (e.g., managed care organization, hospital, community health center, academic health center, individual practice).

List by name the primary healthcare providers who address the needs of uninsured and/or Medicaid populations and have significant presence in the community. List in order of the proportion of care provided to the community (Bartlett et al, 1996).	What types of services do they provide? (e.g., ob/gyn, well-child, comprehensive primary care)	To what population(s) do they provide these services? (e.g., women, children, homeless)	How do these providers do in providing care to uninsured populations? 1=poor, 3=good, 5=excellent	How do these providers do in providing care to Medicaid populations? 1=poor, 3=good, 5=excellent
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown

2. Based on the above table, rate the availability and willingness of primary healthcare providers who serve the community's Medicaid, uninsured, underinsured, and other low-income populations in the community.

Poor		Good		Excellent
1	2	3	4	5

In Boulder County (CO), one reason for transitioning services was the existence of four community health centers (CHCs) with the willingness and desire to expand service capacity to low-income families, particularly since the funding mechanism for Medicaid patients provided more favorable reimbursement rates to CHCs than to the health department. To maximize resources that would be used to expand capacity to care for the county's indigent population, it was desirable to attract these additional resources. The health department wanted to increase not just its capacity but the capacity of the entire county.

3. Complete the following table on preventive healthcare providers (Bartlett et al, 1996)

A preventive healthcare provider is a trained healthcare provider/entity (e.g., community health center, hospital, academic health center, private practice) that provides clinical preventive and/or population-based services.

List the preventive healthcare providers in the community that address the needs of Medicaid and/or uninsured populations and that have a significant presence. List in order of the proportion of care provided to the community (Bartlett et al, 1996).	What types of services do they provide? (e.g., health education, immunization, family planning)	To what population(s) do they provide these services? (e.g., women, children)	How do these providers do in providing care to uninsured populations? 1=poor, 3=good, 5=excellent	How do these providers do in providing care to Medicaid populations? 1=poor, 3=good, 5=excellent
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown
			1 2 3 4 5 unknown	1 2 3 4 5 unknown

4. Based on the above table, rate the availability and willingness of preventive healthcare providers who serve the community's Medicaid, uninsured, underinsured, and other low-income populations in the community.

Poor		Good		Excellent
1	2	3	4	5

5. Is there sufficient provider capacity to serve special or vulnerable populations such as:

____Uninsured or underinsured persons
____Rural/frontier populations
____Underserved mothers and children
____Elderly persons
____Racially/ethnically diverse groups
____Public-housing residents
____High-risk pregnant women
____Homeless families and individuals
____Immigrants
____Migrant farm workers
____Persons with chronic illnesses
____Other: ____________________________

Conclusions

- As the LPHA makes decisions about the service delivery system, one of the most important activities is to assess the availability of primary and preventive healthcare providers in the community, the services they offer, and the populations they serve.
- The community may have many providers, but they may not serve Medicaid, uninsured, underinsured, and/or other special populations. Or, they might do a poor job in doing so.
- If the LPHA decides to transition one or more services, one of the most important considerations is the availability and willingness of providers to take on these services.
- The LPHA also needs to determine the capacity and infrastructure of providers to serve the LPHA's patient base.
- The LPHA's responsibility is to ensure that patients do not fall through the cracks during the transition.

Managed Care

Managed healthcare continues to evolve in response to customer demands, state and federal legislation, and the healthcare environment. Although managed care organizations (MCOs) differ in their administrative mechanisms and services, they have a common goal of providing a defined population with accessible, cost-effective, quality healthcare.

1. How significantly has managed care penetrated the LPHA's geographic area in the last few years?

Not at all		Some Presence		Very Significant Presence
1	2	3	4	5

2. Is there Medicaid managed care in the community?

- ❑ Yes
- ❑ No
- ❑ Being considered

***If yes*, is it mandatory?**

- ❑ Yes
- ❑ No

How well are the healthcare needs of Medicaid recipients being met by Medicaid managed care?

____Better than before
____As well as before
____Not adequate
____Unknown

***If not adequate*, list the specifics of the inadequacy:**

____Not enough providers/clinic locations
____Lack of translation services
____Transportation barriers
____Lack of culturally specific care
____Other: _____

In the last few years, what has been the impact of Medicaid managed care on the LPHA's provision of direct clinical services?

____Increase in clinical services provision
____Decrease in clinical services provision
____No impact
____Other: _____

***If there was a decrease in clinical service provision by the LPHA,* the reason was:**
____Decrease in patient numbers
____Decrease in resources
____Other: _____

In the last few years, has the community presence of Medicaid managed care changed the need/demand for LPHA involvement in the direct delivery of clinical services?
❑ Yes
❑ No

In the last few years, what has been the impact of Medicaid managed care on the LPHA's ability to address the 10 essential services?
____Increase in time and resources spent on the 10 essential services
____Decrease in time and resources spent on the 10 essential services
____No impact
____Other: _____

3. **Does the LPHA interact with MCOs to provide or purchase various services?**
   ❑ Yes
   ❑ No
   ❑ Considering

4. **What type of agreements does the LPHA have with MCOs?**

   _____
   _____
   _____
   _____

5. **What is the status of MCOs' future viability as Medicaid managed care providers?**
   ❑ Stable
   ❑ Uncertain
   ❑ Unknown
   ❑ Other: _____

When Medicaid managed care came to Ohio, the Mahoning County Board of Health decided it was best not to compete for contracts because the financial risk did not seem appropriate, and they did not want to gamble with public dollars. Given that the county was about to revert to mandatory Medicaid managed care, the LPHA felt pressure to change its structure and services. The LPHA was to lose approximately 50% of pediatric patients and 80% of prenatal patients to Medicaid managed care and thus a great deal of Medicaid revenue. The families without health insurance remained with the LPHA. Therefore, the advent of Medicaid managed care was a big impetus to reengineer the agency's maternal and child health programs. The county changed its focus from funding clinical service delivery to forming partnerships with local organizations and ensuring access to care.

Other Items to consider
- Is the proportion of the population enrolled in managed care expected to increase, decrease, or remain the same over the next few years?
- What would happen if MCOs stopped providing care to Medicaid populations?
- Is there overlap between the primary and preventive healthcare services the LPHA offers to Medicaid populations and services offered by MCOs?
- Does the LPHA have the capacity to deliver competitive services in a managed care environment?

Conclusions

- With the large numbers of Medicaid recipients entering into managed care, the patient base for many LPHAs has decreased significantly. In response, LPHAs are reassessing and redefining their roles in the healthcare system.
- The potential roles for LPHAs in a managed care environment vary considerably. In addition to the challenges, managed care also means opportunities for LPHAs to develop new strategies to carry out the 10 essential services.
- LPHAs have much to offer MCOs, including: effective service delivery strategies for at-risk populations, understanding of community issues, expertise in data-related activities, epidemiologic approaches to population health and prevention, and expertise in community assessment, intervention, and outreach services.
- LPHAs and MCOs have not traditionally worked together and therefore often fail to recognize their common goals.
- Many partnerships have been developed between MCOs and LPHAs -- out of necessity, as a result of legislative or regulatory directives, or from good leadership that recognized the importance of such partnerships.
- Common obstacles to collaboration include different populations, different cultures, different languages, and turf issues. Many MCOs and LPHAs have overcome these barriers by partnering on activities such as service delivery, quality of care, and policy development (NACCHO, 1999).
- Fluctuations in the healthcare environment must be considered. Before LPHAs transition services to other providers, they must consider the viability of the managed care marketplace. As recently evidenced in many communities with Medicaid managed care, health plans have begun to struggle financially and, as a result, have stop participating in the program. (See Appendix A for references on managed care.)

Local, State, and Federal Policy

1. What is the LPHA's structural relationship to the state public health agency?

____ Decentralized (operates under the government's direct authority)
____ Centralized (operates as a local unit of the state health department)
____ Mixed (operates under mixed or shared authority of local, state, and/or other jurisdictions)

New Mexico has a centralized public health system in which LPHAs are operated by the state department of health and function directly under the health department's authority. Thus, employees who work at the local level are considered state employees. Technically, New Mexico does not have a local health department system. At the regional level, public health district offices — administrative units of the State Department of Health/Public Health Division — are located throughout the state. The district offices supervise the work performed at the county level by the local health offices.

2. Rate the LPHA's working relationship with the state public health agency.

Poor		Good		Excellent
1	2	3	4	5

3. List the types of authority the state public health agency has over LPHAs (e.g., budgetary, regulatory, programmatic).

_____
_____
_____
_____

Other items to consider

- What type of working relationship does the LPHA have with other state agencies responsible for assuring and purchasing healthcare services (University of Washington, 1996)?
- What significant changes in state/federal policy and/or activities have had an impact on the LPHA's budget and/or activities in the last few years (Bartlett et al, 1996)?
- What changes in state/federal policies or activities might affect the LPHA's budget or activities in the near future (Bartlett et al, 1996)?

For the Pinellas County (FL) Health Department, changes in the private healthcare sector's economics, improved Medicaid reimbursement rates for prenatal and delivery services, and the advent of Medicaid managed care led to the transitioning of some clinical services. In 1988, the health department provided prenatal care to more than 3,000 maternity patients. As the 1990s progressed and Medicaid reimbursement increased, these patients became not only acceptable to the private sector but also increasingly attractive. Private practitioners became more competitive in attracting patients, and, given sufficient numbers of private-sector providers in the county, the health department decided not to enter into the competition. As a government entity, the health department could not compete under the same rules as the private sector, which could provide direct clinical services for patients at less cost.

4. Has the state created or is it planning to create any guidance, policy statements, or documents related to the LPHA's role in providing direct clinical services?

❑ Yes
❑ No

***If yes*, what is stated with regard to the LPHAs' role in the provision of direct services?**

_____
_____
_____
_____

Other items to consider

- What impact will these policy statements/documents have on the LPHA's funding levels?

5. Does the state public health agency encourage or discourage direct service delivery by LPHAs?

❑ Encourage
❑ Discourage
❑ Neither

6. Has the state helped the LPHA strengthen its capacity to perform the 10 essential services?

❑ Yes
❑ No

Other items to consider

- What are the most significant local statutes or regulations that support and protect local public health?
- What are the most significant local statutes or regulations that inhibit innovation and competition in the local public health sector?

Conclusions

- The relationship between state and local health agencies plays an important role in defining an LPHA's responsibilities and authority in the community. This relationship varies from state to state.
- State-local relationships affect the delivery of public health services at the local level. They also might help to determine funding allocations, program development, and quality assurance at the local level (NACCHO, 1998).
- The challenges associated with the changing healthcare environment do not have to be tackled by the LPHA alone. The state public health agency can help the LPHA respond to these challenges by: 1) advocating for

strong support for local public health activities, 2) ensuring that LPHA perspectives are included in the state health policy development process, 3) evaluating the LPHA's performance on the 10 essential services, 4) developing a strategic plan for public health that will help guide LPHAs, 5) assessing and responding to LPHAs' training needs, and 6) offering technical assistance in areas such as data systems development, contract negotiations, and provision of population-based services.

- The state's philosophy has a tremendous impact on the type of activities in which the LPHA engages. The state public health agency is a key stakeholder in the LPHA's decision about whether or not to transition out of direct care.
- The state can be an important source of technical assistance to LPHAs. It is often the state public health agency that encourages the LPHA to transition out of direct care.
- The better the relationship and the more open the communication channels between the LPHA and the state public health agency, the easier the decision-making process will be.

Relationship to Policymakers

1. Do state policymakers usually consult with the LPHA on key legislative issues related to public health?

❑ Yes
❑ No

2. Do state policymakers support the provision of direct clinical services by LPHAs in the state?

❑ Yes
❑ No

***If yes*, how strongly do they support the provision of direct clinical services by the LPHA?**

Very Strongly		Strongly		Not Strongly At All
1	2	3	4	5

***If no*, what do they see as the roles and responsibilities of LPHAs?**

_____
_____
_____
_____

3. Do local policymakers usually consult the LPHA on key legislative issues related to public health?

❑ Yes
❑ No

4. Do local policymakers support the provision of direct clinical services by the LPHA?

❑ Yes
❑ No

***If yes*, how strong is their support?**

Very Strongly		Strongly		Not Strongly At All
1	2	3	4	5

***If no*, what do they see as the role and responsibilities of the LPHA in the community?**

_____
_____
_____
_____

5. Is there a board of health in the community?

❑ Yes
❑ No

A board of health is a: "legally designated governing body whose members are appointed or elected to provide advisory functions and/or governing oversight of public health activities, including assessment, assurance, and policy development, for the protection and promotion of health in their community" (NACCHO, 2000).

***If yes*, list the types of authority the board of health has over the LPHA (e.g., budgetary, regulatory, programmatic).**

_____
_____
_____
_____

Does the board of health consult the LPHA on matters related to the community's health?

❑ Yes
❑ No

Does the board of health support the provision of direct clinical services by the LPHA?

❑ Yes
❑ No

***If yes*, how strong is their support?**

Very Strongly		Strongly		Not Strongly At All
1	2	3	4	5

***If no*, what do they see as the LPHA's role?**

_____
_____
_____
_____

Conclusions

- Understanding recent changes in federal and state policy is important as the LPHA assesses its role in the healthcare environment.
- It is critical to investigate policymakers' attitudes and perceptions toward public health and find out what they see as the LPHA's role. The level and importance given to public health at the state and local levels will have a major impact on the path the LPHA decides to follow (Bartlett et al, 1996).
- Political will can be a critical factor in changing a city or county's public health structure. Policymakers can often be the driving force behind this change. They may see transitioning of LPHA services as a way to reduce the government's size without taking into consideration the consequences of doing so.
- Many LPHAs have been quick to recognize the need to work closely and maintain relationships with political powers and elected officials. Decisions to transition services involve financial and other resources that these groups may have a stake in.
- Working with both state and local governance can translate into increased backing of LPHAs, financial support, and decision-making authority.
- LPHAs must assess the political environment before engaging in any transitioning efforts and keep the political powers apprised of plans.
- LPHAs often spend a great deal of time working with local decision-makers to ensure a common

understanding of public health and agreement on local priorities.

- Since approximately 81% of LPHAs work with a local board of health, members should be included in decision-making as key stakeholders (NACCHO, 1998).
- Successful, innovative programs generally require the awareness and support of key decision-makers. Several LPHAs have found that having local politicians champion their cause was key to their accomplishments. (See Appendix A for references on political support.)

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Organizational Assessment

Purpose
The *Organizational Assessment* provides an opportunity to look at the LPHA and the factors that affect its operation. The *Organizational Assessment* also considers how well the LPHA is performing the 10 essential services, addresses alternatives to service delivery, and covers services the LPHA might consider transitioning. All organizations should, at some point, complete a more comprehensive organizational assessment if they have not already done so. Completing this section might provide the impetus to engage in such a process.

Timeline
Factors that affect the timeline include the team members' experience and expertise and the availability of information to support the process. LPHAs that have conducted an organizational assessment, such as the *Assessment Protocol for Excellence in Public Health* (APEX*PH*) Part 1, already have much of the information needed to complete this section. If an LPHA has not conducted an organizational assessment in the past few years, the process should be reviewed. The priority issues identified should be evaluated and revised on an ongoing basis.

Participants
The decision-making team will play a vital role in completing the assessment. However, it will be necessary to include all levels of LPHA staff at some point to gain their perspective. It might be useful to ask different staff members to complete specific subsections and then compare responses. Staff meetings can provide an excellent opportunity to gather input from staff, talk about the process, and gain support and buy-in. The larger planning team, plus outside consultants, can be included as needed.

Overview
LPHAs can complete the *Organizational Assessment* before, after, or concurrently with the *Community Assessment*. Although completing the two assessments at the same time may be time consuming for the decision-making team, each requires different expertise and resources. The *Community Assessment* is more likely to involve external stakeholders, whereas the *Organizational Assessment* will require significant time and resources from LPHA staff.

The following LPHA resources might be helpful to have on hand for the *Organizational Assessment* (University of Washington, 1996):

- Budget
- Organizational chart
- Financial statements
- Annual report
- Chart of accounts
- Cost and staff projections
- Key internal memoranda or reports
- Strategic plan
- Any previous organizational assessment
- Interagency agreements
- Staffing plans
- National Public Health Performance Standards Instrument

The *Organizational Assessment* has nine parts:
1. Assessment Activities — Previous assessment efforts, priority issues identified, important stakeholders, and externally imposed mandates.
2. Mission — Organizational mission, especially as it relates to the provision of clinical and population-based services.
3. Financial Assessment — Examination of expenditures and revenue; an in-depth look at the agency's budget related to direct clinical services.
4. Organizational Capacity — Accounting systems, financial planning, and data systems and the capacity of these resources to create advantages for the LPHA in a changing healthcare environment.

5. Performance of the 10 Essential Services — Assessment of performance of the 10 essen-tial services and the priority placed on each.
6. Current Services — Services and programs provided, the priority placed on each, and the organizational capacity/responsibility in the community for these services.
7. Stakeholders — Views and influence of the LPHA's patients, staff, and leadership.
8. History of the Service-Delivery System — History of the LPHA's clinical service delivery and the forces that have influenced the current role in service provision.
9. Alternatives to Service Delivery — Pros and cons of alternative plans for service delivery, the projected impact on funding and on per-formance of the essential services, and the possible consequences of implementation.

Assessment Activities

1. Has the LPHA conducted an organizational capacity assessment (e.g., APEX*PH* Part I) in the last 5 years?

❑ Yes
❑ No

Note: If yes, it will be useful to review the assessment before completing this process.

***If yes*, when was the organizational assessment last updated?**

____ During the past year
____ 1-2 years ago
____ 3-5 years ago
____ >5 years ago

One factor in the decision of the Boulder County (CO) health department to transition services was that they had completed the internal and external assessments of the APEX*PH* process and instituted a 3-year work plan. It was clear that several unmet public health needs could be addressed if energy and resources devoted to primary care services were redirected to core public health services. The planning process was fundamental to the decision to transition personal health services to several area community health centers.

APEX*PH* Part 1

APEX*PH* Part 1 helps LPHAs focus on improving organizational performance and capacity. The process, which is usually conducted by the LPHA director and a team of staff, assists LPHAs in creating an organizational action plan and setting priorities. The eight steps in assessing organizational capacity are:

1. Prepare for the assessment — Decide to conduct an assessment, orient staff, form an assessment team, and plan how the team will operate.
2. Score indicators for importance and current status — Assign indicators a score based on perceived importance, and rate the current status of the agency. Indicators include authority to operate, community relations, community health assessment, public policy development, assurance of public health services, financial management, personnel management, program management, and policy board procedures.
3. Identify strengths and weaknesses — Determine indicators for which LPHA performance is particularly strong or weak.
4. Analyze and report strengths — Define strengths and contributing factors, and celebrate progress.
5. Analyze weaknesses — Define problems, and identify the source of each problem, resources available for addressing the problem, and potential barriers.
6. Rank problems in order of priority — Assign priority ranks based on the magnitude of each problem, the seriousness of the consequences, and the feasibility of corrective action.
7. Develop and implement an action plan — Establish goals and objectives, assign responsibility, specify methods, and implement the plan.
8. Institutionalize the assessment process — Implement a cycle of improvement.

2. Based on the information collected from the organizational assessment, was the LPHA able to identify priority problems?

❑ Yes
❑ No

***If yes*, what were the top five problems?**

1. _____
2. _____
3. _____
4. _____
5. _____

The identification of priority issues is an important part of an organizational assessment. To define and prioritize each issue, consider the following questions (Bryson and Alston, 1996):

- Is it possible for the organization to do something about this issue?
- What are the consequences for not addressing this issue?
- What makes this a priority for the organization? How does it relate to the organization's mandate, mission, values, and internal and external strengths and weaknesses?
- What goals should the organization have to address this issue?

3. Do any externally imposed mandates (formal or informal) require the LPHA to provide direct clinical services?

Review legislation, ordinances, charters, articles, and contracts (Bryson and Alston, 1996).

❑ Yes
❑ No

In North Carolina, county health departments are required to conduct communicable disease tracking and vital records registration. The state legislature prohibits the privatization of these services; they are considered essential public health functions (Halverson et al, 1997).

If yes, the mandate(s) may be a major constraint to any desired changes. To gain a clear understanding of any mandates and their possible implications for the LPHA's service delivery system, consider these questions (Bryson, 1995):

- What is required by these mandates?
- What is ruled out by these mandates?

4. Identify the key internal and external stakeholders who should be involved in an organizational assessment.

A stakeholder is "any person, group, or organization that can place a claim on the organization's resources, attention, or output, or is affected by its output" (Bryson, 1995).

Internal Stakeholders	**External Stakeholders**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other items to consider (Bryson and Alston, 1996)

- How would each of these stakeholders evaluate the organization's performance?
- How does each stakeholder influence the organization?
- What does the organization need from each stakeholder?
- How important is each stakeholder to the organization's functioning?
- Which stakeholders should be involved in the strategic planning process? How and when should they be involved?

See Appendix A for resources on assessment/strategic planning.

Mission

A mission statement is "an action-oriented formulation of the organization's reason for existence" (Bryson, 1995).

1. **Does the LPHA have a mission statement?** (See APEX*PH*'s worksheet on mission and role development)
   - ❑ Yes
   - ❑ No

   ***If yes*, what is the mission statement?**

   _____

   _____

   _____

   Does the mission statement mention the LPHA's involvement in the provision of clinical services?
   - ❑ Yes
   - ❑ No

   Does the mission statement mention the LPHA's involvement in population-based activities?
   - ❑ Yes
   - ❑ No

Other items to consider

- Does the mission statement address the LPHA's role in ensuring that direct clinical services are provided in the community?
- Do the LPHA's current priorities and practices support the mission?
- Which of the following groups have a good understanding of the agency's mission:
  - LPHA staff
  - Policymakers
  - Community members
  - Other healthcare providers/organizations

2. **What are the LPHA's current focus areas (Reid et al, 1998)?**
   - ____ Concentrate on basic public health services, especially vital statistics, communicable disease control, maternal and child health, and health education.
   - ____ Provide preventive and/or health promotion services (e.g., smoking cessation, blood pressure screening, health education).
   - ____ Provide direct clinical services to special populations (e.g., homeless, uninsured, immigrant, migrant populations) that are underserved by the private sector.
   - ____ Provide direct clinical services to underserved areas.
   - ____ Provide traditional public health services and a range of primary care services to the general population, regardless of income or special status.
   - ____ Other: _____

"A good mission statement should accurately explain why your organization exists and what it hopes to achieve in the future. It articulates the organization's essential nature, its values, and its work" (Radtke, 1998).

Conclusions

A mission statement:

- Helps clarify an organization's purpose (Bryson, 1995).
- Identifies the organization's purpose, identity, philosophy, and core values, and the factors that make it distinctive and unique (Bryson, 1995).
- Answers these questions:
  - What are the opportunities or needs that the agency exists to address? (*Purpose*)
  - What is the agency doing to address these needs? (*Business*)
  - What principles or beliefs guide the agency's work? (*Values*) (Radtke, 1998)
- Clarifies the organization's justification for existence, the needs it should fill, and the problems it should address.
- Inspires commitment, innovation, and courage; motivates those who are connected to the organization.
- Is articulated in a way that is convincing and easy to grasp; is proactive and free of jargon; is short enough that anyone connected to the organization can readily repeat it.
- Considers the primary stakeholders and the organization's relationship to them (Bryson, 1995).
- Is based on the 10 essential services and clarifies the organization's commitment to them; defines the key functions so that they can be understood by all relevant stakeholders (Sutton, 1999).

The Director of the DeKalb County (GA) Board of Health sought to change the agency's focus from medically-related to community-related activities. The revised focus was to emphasize promotion of wellness and health, policy development, surveillance, epidemiology, and community collaboration. Management wanted to change its mission from supplying personal services to individuals, particularly those deemed most in need, to providing essential services to the whole community (Wiesner, 1997).

In addition to creating a mission statement, the LPHA may want to develop values and vision statements.

- A values statement communicates a code of behavior and ethics to which an organization aspires (Bryson and Alston, 1996). Examples of core values are trust, respect, leadership, and social justice.
- A vision statement is a step beyond a mission statement. It provides a picture and description of how the organization will look when it is operating at its fullest potential (Bryson and Alston, 1996).

Financial Assessment

Direct clinical services are services provided to individuals rather than to communities. Direct clinical services include primary care, clinical prevention services, specialty care, hospital care, emergency care, and rehabilitative care services.

1. Complete the following table on expenditures and revenues.

	Amount	Year
What were the LPHA's total expenditures for the most recent fiscal year?	$	
What was the LPHA's total revenue during the most recent fiscal year?	$	
What were the LPHA's total expenditures associated with the provision of direct clinical services for the most recent fiscal year (including tax levies and grants)?	$	
What was the LPHA's total revenue associated with the provision of direct clinical services for the most recent fiscal year?	$	

If revenues were more than expenditures:
On what did the LPHA spend the extra revenue (e.g., less profitable services, population-based services, uninsured patients, uncompensated care)?

_____
_____
_____
_____

If revenues were less than expenditures:
How did the LPHA make up the difference?

_____
_____
_____
_____

2. In the past 3 years, has the total revenue from direct clinical services:

❏ Increased
❏ Decreased
❏ Remained the same
❏ Unknown

***If revenue decreased*, what accounted for the change?**

❏ Decline in patient numbers
❏ Decline in direct clinical services provided
❏ Change in reimbursement rates or reimbursable services
❏ Policy change on the state and/or local level
If yes, what was this change? _____
❏ Other: _____

3. Approximately what portion of the LPHA's current budget (including tax levies and grants) is spent on the provision of direct clinical services?

_____

The Jefferson County (AL) Department of Health began to question whether their services were properly balanced and whether the agency was ready for the future. They were spending most of their resources on assurance, related mainly to primary care delivery in eight locally supported health centers. The health department realized the need to retool the budget and develop different ways of ensuring the delivery of primary care without necessarily transitioning out of primary care. The most important consideration was: If the agency got out of the business of primary care, would there be the capacity or infrastructure in the community to cover the need?

4. **In the last 3 years, has the LPHA lost Medicaid patients to private providers and/or managed care?**
   - ❑ Yes
   - ❑ No

   ***If yes*, what percentage?**
   - ❑ <10%
   - ❑ 10%-25%
   - ❑ 25%-50%
   - ❑ >50%

   Do these private and managed care providers offer services to uninsured and underinsured persons?
   - ❑ Yes
   - ❑ No

   Can the LPHA obtain Medicaid reimbursement sufficient to cover the costs of providing certain direct clinical services (Bartlett et al, 1996)?
   - ❑ Yes
   - ❑ No

5. **What was the total volume of uninsured patient encounters in the last year?**

   _____ Year _____

6. **In the past 3 years, has the number of uninsured patients:**
   - ❑ Increased
   - ❑ Decreased
   - ❑ Remained the same
   - ❑ Unknown

Other items to consider

- What are the consequences of the loss of Medicaid patients on the LPHA's capacity to serve uninsured and underinsured persons?
- If the number of uninsured patients served by the LPHA has increased or decreased, what accounted for this change? What are the consequences of the change?
- How does the LPHA pay for uncompensated care?
- Would these funds be used for other purposes if the LPHA provided less uncompensated care?

Conclusions

- Any decision about service delivery must consider financial implications and requires a detailed financial analysis of costs and revenues.
- Many LPHAs will find that most of their budget and staff resources go to direct clinical services, with little spent on the 10 essential services and population-based services.
- The LPHA may receive much of its revenue from the provision of these services, especially as the result of Medicaid reimbursement for patients served. In addition to supporting service provision, the revenue often supports the provision of care to uninsured patients and subsidizes population-based services.

- Many LPHAs would like to focus more on population-based services, but they believe the resources received from direct clinical care are needed for the agency's operation.
- To avoid competing with managed care plans for services, many LPHAs are decreasing their level of direct clinical services and increasing the focus on population-based services.
- Although LPHAs may decrease their service delivery, it is important to determine if uninsured patients are receiving services elsewhere. Other providers, such as community health centers, may have a mission to serve this population. If other providers are not willing to offer care to uninsured persons, however, the LPHA needs to continue to provide services to the uninsured.
- Although cost is an important factor, and often the driving force behind any decision, other factors must also be considered. Many of these factors are addressed in this workbook.

Organizational Capacity

1. Does the LPHA have:
   - ____ A diverse funding base to lessen the disruption of services caused by reduction of funds from any one source (NACCHO, 2000)?
   - ____ Predictable source of funds to allow for development and implementation of a long-range plan (NACCHO, 2000)?
   - ____ Resources to acquire or improve equipment and facilities (Reid et al, 1998)?
   - ____ Sound financial planning, working capital, and a capital-budgeting process (Reid et al, 1998)?
   - ____ Sound accounting systems (Reid et al, 1998)?
   - ____ Capacity to administer the financial aspects of providing population-based services?
   - ____ Management information system that allows the analysis of administrative, demographic, epidemiologic, and utilization data to provide information for planning, administration, and evaluation (NACCHO, 2000)?
   - ____ Capacity to manage contracts/grants for primary care and clinical preventive services?
   - ____ Data system that can provide a count and demographic profiles of the client population (Bartlett et al, 1996)?
   - ____ Cost allocation/accounting system that can determine total costs associated with providing specific services on a per-unit basis (Bartlett et al, 1996)?
   - ____ Ability to identify revenues received from different payers for provision of different services (Bartlett et al, 1996)?
   - ____ Data systems and expertise to determine the costs and revenues associated with services provided (Bartlett et al, 1996)?

Conclusions

- LPHAs that decide to transition one or more services must first develop the capacity to do so. Capacity-building includes updating accounting systems, data systems, and administrative functions.
- Updated accounting systems enable LPHAs to analyze the costs and revenues associated with each service provided and to determine the fiscal implications of different service delivery decisions.
- An updated data management system can generate in-depth profiles of patients.
- Staff expertise in administration and information technology functions is critical to maintaining the LPHA's infrastructure.
- Since capacity is an important issue in strategic decisions about service delivery, weaknesses in managerial resources and personnel, financial systems, and management information systems will limit an LPHA's activities.
- If these systems are lacking, technical assistance is often available from community boards of health, state health departments, and outside consultants (Bartlett et al, 1996).

Performance of the 10 Essential Services

1. Complete this assessment of how well the LPHA carries out the 10 essential services (Bartlett et al, 1996; IOM, 1988).

10 essential services	Is priority given to improving or expanding performance?	How well is the LPHA currently performing this service? 1=inadequately, 3=adequately, 5=very adequately	Comment on how this service can be or is being improved.
1. Monitor health status to identify and solve community health problems	Yes No	1 2 3 4 5	
2. Diagnose and investigate health problems and health hazards in the community	Yes No	1 2 3 4 5	
3. Inform, educate, and empower people about health issues	Yes No	1 2 3 4 5	
4. Mobilize community partnerships and action to identify and solve health problems	Yes No	1 2 3 4 5	
5. Develop policies and plans that support individual and community health efforts	Yes No	1 2 3 4 5	
6. Enforce laws and regulations that protect health and ensure safety	Yes No	1 2 3 4 5	
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable	Yes No	1 2 3 4 5	
8. Assure a competent public and personal health care workforce	Yes No	1 2 3 4 5	
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services	Yes No	1 2 3 4 5	
10. Research new insights and innovative solutions to health problems	Yes No	1 2 3 4 5	

2. Complete the following table on funding sources that support the provision of population-based services and the 10 essential services.

List the current funding sources that support the LPHA's provision of population-based services and the 10 essential services. *	What portion comes from each of these sources?

* Consider these sources: City/township/town, county, state, federal (block grants), private foundations, private health insurance, patient fees, regulatory fees, etc.

3. Are the funding sources listed above adequate to meet the LPHA's costs of the desired level of population-based services and 10 essential services?

❑ Yes
❑ No

4. Do other funding sources exist to support these activities?

❑ Yes
❑ No

***If yes*, what are these funding sources?**

_____

_____

_____

Other items to consider

- Based on the above tables, does the LPHA's budget accurately reflect the LPHA's priority areas identified earlier?
- How can the agency better align the budget with the priority areas identified earlier?

Conclusions

- One of the key reasons LPHAs decide to make changes in their service delivery systems is to be able to concentrate more on the 10 essential services and population-based services.
- As local health officials gain a broader understanding and awareness of the essential services, many are seeking to reorganize around them.
- If a service is a high priority to the LPHA but is being performed inadequately, then the LPHA must expend more resources, time, and energy on this service and consider ways to enhance performance. The decision might be to transition out of providing one or more direct clinical services to leave more financial and staff resources to concentrate on the essential services.
- Even if a service is being performed adequately, the LPHA might still want to think about devoting more resources and time to it. The question is where to obtain the resources to support these services, especially as Medicaid revenue is lost. Currently, Medicaid revenue might be used to support the performance of the 10 essential services. If services are transitioned, this revenue is significantly decreased.
- Unfortunately, there are few resources to support non-categorical, population-based services. LPHAs need to be creative in seeking out local sources of funding, seeking foundation funding, and using the flexibility of funding streams such as the MCH block grant.

See Appendix A for resources on the core public health functions/essential services.

Current Services

Complete the following table (Bartlett et al, 1996). **Complete only for the services that the LPHA offers.**

Service	Rate the LPHA's ability to provide the service. 1=poor, 3=good, 5=excellent	Rate the priority placed on the service by the LPHA, 1=low priority, 3=medium priority, 5= high priority	Do other organizations in the community offer this service?	If yes, do any of these organizations provide the service to Medicaid and uninsured populations?	If the LPHA stopped providing this service, could a local partner provide it instead?	If so, is there an unmet need in the community?	Would the LPHA consider transitioning this service to another provider?
PREVENTIVE CARE							
EPSDT	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Family planning	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Lead screening	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Nutrition counseling	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Pediatric and/ or adult immunization	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Periodic health evaluation for adults	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Prenatal care	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Preventive dental/ oral health	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Tobacco prevention/ control	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Violence/ injury prevention	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Well child and/ or adolescent care	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Well women's care	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
PRIMARY CARE							
Comprehensive primary care	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Pediatrics	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Adult medicine	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
OB/GYN	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No

Service	Rate the LPHA's ability to provide the service. 1=poor, 3=good, 5=excellent	Rate the priority placed on the service by the LPHA, 1=low priority, 3=medium priority, 5= high priority	Do other organizations in the community offer this service?	If yes, do any of these organizations provide the service to Medicaid and uninsured populations?	If the LPHA stopped providing this service, could a local partner provide it instead?	If so, is there an unmet need in the community?	Would the LPHA consider transitioning this service to another provider?
OTHER SPECIAL SERVICES							
Family support services	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
HIV testing and counseling	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
HIV treatment	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Home health care	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
School-based services	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
STD testing and counseling	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Substance abuse treatment	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
TB treatment	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Women, Infant and Children (WIC) program	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
ENABLING SERVICES							
Case management	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Child care	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Culturally/linguistically appropriate services* (including interpreter services)	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Outreach	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Transportation	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
OTHER					__Uninsured		
Other _____	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Other _____	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No
Other _____	1 2 3 4 5	1 2 3 4 5	Yes No Unknown	__Medicaid __Uninsured	Yes No Unknown	Yes No Unknown	Yes No

* Department of Health and Human Services, Office of Minority Health, created standards for assuring cultural competence in healthcare. (See page 50)

Conclusions

- If an LPHA's ability to provide a service is poor, then the LPHA may not be the most appropriate provider. Other providers in the community might have more energy and resources to devote to the provision of this service and thus have an increased level of performance.
- If an LPHA's ability to provide a service is excellent, then the LPHA might want to consider retaining it. However, other providers might still be able to deliver this service just as well and more cost effectively and efficiently.
- Private providers may have more financial flexibility than government agencies, which are often bound by strict spending regulations (Bechamps et al, 1999). Private providers often have more infrastructure, capacity, and resources for service delivery. However, many private providers are unable to devote individualized attention to patients. In addition, their philosophies might differ from that of the LPHA.
- Any provider to which an LPHA considers transitioning services must be willing to serve Medicaid and uninsured patients and have the ability and infrastructure to support the patient base currently served by the LPHA.
- If the priority the LPHA places on a service is low, then the resources needed to retain this service might not exist. Even if the LPHA ranks a service as a high priority, it is still worth deciding whether it is worth the expenditure of increased time and energy. This is especially true if other providers have the capacity to deliver the service.
- The answers to many of the questions will be different for LPHAs located in communities where there are no other providers that offer one or more of the services listed.
- Other providers in the community might deliver a service but do not and are not willing to provide the service to Medicaid and/or uninsured populations. In this case, it is critical to determine if these populations will have a place to go for care if the LPHA transitions the service. For many LPHAs this is an impetus to find creative solutions, such as bringing a community health center into the area to serve the LPHA population.

If yes is the answer to the question "Would the LPHA consider transitioning this service to another provider?" then complete the *Individual Services Assessment* for this service. This will allow a more-in-depth individual assessment of the service. First, complete the remainder of the *Organizational Assessment.* Then, proceed to the *Individual Services Assessment*.

Stakeholders

Patients

1. Has the LPHA ever conducted surveys (or focus groups, interviews, etc.) of patients to determine their satisfaction with the services they receive (Bartlett et al, 1996)?

- ❑ Yes
- ❑ No

***If yes*, how often does the LPHA conduct patient satisfaction surveys?**

_____

Overall, based on these surveys, are the patients:

- ❑ Dissatisfied
- ❑ Satisfied
- ❑ Very satisfied
- ❑ Do not know

Other items to consider

- Is the LPHA able to attract and retain patients? Why or why not?
- If the LPHA is not able to attract and retain patients, how is this being addressed?

The Mahoning County (OH) District Board of Health started its re-engineering process after patient satisfaction surveys showed clients wanted services that agency clinics could not provide. Utilization data showed that, with an average of <4 prenatal visits per client, the agency was not assuring continuity of care between Board of Health clinics and the private obstetricians who delivered the babies.

Conclusions

- It is important to assess patient satisfaction with each service provided.
- If patients are dissatisfied with one or more services, the LPHA must assess the reasons for the dissatisfaction and make the necessary improvements.
- If the LPHA is not meeting needs, patients may go elsewhere to receive services. This will result in decreased patient revenues.
- If patients are dissatisfied with the LPHA, one option is to transition service(s) to another provider that can meet patients' needs. However, the LPHA must determine if the other provider can provide quality services and increased access to care.
- Patients are important stakeholders in the LPHA's decision-making process. They should be consulted during the process, preferably at the beginning.
- If an LPHA decides to transition services, communicating with patients and community members is important to raise public awareness and increase support of and buy-in for the changes.

Staff

1. **Does the LPHA seek input from staff on strategic planning issues?**
   - ❑ Yes
   - ❑ No

2. **Does the staff support the LPHA's current mission, vision, and values?**
   - ❑ Yes
   - ❑ No

Other items to consider

- Are the employees unionized?
- If yes, how active is the union? Is the union included in all staff-related negotiations?

Conclusions

- Personnel issues can be barriers to change. It is in the LPHA's best interest to include staff in the decision-making process. Their inclusion helps to create more support for whatever decision is made.
- Since staff members are often fearful about how changes will affect their job, rumors need to be confronted and fears allayed through consistent and frequent communication.
- The public sector often provides higher wages and better health and pension benefits than the private sector. LPHAs must address employees' fears that a move to the private sector will result in a decreased quality of life (Bernhardt et al, 2000).
- If the LPHA moves out of direct services, staff may need retraining in population-based services.
- Depending on the political climate, the LPHA might need to consider the presence and influence of unions; they are often a significant force in employee relations. Communicating and collaborating with unions early in the process might be a critical step (Bechamps et al, 1999). (See section on Labor-Management Cooperation.)

LPHA leadership

1. **Does the executive management support/encourage (Nelson et al, 1998):**
   - ____ A vision for improving community health status?
   - ____ Partnerships with internal and external stakeholders?
   - ____ Internal planning?
   - ____ Use of teams?
   - ____ Staff demonstration of leadership in all levels of the organization?
   - ____ Outreach to and involvement of external stakeholders in program planning?
   - ____ Acquisition/dissemination of new ideas from outside and inside?
   - ____ Active collaboration with community partners?
   - ____ Continuous improvement practices in the organization?
   - ____ Thorough analysis of community needs and capacity?

2. **What does the executive management want to see in the LPHA's future?**
   - ____ Move out of direct provision of clinical services and focus on population-based services.
   - ____ Provide direct clinical services when there is no one else to do it.
   - ____ Provide both population-based services and direct clinical services.
   - ____ Other: _____

Other items to consider

- How does the executive management's view influence the decision-making process?

Conclusions

- Management's philosophy is an important factor in the decision. If management feels one way, it will be difficult to move the LPHA in a different direction.
- Good leaders consider the views of key stakeholders, such as staff, politicians, patients, and other community providers, before deciding what is best for the community.
- The executive management's role in the decision-making process is critical to the success of any organizational changes.
- Management should keep an open mind and avoid driving the decision-making process.

History of the Service-Delivery System

1. **How did the LPHA's current level and scope of involvement in providing direct clinical services come about** (University of Washington, 1996)**? Explain the history.**

   _____

   _____

   _____

   _____

New Mexico's local health offices have a long history of providing personal health services, such as well-child checks, family planning, immunizations, adult healthcare services, blood pressure and cholesterol screening, and prenatal care. While providing these services, local health offices provided few population-based services. In the late 1980s, clinic services run by local health offices were cut back, starting with prenatal care and then progressing to other direct clinical services.

2. **Are the reasons for the LPHA's initial involvement in direct service provision still relevant?**
   - ❑ Yes
   - ❑ No

Other items to consider

- Have local politics/preferences played a role in the current level of service provision (University of Washington, 1996)?
- Has the availability of categorical funds played a role in the current level of service delivery (University of Washington, 1996)?

Conclusions

- It is important to consider how the current service delivery system came into being. Years ago, the LPHA might have begun providing services for a reason that no longer exists. External forces, such as politics or market forces at the time, might have been a major influence.
- In the 1960s, with the advent of Medicaid and Medicare, many LPHAs began to provide services or expand their service delivery systems. Also, categorical funding for services such as maternal and child health provided an incentive to begin offering services.
- The LPHA's mission might not have been revisited since services began to be provided.
- Often, the LPHA is so deep-rooted in service delivery that additional options might never have been considered.

Alternatives to Service Delivery

1. Is there a plan to transition any of the LPHA's clinical services to other providers?

❑ Yes
❑ No

***If yes*, describe the plan:**

_____
_____
_____
_____

The Mahoning County (OH) Board of Health belongs to the Mahoning County Child and Family Health Services Consortium, made up of 35 local health and social service providers. The goal is to ensure that low-income children and pregnant women in the county have an ongoing source of primary healthcare, including both preventive and episodic care. The consortium provides an excellent networking opportunity for organizations to share activities and collaborate when appropriate. The Board of Health, realizing the changing health systems environment, decided to consult the consortium about its service delivery system. The consortium endorsed looking outside of the county's usual source of service delivery, which has focused on the operation of clinics. As a result, the Board is providing more financial support to partners, which enables it to concentrate on the core public health functions.

Other items to consider

- Will quality and efficiency be improved if this plan is implemented?
- What are the plan's strengths?
- What are the plan's weaknesses?
- What is the timeline for implementing the plan?

2. What are the pros and cons of retaining the current level of service delivery?

Pros	Cons

3. What are the pros and cons of transitioning one or more direct clinical services?

Pros	Cons

The Tacoma-Pierce County (WA) Health Department started with four assumptions to guide decisions about service delivery:

1 It could more effectively affect health status by focusing on population-based prevention.
2. It was not sufficiently funded to provide both individual healthcare and population-based prevention services.
3. It currently served only a fraction of the county's indigent patients.
4. Private medical providers, disconnected from disease control systems, could become key partners.

From these assumptions, the health department shifted clinical care services to the private sector, created a new disease control system, and built an infrastructure for prevention.

4. Using the list of stakeholders identified in the beginning, complete this table.

Who are the stakeholders that need to approve and support any changes in the LPHA's structure?	When and if the LPHA transitions services, what are the expected reactions of these stakeholders when changes are proposed?	How will the LPHA manage the stakeholders' reactions?

Other items to consider

- What will be the future revenue sources to support population-based services if the LPHA transitions direct clinical services?
- Does the LPHA have funding streams to support population-based activities in the absence of clinical service delivery and Medicaid revenue?
- Which services/programs will be most affected by a change?
- Which stakeholders will be most affected by a change?
- How will the stakeholders be involved in the planning and implementation of the plan?
- What are the short- and long-term goals and expectations if the plan is implemented?

Conclusions

- There are many options to consider when making decisions about service delivery. LPHAs may develop more than one plan for changing the current method of service delivery.
- Scenario development is a popular component of strategic planning for LPHAs. It is important for the LPHA to consider the pros and cons of each plan and predict the consequences if the plans were implemented.
- Key stakeholders, such as staff, local policymakers, and other community providers, need to be considered and included in the decision-making process, preferably in the initial stages to create more support and buy-in.

It is important to remember that transitioning of services is not an all-or-nothing course of action; what might be appropriate for one service may not be appropriate for another. The *Individual Services Assessment* provides an opportunity to assess each service and its potential for transitioning to other providers.

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Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda

Recommended Standards for Culturally and Linguistically Appropriate Health Care Services

Based on an analytical review of key laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations, these proposed standards were developed with input from a national advisory committee of policymakers, providers, and researchers. In the [full report], each standard is accompanied by commentary that addresses its relationship to existing laws and standards, and offers recommendations for implementation and oversight to providers, policymakers, and advocates.

Preamble:
Culture and language have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse populations, health care organizations and providers should:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.

2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.

3. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training and, as appropriate, treatment planning.

4. Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.

5. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.

6. Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.

7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.

8. Translate and make available signage and commonly-used written patient educational material and other materials for members of the predominant language groups in service areas.

9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.

10. Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff.

11. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

12. Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs.

13. Develop structures and procedures to address cross-cultural, ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services.

14. Prepare an annual progress report documenting the organizations' progress with implementing CLAS standards, including information on programs, staffing, and resources.

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Individual Services Assessment

Once the Organizational and Community Assessments have been completed, return to the "Current Services" table in the *Organizational Assessment* to select services to consider for transitioning to other providers. Complete an *Individual Services Assessment* for each of the services selected.

Purpose

Questions in this section are similar to those in the previous two sections. However, the focus here is on the individual service rather than the LPHA.

- For each service, questions about finances and the availability of other community providers help to assess whether it is in the best interest of the LPHA and the community to retain this service in the public sector or to transfer it to another provider.
- If the decision is to transition the service out of the LPHA, then the decision-making team can begin to consider how to do so and where the service should be located.
- If the decision is to retain the service, the LPHA should consider contacting any of the LPHAs listed in Appendices B, C, and D that made similar decisions.

Timeline

- LPHAs that have a sophisticated accounting system will have an easier time collecting information on revenues and expenditures associated with an individual service.
- Organizations knowledgeable about their communities will be able to identify potential partners quickly.
- The timeline will differ depending on the number of services to be transitioned.

Participants

The decision-making team will play a vital role in completing this section.

- Also include the management of the LPHA and the staff currently providing the service being assessed.
- As appropriate, bring in representatives from potential partner organizations to discuss the feasibility of transitioning the service to them.
- Include LPHA accounting staff and those in charge of the program's budget to ensure an accurate financial picture of the service.
- Bring in members of the larger planning team and outside consultants as needed.

Components

The Individual Services Assessment has three main components:

Financial Resources — By considering the budget, staffing, and sources of funding for the service, the LPHA can begin to develop a financial profile and identify trends. A cost analysis of expenditures and revenues can help determine the dependency of the service on Medicaid revenue and the ability of the LPHA to compete in this market.

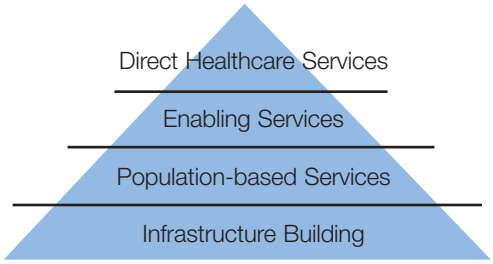
Other Providers/Partners — This is where the LPHA identifies the other providers in the community that also offer this service, determines whether they offer services to Medicaid and uninsured populations, and assesses the motivation and outcome of doing so. The LPHA can consider other organizations' willingness and ability to take on the LPHA's role in delivering this service if necessary. Similarly, the LPHA should consider its partnerships related to this service.

The Decision — In this section, the LPHA begins to examine the possible consequences of either retaining or transitioning the service. A Decision Tree is included to help reinforce a decision that the LPHA is already considering. Upon completion of this section, the LPHA will have a much clearer idea about whether it makes more sense to transition to other available, appropriate, and willing partners or to continue providing this service to the community.

Complete the following assessment for each service being considered for transfer to another provider. Make as many copies of the assessment as needed.

Program/Service : _____

1. **What type of service is this?**
   ____ Direct healthcare service (e.g., prenatal care, child health)
   ____ Enabling service (e.g., case management, home visiting)
   ____ Population-based service (e.g., health education, immunization)
   ____ Infrastructure building (e.g., applied research, quality assurance)



The Mahoning County (OH) Board of Health used the Public Health Pyramid to guide the distribution of resources among public health services. Findings showed that most spending occurred at the top half of the pyramid, i.e., for direct care and enabling services. Little was spent on the bottom half of the pyramid, i.e., population-based services and public health infrastructure. With the "pyramid" approach, the idea is for an agency to allocate most of its resources to the larger (bottom) half of the pyramid, which includes population-based services (e.g., health education and promotion, outreach, screening) and infrastructure (e.g., community health assessment and planning, monitoring of health outcomes, policy development, quality assurance). Mahoning County identified the need to broaden the base of the pyramid and reallocate resources to the core public health functions of assessment, assurance and policy development.

The Jefferson County (AL) Department of Health used a process called Q-sort to assess the importance of each of its programs. Q-sort is a "ranking procedure that forces choices along a continuum where the difference between the choices is quite small" (Duncan et al, 1998). Each participant sorted 77 of the organization's programs based on perceived relative importance and ranked them from most to least important. In most cases, the lowest priorities were transitioned out of the health department. The priorities revealed by the Q-sort prompted a restructuring of the health department in which community services were separated from personal health services and resources were redistributed accordingly.

Financial Resources

Expenditures

1. **What were the LPHA's total operating expenditures for this service during the last fiscal year?**

   $_____ Year:_____

2. **Approximately what percentage of the LPHA's budget was expended on this service during the last fiscal year?**

   _____% Year: _____

3. **During the last 3 years, has the above percentage:**
   - ❑ Increased
   - ❑ Decreased
   - ❑ Remained the same

   ***If increased or decreased,* explain why:**

   _____

   _____

   _____

4. **What type of budgeting system does the LPHA use?**
   - ❑ Zero-based budget
   - ❑ Program budget
   - ❑ Line-item budget
   - ❑ Other: _____

5. **What were the total expenditures of the service in the last fiscal year?**
   - ❑ Personnel services: _____
   - ❑ Other than personnel services: _____

6. **During the last 3 years, has the above percentage:**
   - ❑ Increased
   - ❑ Decreased
   - ❑ Remained the same

   ***If increased or decreased,* explain why:**

   _____

   _____

   _____

   Is the trend expected to continue or change during the next 5 years?
   - ❑ Continue
   - ❑ Change
   - ❑ Unsure

7. **Does the LPHA know the per-unit cost for the service?**
   - ❑ Yes
   - ❑ No

   ***If yes*, how much is it?** _____

   How was the cost determined?

   _____

   _____

   _____

8. **Does the LPHA charge for the services associated with the program?**
   - ❑ Yes
   - ❑ No

   ***If yes*, how were these charges established?**

   _____

   _____

   _____

***If no*, are there any regulatory constraints regarding service charges?**

❑ Yes
❑ No

9. Does the LPHA know what other organizations charge for the same service?

❑ Yes
❑ No

***If yes*, is the LPHA's pricing structure competitive?**

❑ Yes
❑ No

10. Could cost savings be implemented without negatively affecting patient care?

❑ Yes
❑ No

Program resources/revenue

1. How many Full-time Equivalents (FTEs) support this service?

_____ FTEs

Break down the number of FTEs by position.

Position	FTEs
Biostatisticians	
Certified nurse-midwives	
Dentists	
Other dental workers	
Dieticians/nutritionists	
Environmental scientists/engineers	
Epidemiologists	
Health educators	
Health information systems specialists, computer specialists	
Health service managers or administrators, health director (including top agency health official)	
Laboratory specialists	
Nurses – registered/licensed	
Nurse practitioners	
Nursing assistants	
Occupational safety and health specialists	
Physician assistants	
Physicians	
Policy analysts	
Psychologists	
Social workers	
Other mental health providers	
Other:_____	
Other:_____	

2. Specify/estimate the resources provided to this service in the last fiscal year (NACCHO, 1995).

Source	Total dollar amount	Percentage of the budget for this service	If this service is transitioned, will the LPHA be able to use all or part of this funding source to support another activity?
Local	$	%	Yes No Unknown
State (non-Medicaid)	$	%	Yes No Unknown
Federal (non-Medicaid)	$	%	Yes No Unknown
Medicaid revenue	$	%	Yes No Unknown
Medicare revenue	$	%	Yes No Unknown
Other third-party payers	$	%	Yes No Unknown
Self-pay	$	%	Yes No Unknown
Fees and fines	$	%	Yes No Unknown
Private grants (corporations and foundations)	$	%	Yes No Unknown
Charitable contributions	$	%	Yes No Unknown
Other (specify) _____	$	%	Yes No Unknown
Other (specify) _____	$	%	Yes No Unknown
Other (specify) _____	$	%	Yes No Unknown

3. Do these funding sources cover the costs of providing the service?

❑ Yes
❑ No

***If no,* explain:**

_____

_____

_____

4. Does the LPHA use the extra Medicaid revenue obtained from providing this service to support other activities, such as population-based services and care for the uninsured?

❑ Yes
❑ No

***If yes*, what services/programs/activities (performance of population-based services, less profitable services, uninsured patients) depend on this revenue?**

_____

_____

_____

Other Items to Consider

- If this service is reimbursable by Medicaid, what are the reimbursement rates (Reid et al, 1998)?
- Are changes likely to occur in these rates or in the Medicaid program that will affect this service? What will be the effect of these changes on the service?
- Can the LPHA provide this service for less cost than the competitors and with better outcome (Reid et al, 1998)?

Conclusions

- It is difficult to make resource and policy decisions without knowing the costs of providing specific services.
- For advocacy purposes, it is helpful to estimate how much money will be saved by transitioning a particular service to another healthcare provider.
- Knowing the amount of money spent on public health activities makes it easier to advocate for resources and decide how resources should be allocated (ASTHO, NACCHO, NALBOH, and PHF, 2000).
- Collecting data on the costs of service provision not only helps identify areas of efficiency but also helps demonstrate the value of public health to the community (Leviss, 2001).

Other Providers/Partners

For the questions in the following table, it might be helpful to consider the following types of providers/agencies (NACCHO, 1995):

- Other LPHAs
- State health department
- Hospitals
- MCOs/HMOs
- Community health centers/migrant health centers
- Private physicians
- Universities/academic health centers
- Community-based organizations
- Faith communities
- Other voluntary/non-profit organizations

1. Complete the following table.

What other providers offer the same service? List in order of the proportion of care to the community. Limit the number listed.	Does this provider offer services to Medicaid populations?	Does this provider offer services to the uninsured?	If yes, how well does this provider offer services to the uninsured?	Does this provider have a mission similar to the LPHA's mission?	Rate the provider's ability to perform this service. 1=poor, 3=good, 5=excellent	Does the LPHA have an informal or formal (contractual) relationship with this provider?	Rate the LPHA's relationship with this provider 1=poor, 3=good, 5=excellent
	Yes No Unknown	Yes No Unknown	Very Well OK Not well at all Unknown	Yes No Unknown	1 2 3 4 5	Yes No Unknown	1 2 3 4 5
	Yes No Unknown	Yes No Unknown	Very Well OK Not well at all Unknown	Yes No Unknown	1 2 3 4 5	Yes No Unknown	1 2 3 4 5
	Yes No Unknown	Yes No Unknown	Very Well OK Not well at all Unknown	Yes No Unknown	1 2 3 4 5	Yes No Unknown	1 2 3 4 5
	Yes No Unknown	Yes No Unknown	Very Well OK Not well at all Unknown	Yes No Unknown	1 2 3 4 5	Yes No Unknown	1 2 3 4 5
	Yes No Unknown	Yes No Unknown	Very Well OK Not well at all Unknown	Yes No Unknown	1 2 3 4 5	Yes No Unknown	1 2 3 4 5
	Yes No Unknown	Yes No Unknown	Very Well OK Not well at all Unknown	Yes No Unknown	1 2 3 4 5	Yes No Unknown	1 2 3 4 5
	Yes No Unknown	Yes No Unknown	Very Well OK Not well at all Unknown	Yes No Unknown	1 2 3 4 5	Yes No Unknown	1 2 3 4 5
	Yes No Unknown	Yes No Unknown	Very Well OK Not well at all Unknown	Yes No Unknown	1 2 3 4 5	Yes No Unknown	1 2 3 4 5
	Yes No Unknown	Yes No Unknown	Very Well OK Not well at all Unknown	Yes No Unknown	1 2 3 4 5	Yes No Unknown	1 2 3 4 5

Other Items to Consider

After developing a list of healthcare providers in the community and reviewing their services, take these steps to identify potential partners (Orlando and Leviss, 1999):

- Find out if any other providers are expected to provide this service in the near future.
- Find out if the LPHA expects to collaborate with other partners on this service in the near future.
- Develop a list of evaluation criteria for selection of providers.
- Develop an outline of services to be transferred.
- Hold preliminary discussions with providers to determine their interest and willingness to provide services, their capacity to provide services, and other relevant information. Assess if these providers can deliver the service more cost effectively, with improved quality and increased continuity of care, compared to the LPHA.
- If a contract is necessary, draft a request for proposal.

Decision Tree

The next step is to complete a *Decision Tree*. This is an abbreviated decision tool. The questions have been identified by local health officials as those most critical to the decision-making process. Points are listed next to each response. At the end of the questionnaire, add up the points, and divide by the number of responses. Use the scale at the end to score the results. Ideally, the *Decision Tree* should be completed after the *Community Assessment* and *Organizational Assessment*. However, many LPHAs have already participated in a comprehensive assessment process. Therefore, this might be all that is needed to reinforce a decision about a particular service.

Mission

1. Do any externally imposed mandates require the LPHA to provide direct clinical services?

- ❑ Yes (0)
- ❑ No (6)

***If yes*, consider the possibility of changing these mandates. If that cannot be done, then the LPHA will not be able to transition services at this time.**

2. Does the LPHA's mission state that the agency should provide direct services, including acting as a provider of last resort?

- ❑ Yes (0)
- ❑ No (5)

3. How important is this service in fulfilling the LPHA's mission?

- ❑ Very important (0)
- ❑ Moderately important (1)
- ❑ Not very important (2)
- ❑ Not important at all (4)

Provider capacity

1. How much is this service needed in the community?

- ❑ Very much (0)
- ❑ Somewhat (2)
- ❑ Not at all (4)

2. How many other providers in the community offer this service to the population served by the LPHA (Medicaid, uninsured, underinsured)?

- ❑ Many (5)
- ❑ Some (3)
- ❑ A few (2)
- ❑ None (0)

2. Do one or more providers in the community have or potentially have the infrastructure and capacity to support the LPHA's patient base if this service is transitioned?

- ❑ Yes (4)
- ❑ No (0)

3. How willing are other providers to take on the LPHA's patient base if this service is transitioned?

- ❑ Very willing (5)
- ❑ Somewhat willing (3)
- ❑ Unwilling (0)

4. What is the level of expertise of other providers in relation to the provision of this service to low-income populations?

- ❑ High level of expertise (5)
- ❑ Some expertise (3)
- ❑ Low level of expertise (1)
- ❑ No expertise (0)

Financial assessment

1. In the last 2 years, what percentage of the LPHA's Medicaid patients who use this service were redirected to Medicaid managed care or other private providers?

- ❑ None (0)
- ❑ <10% (2)
- ❑ 10%-25% (3)
- ❑ 26%-50% (4)
- ❑ >50% (6)

2. In the last 2 years, what has happened to the amount of Medicaid revenue received from the provision of this service?

- ❑ Large decrease (>50%) (6)
- ❑ Moderate decrease (25%-50%) (4)
- ❑ Small decrease (<25%) (2)
- ❑ No decrease (1)
- ❑ Increase (0)

3. How adequate are the resources used to cover the cost of providing this service?

- ❑ Very adequate (0)
- ❑ Adequate (1)
- ❑ Inadequate (3)
- ❑ Very inadequate (5)

4. Can other providers offer this service for less cost than the LPHA?

- ❑ Yes (4)
- ❑ No (0)

5. Does the LPHA use the excess revenue (e.g., Medicaid revenue) obtained from providing this service to support other LPHA activities (e.g., population-based services, less profitable services, services to uninsured patients)?

- ❑ Yes (0)
- ❑ No (4)

6. How flexible are the funding sources that support this service?

- ❑ Very flexible (funds can be used to support other activities if necessary) (4)
- ❑ Flexible (part of the funds can be used to support other activities if necessary) (2)
- ❑ Inflexible (funds can be used only for this service; funding will be lost if the service is transferred) (0)

Population-based services

1. How much additional time and resources would the LPHA like to allocate to the provision of population-based services and the 10 essential services?

- ❑ Much more (6)
- ❑ Some more (4)
- ❑ A little more (2)
- ❑ None (0)

2. **If this service is transitioned, what will be the impact on the LPHA's ability to provide population-based services and perform the 10 essential services?**
   - ❑ Very positive (6)
   - ❑ Positive (5)
   - ❑ None (3)
   - ❑ Negative (1)
   - ❑ Very negative (0)

Stakeholders

1. **As a whole (based on customer satisfaction surveys), how do LPHA clients rate their satisfaction with this service?**
   - ❑ Very satisfied (0)
   - ❑ Satisfied (1)
   - ❑ Dissatisfied (2)
   - ❑ Very dissatisfied (4)

2. **How strongly do local policymakers support the provision of direct services by the LPHA?**
   - ❑ Very strongly (0)
   - ❑ Strongly (1)
   - ❑ Somewhat strongly (2)
   - ❑ Not strongly at all (4)

3. **How strongly do LPHA staff support the provision of direct services by the LPHA?**
   - ❑ Very strongly (0)
   - ❑ Strongly (1)
   - ❑ Somewhat strongly (2)
   - ❑ Not strongly at all (4)

4. **How strongly does the community support the provision of direct services by the LPHA?**
   - ❑ Very strongly (0)
   - ❑ Strongly (1)
   - ❑ Somewhat strongly (2)
   - ❑ Not strongly at all (4)

5. **How strongly does the state health department encourage service delivery by the LPH**A?
   - ❑ Very strongly (0)
   - ❑ Strongly (1)
   - ❑ Somewhat strongly (2)
   - ❑ Not strongly at all (4)

6. **How strongly do other key stakeholders support the provision of direct services by the LPHA?**
   - ❑ Very strongly (0)
   - ❑ Strongly (1)
   - ❑ Somewhat strongly (2)
   - ❑ Not strongly at all (4)

Scoring

If the score averages between 4 and 6:

- The results support a decision to transition the service to another provider. A transfer of services would likely be in the best interests of the LPHA, patients, and community.

If the score averages between 2 and 4:

- Before completing the *Decision Tree*, the LPHA may have decided to transition this service. Although it is possible to do so, some work and time are needed to discuss and address the questions scored between 0 and 2.

If the score averages between 1 and 2:

- The results support a decision to retain the service. Based on the responses, it seems in the best interests of the LPHA and the community to retain this service in the public sector. The decision can, however, be reconsidered at another time, especially as the healthcare environment changes.

Conclusion

The *Decision Tree* is a simple instrument that is designed not as a standalone tool but rather as a mechanism to reinforce a decision that the LPHA has already made. If several services are being considered for transfer, the *Decision Tree* may help to determine the order of the transfer. For example, the LPHA may want to transition services that averaged the highest scores first.

The Decision

Before deciding which services to transition, the Dutchess County (NY) Department of Health evaluated each service based on:

- Community need
- Current enrollment
- Community/provider capacity to provide the service
- Strengths and weaknesses of various options
- Cost analysis
- Political impact
- Fit with core public health functions

Before deciding which services to transition, Public Health-Seattle and King County (WA) assessed each clinical service based on:

- Public health impact
- Level of unmet need
- Capacity of other community-based providers to serve that need
- Economic efficiency of the delivery model
- Maximum capacity to leverage resources to serve this need
- Political/community support for the service

1. **Based on the information from the *Decision Tree* and the other two assessments, should the LPHA retain this service?**
   - ❑ Yes
   - ❑ No
   - ❑ Unsure

   ***If yes*, to what degree or level should this service be retained?**
   - ____ Make no changes
   - ____ Maintain current level and develop collaborations for provision of the service
   - ____ Partial divestiture (e.g., limit scope of service, no agreement with other providers)
   - ____ Limit scope of service, agreement with other providers
   - ____ Increase provision of the service
   - ____ Other: _____

Other Items to Consider

- What would be the value added (e.g., to the LPHA, community and political environment) in retaining this service?
- What opportunities would be lost by retaining this service (Guarino, 1997)?

***If no*, to what degree or level should this service be transitioned?**

____ Eliminate/consolidate health department into integrated corporate structure
____ Complete divestiture (eliminate service, no agreement with providers)
____ Eliminate service, agreement with other provider for full scope of service
____ Partial divestiture (limit scope of service, no agreement with other providers)
____ Limit scope of service, agreement with other providers
____ Other: _____

Other Items to Consider

- If this service is eliminated or decreased, how will the change affect the community?
- How will agency staff be affected? Will their responsibilities, wages, and benefits change as a result of the transition?
- What will be the political impact of transitioning?
- What are the possible consequences to the LPHA if this service is transitioned?
- How will the change deter or encourage adherence to the departmental mission?
- How will the change affect the LPHA's vision?
- What will be the future sources of revenue to support population-based services if the LPHA transitions this service to another provider?
- How will the change be accepted publicly and politically in the long run?

Conclusions

Hopefully, after completing the *Community, Organizational,* and *Individual Services Assessments*, the LPHA feels confident about the decision to either transition or retain particular services.

- If the decision is to retain the service, the decision may need to be revisited as the healthcare environment continues to change. Even though the LPHA is retaining the service, it may decide instead to make changes in the way the service is delivered. The best source of support and technical assistance will come from LPHAs that have made similar decisions. See the case studies in Appendices B, C, and D for examples of LPHAs that decided to retain their services. All of the contact persons listed have agreed to share any advice or lessons learned to help others.
- If the decision is to transition one or more services to another provider, it is now time to decide how to do so most effectively. Continue to the Transitioning Section for suggestions for developing a work plan, engaging the community, developing community and political will, locating resources to support population-based activities, and carrying out other steps in the transitioning process.

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Developing a Work Plan

By reading this chapter, you will learn more about:
1. How to develop a work plan to guide you through the transitioning process.
2. How to create a purpose statement to articulate what will occur.
3. How to develop a communication plan for internal and external audiences.

After completing the *Decision Tool*, the local public health agency (LPHA) will have a much clearer vision of where it is headed and whether or not to transition services to other healthcare providers. If the decision is to transition one or more services, then a reasonable first step is to develop a work plan. The work plan will specify the agreed-upon steps of the transition for the team members and communicate the details of the process to staff members.

This section describes the components of a work plan. These components were derived from the experiences of local health officials and others who have transitioned services. Depending on the timing of the transitioning process, separate work plans may be needed for each service. Although most components of the work plan will be uniform across services, some services may require unique action steps.

Develop a Purpose Statement

The purpose statement articulates the LPHA's decision about the transfer of services. The team that participated in the decision-making process is best equipped to develop the purpose statement, with consultation from the larger planning group, LPHA staff, partner organizations, policymakers, and other interested parties.

1. The purpose statement should:
   - Identify which services are being transitioned and where.
   - Discuss planned organizational changes and the effect on the LPHA.
   - Communicate the LPHA's future role, function, and organization.

2. Ensure that the purpose statement is in line with the LPHA's mission
   - Revise the mission statement as needed to reflect the LPHA's future role, functions, and structure.
   - Throughout the transitioning process and beyond, re-examine the mission statement and revise it as needed, based on the LPHA's changing situation and focus.
   - Remember that the purpose statement is not written in stone and may change as the process evolves. Be flexible, and allow for necessary changes.

Identify Stakeholders/Partners

1. Identify persons who will have a stake in the transitioning process. Stakeholders are persons, groups, or organizations that can "place a claim on the organization's resources, attention, or output, or [are] affected by its output" (Bryson, 1995). Partners are stakeholders with whom the LPHA has a more formal working relationship. Key partners are the organizations to which services will be transitioned.
   - Consider the needs of both internal stakeholders (e.g., staff, patients) and external stakeholders (e.g., policymakers, partner organizations, union representatives, community members, attorneys).
   - Many of the stakeholders will be similar to those identified during the decision-making process; however, other stakeholders may need to be considered as well. In addition, some stakeholders may no longer need to be involved in the process.
   - Stakeholders will differ depending on the service being considered.

2. In identifying stakeholders, think in terms of specific arenas. For example, consider who in the political, community and health/medical realms should be included.

The Boulder County (CO) Health Department realized the importance of identifying organizations to which they were referring patients for a particular service. These organizations needed to be included as stakeholders in the transitioning process because they would be affected when the LPHA stopped referring patients. Also, the health department gained insight by including staff at all levels, not just management. Staff members will have the ultimate stake in the process, especially given the effect of the transition on their roles and responsibilities.

3. Once internal and external stakeholders have been identified, consider the following questions (Bryson and Alston, 1996):
   - How will each stakeholder evaluate the performance of the organization?
   - How will each stakeholder influence the organization?
   - What does the organization need from each stakeholder?
   - How important are the stakeholders to the organization's functioning?
   - Which stakeholders should be involved in the transitioning process? How and when should they be involved?

4. Communicate the purpose statement, the rationale for the transitioning decision, and the LPHA's mission, vision, and strategic direction to the stakeholders. Institutionalize a continuing effort to inform stakeholders of the LPHA's actions and strengthen buy-in and support for proposed changes.
   - Resistance from stakeholders can be a barrier to change. Communicating with them from the start helps to thwart potential problems.
   - The hope is that, by understanding the rationale for change, stakeholders will support the need for change.

5. Communicate with stakeholders in a language understood by all. Clarify terminology, as the group requires. Be aware of different backgrounds and perspectives.

The Southwest Washington (WA) Health District realized that, to achieve its goal of a new health department structure, four key groups needed to be involved: the board of health, staff members, the union, and leaders in the provider community. If the restructuring was to be successful, board members had to understand the need for change and support the reorganization. Changes could not be planned or implemented without staff involvement and support. Based on a historically good relationship with the union, the health department knew that it could count on union support. As the restructuring began to take shape, the major healthcare providers in the community were identified as potential sources of support (Milne, 1997).

Identify a Transition Team

1. Form a transition team made up of LPHA management, staff representatives, representatives from partner organization(s), and a few additional stakeholders. This is one way to gain a variety of perspectives while maintaining a manageable size and structure.
   - Include representatives from the organizations that will be taking over the service.
   - The makeup of the transition team will vary depending on the service being transitioned.

2. Select participants who provide needed resources and expertise and represent perspectives that are critical to the success of the process. To establish continuity, include key members of the decision-making team.

3. Before recruiting team members, decide on the number of participants desired and their roles.

4. As needed, form a larger planning committee to provide additional resources and technical assistance. This group may be similar to the decision-making team. Members of the larger planning committee may be an excellent source of funding for the transition.

5. Once members have been identified to serve on the transition team, assess their expectations, enthusiasm, long-term availability, interest, and time constraints to ensure a continued commitment to the process.

6. Identify a team leader. Ideally, the leader should be knowledgeable about the LPHA and about organizational change. Most important, the leader should be committed to the process.

7. Include different persons at various stages in the transitioning process as necessary. Add members when specific expertise is needed. (See the section on Technical Assistance Resources.)

In Fort Worth, Texas, the Health Department's transition team consisted of the city manager, acting public health director, LPHA financial officer, assistant director of public health, deputy city attorney, and city budget analyst. Additional persons were brought in as needed throughout the process. For example, a subteam on human resources, consisting of human resources staff from the partner organization and LPHA, made decisions on personnel issues related to the transitioning of services.

8. As needed, involve the broader community through focus groups, meetings, and other mechanisms.

Develop Steps and Timetables

1. Identify the roles, responsibilities, and most appropriate persons to perform the tasks in the transitioning process.
   - Although the transition team is ultimately accountable for completion of these tasks, enlist additional staff as needed.
   - Enlist members of the larger planning team and outside consultants as needed.

The Boulder County (CO) Health Department realized the difficulty in involving clinicians in the transitioning process due to their time limitations and competing responsibilities. The health department also recognized the importance of including service providers in the discussion given their medical expertise. Staff meetings served as an excellent mechanism for communicating and gathering feedback from clinicians.

2. Ask the following questions about each task (Himmelman, 1996):
   - How should we complete this task?
   - What resources do we have to complete it?
   - Who should be involved in getting it completed?
   - What should be the timeline?
   - How will we know when it has been completed?

3. Develop a timeline specifying all tasks, the persons responsible for each task, the time required for each task, and the target completion date. The timeline should be developed by the transition team, with consultation from the persons who will be performing each task.

4. Post a master calendar in a visible location. The calendar will keep staff informed of what is happening and hold persons accountable for their tasks.

5. Develop a list of short-, intermediate-, and long-term plans, as appropriate.

6. Individualize the timeline, based on the service being transitioned.

Involve the Community

1. Community support is crucial to the smooth transition of services to other providers and to creating change and improving health.

The health official in DeKalb County (GA) wanted the provision of public health services to be a community venture. He decided to go beyond the health department and involve the community. He accepted every opportunity to speak to community groups, often in forums or breakfast clubs. He shared data on the community's health status and informed community members about what was occurring in terms of public health. The health department maximized the use of print, radio, and television to spread the public health message. Health department staff emphasized that the community's health status was the responsibility of many different sectors and highlighted model ventures. Each encounter with an individual or group was an opportunity to sell the importance of public health. By being persistent, positive, and patient, they were able to develop a constituency. The hope was that an informed and organized public would contribute positively to the health status of the community (Wiesner, 1997).

2. Organizational performance and community health improvement depend on the support of the community. Plan to spend a significant amount of time building community constituencies and evaluating and improving their involvement (Hatcher and Nicola, 2001).

3. Increase communication to constituents to decrease anxiety and facilitate LPHA reorganization processes. See Appendix A for references on community involvement and support.

The National Public Health Performance Standards Program (CDC and NACCHO, 2000) includes several indicators for mobilizing community partnerships to identify and solve health problems. The model community standards consist of:

- Developing a media/communications strategy to inform stakeholders about the benefits of public health and their role in the community, and using formal mechanisms or events such as councils, newsletters, and town meetings to facilitate communication among organizations.
- Maintaining a comprehensive directory of stakeholders, and strengthening linkages with these organizations/persons.
- Obtaining feedback from constituents (via online resources, community meetings, ballot votes, surveys, focus groups), and communicating information to community officials.

Develop Partnerships

1. Establish a clear partnership agreement with the organization(s) to which services will be transferred. Partnerships can be either non-contractual or contractual, depending on the needs of the partnership and the goals and objectives stated in the work plan. See section on Transitioning Models.

2. Develop protocols for interorganizational communication, information sharing, and data exchange.

3. Ensure that partners understand the need to continue to devote time and energy to the partnership to achieve success. See the section on Developing Partnerships and Appendix A.

Address Conflict

1. Some persons may take issue/disagree with the LPHA's message or find it offensive in some way. Take steps to understand the disagreement and the source of the conflict. Try to establish communication with those who oppose the LPHA's plans. Ask the following questions when conflict arises:
   - Are disagreements based on political and/or philosophical differences? Or, are they based on the wording or presentation of the message?
   - Does the opposition feel that the message is unfair to a particular group or that it misstates an issue?
   - Can the message be changed to respond to these concerns?
   - Can the LPHA respond to the concerns without compromising its goals or principles?
   - What, if any, points are agreed upon?
   - Can the LPHA and the opposing faction(s) work together in some ways?
   - What are the consequences of continued disagreement?

   See Appendix A for references on conflict resolution.

2. If the differences are not resolvable, be sure to state the LPHA's point of view clearly and correctly. Ask persons with status or credibility in the community to state the LPHA's position. Continue to treat the opposition with respect. Concentrate on conveying the LPHA's message to its supporters.

According to the Manager's Electronic Resource Center (2001) operated by Management Sciences for Health — www.erc.msh.org/planning/ — a work plan should identify:

- The problem or need that the partnership will address and the expected outcome
- Goals and objectives of the partnership and the timeframe for achieving them
- General activity plan for the partnership's term, including how activities will be carried out, who will be responsible for each, and when each major activity will be completed
- Plan for monitoring progress and evaluating outcomes
- Reporting plan and schedule, including how finances will be handled
- Projected budget for at least the first year and a summary budget for the length of the partnership.

Address Fiscal/Budgetary Considerations

1. Determine how the LPHA will pay for the transitioning process. Consider the resources needed, including staff time, consultant fees, data collection, information gathering, and meeting space.
   - The budget will depend on the timeline, the number of participants, and the information and technical assistance available. Securing resources from all partners as needed is a sign of their commitment to the process.
   - Refer to the financial information collected as part of the *Organizational Assessment*.
   - Determine whether the transfer of a service will be cost saving to the LPHA. This information will help gain support from key stakeholders.

2. A transition budget needs to include the costs of: contract monitoring, legal assistance, outside consultants, employee assistance programs, and staff retraining. The budget also needs to reflect any exchange of money between the LPHA and the partner organization(s).

3. To forecast revenue, determine when changes in revenue will occur and the extent to which revenue will drop when the service is transitioned to another provider. For example, when Medicaid patients are transitioned to another provider, Medicaid revenues are lost. When revenues decrease, so do costs.
   - If revenues from the transitioned service support core public health functions, the LPHA will have to find another source of funding to support these activities (Milne, 1997). (See section on Funding Ideas to Support Population-Based Activities and Appendix A for related references.)

4. As necessary, negotiate with funders about the use of resources.
   - The LPHA may be able to use funds earmarked for direct services to support population-based activities. If the funding is not flexible, however, then the LPHA should consider it lost when the service is transitioned and plan accordingly.
   - The state health department may be able to secure some funding for the LPHA. For example, there may be flexibility in the Maternal and Child Health (MCH) Block Grant or the Preventive Services Block Grant to support the 10 essential services. (See section on Funding Ideas to Support Population-Based Activities and Appendix A for references on expenditures/financial resources.)

The Tacoma-Pierce County (WA) Health Department found resources to support the transitioning of services. The health department de-layered its divisional structure, which resulted in a savings of 40%. The health department reduced the number of divisional managers and section managers and compressed seven levels of management to four. By reducing the administrative overhead, money was freed up to pay for the re-engineering. Costs associated with transitioning included furniture, equipment, site rentals, computers, software, training, legal services, and severance pay. The privatization of services saved millions of dollars for the health department (Cruz-Uribe, 1999).

Address Personnel/Human Resources Issues

Personnel issues (e.g., union negotiations, employees' resistance to change) are the most common barriers to transitioning. Staff members become concerned about changes in their job responsibilities, especially if they fear their positions are in jeopardy.

1. Identify staff members who are most vulnerable to the change in service delivery. Service providers, especially nurses, are often most affected; their job responsibilities will likely become more population-focused, and they will need retraining to perform their new responsibilities. (See Appendix A and the section on Workforce Development.)

2. Organized labor's effect on the LPHA's decision and on personnel changes can significantly influence the transitioning process. Therefore, including union representatives in the process is important. In negotiations with the union, it might be possible for the LPHA to avoid or minimize any layoffs of staff or to find additional opportunities for staff in the community. Collective bargaining and relationship-building will significantly aid the process (Bechamps et al, 1999). (See section on Labor-Management Cooperation.)

By working with the union, the Southwest Washington (WA) Health District was able to minimize layoffs associated with transitioning. LPHA administration and staff collectively decided to: 1) search for new revenue sources, 2) offer voluntary furloughs, and 3) reduce hours for all union and management staff. If these steps did not address the fiscal problems, then the union and health district agreed that layoffs would occur. Both the union and staff were pleased with management's pledge to share in the reduction of hours. Existing staff ended up filling all of the new positions in the health department, and the proactive response minimized layoffs (Milne, 1997).

3. Rumors of transitioning generate fears about job security and hinder organizational change. The public sector often provides higher wages and better access to health and pension benefits than the private sector. De-unionization is also an issue. Address employees' fears that a move to the private sector will result in decreased quality of life. Consider the following questions:
   - Will workers lose their jobs?
   - How will salaries and benefits change?
   - Will staff have adequate training to handle new responsibilities?

4. Strive to keep personnel in place through retraining and other creative alternatives. If staff must be laid off, help employees find other opportunities. For example (Milne, 1997):
   - Establish a job bank of opportunities in the community.
   - Institute a hiring freeze.
   - Provide retirement incentives.
   - Establish formal agreements with partnering organizations to require them to take on former LPHA employees and provide them with similar benefits and salaries.
   - Assure staff that, once positions open up in the LPHA, they will be the first to be considered. Reorganization may also open up new positions in the LPHA.

The Atlantic City (NJ) Health Department developed a contract requiring their partner organization to employ 34 former health department employees. However, after just one year, 75% of the employees left because of reduced benefits or philosophical differences (Bechamps et al, 1999).

5. Employees will experience issues of grief and loss even if they do not lose their jobs. Many will face dramatic changes in their job descriptions and responsibilities.
   - Institute an employee-assistance program to provide counseling and support through the transition.
   - The book *Managing Transitions* is an excellent resource for employees who are grappling with organizational change. It provides specific concrete steps for dealing with this change (Bridges, 1991). (See Appendix A for additional references on organizational change.)

6. Develop a staff communications plan to encourage effective communication mechanisms and gain staff buy-in and support. Keep staff fully informed of the transitioning process. When possible, involve them in implementing changes.
   - Provide opportunities for employees to engage in dialogue about transitioning issues.
   - Hold ongoing meetings with staff to update them on the process.
   - Consider other communication mechanisms, such as newsletters, staff retreats, brown bag meetings, and informal discussions (Milne, 1997).

The Boulder County (CO) Health Department identified staff members who would be most affected during the transition. Each staff member met with a representative from Human Resources and a member of the transition team to discuss the employee's job preferences, provide an update on the transitioning process, inform the employee about training programs, and explain benefits such as the employee-assistance program. Subsequent meetings kept each employee updated on the current situation and the available choices and opportunities. Although some staff left for other opportunities, most employees remained with the health department or transferred to the partner organizations.

Develop a Communication Plan

1. Communication with internal and external audiences about changes in the LPHA's role and structure needs to happen from the beginning. Therefore, mechanisms to do so need to be planned. External audiences include patients, partners, community members, and politicians. It is important to get the message out so that at any point in time people know where the LPHA is in the process. Also, since the content and delivery of the message is important, it is critical it be tested on a sample audience.
   - A point person or team of people in the LPHA should handle all communications to ensure a consistent message is being articulated to key stakeholders. It is important the LPHA control all of the messages that go out to the community in order to maintain consistency.

2. Notify all appropriate community organizations of the transition plan. These entities also have some responsibility for the health of a community, and their involvement and input are crucial. They can help to communicate information to their patients and colleagues, and can bring other partners into the collaborative process.

3. As necessary, the health official or other top LPHA management staff should meet with politicians, directors of other organizations, board members of the partner organization(s), and other highly visible persons to discuss the transition and provide them with a one-on-one opportunity to react. (See section on Creating Political Will and Appendix A for references on political support.)

4. Assess the effectiveness of the LPHA's communication and involvement with the community.

5. Appropriate communication with the public is necessary for a successful transition. Plan community meetings and information sessions to raise awareness and generate support. Be clear about the purpose/goals of the transitioning effort and the populations who will be affected. This is also a good opportunity to acknowledge the capability and competence of the partner organization(s). (See Appendix A for references on community involvement and support.)

6. Seek input from community residents and patients early in the transition process, and maintain direct contact and communication. Provide frequent reminders about the factors involved in and the benefits of the decision.

7. Develop a plan to maximize the use of print, radio, and television. (See Appendix A for references on marketing public health.)

The Bergen County (NJ) Health Department recognized the importance of internal and external communications during the transitioning process. The health education office acted as liaison for departmental communications and handled public relations and external marketing responsibilities. By concentrating on marketing, the health department was able to frame the strengths and values of the department in sellable and attractive terms. By expanding informational offerings through newsletters and web site activities, the health department also developed name recognition and enhanced the community's perception of its work. A specialist in public relations and public information was hired to help with public perception about the health department (Guarino, 1997).

Market Public Health

1. Communicate to the public what public health is all about.
   - The community must understand the LPHA's changed role and new responsibilities. The LPHA will have to work on selling its new identity. This will require a familiarity with some typical business techniques.
   - Understand and apply marketing principles to confront challenges to both the public's health and the survival of the public health profession (Siegel and Doner, 1998).

Without a clear understanding of public health's contribution to society, community members' investment in public health systems will remain small. To address this concern, NACCHO helped to convene a coalition of leading national public health organizations in Summer 2000. With the help of an advertising and communications firm, the coalition hopes to increase: 1) the recognition and support of public health efforts, particularly the roles of government public health agencies, and 2) the investment in public health efforts at the local, state, and national levels. The firm will conduct research to identify current efforts in public health marketing, brand identification, audiences, trends, and attitudes, and will design communications materials with common themes and messages. The campaign will eventually provide tools for local practitioners to use in communicating with their communities.

2. Use social marketing concepts to market public health and new policies and programs.
   - Social marketing is the application of commercial marketing and communication principles to public initiatives/programs to achieve social goals through behavior change.
   - The mission of social marketing is to benefit the consumer and/or society, not the host organization. Consumers include the media, legislators, administrators, policymakers, and organizational leaders (Sutton, 1999).
   - Social marketing helps the LPHA reach target audiences, customize messages to target audiences, and create greater and longer-lasting behavior change in those audiences (University of Kansas, 2000).

Address Legal Issues

1. Have an attorney review all of the rules and regulations associated with contracts, purchasing, funding, bidding, and personnel. Involve legal counsel right away, possibly as a member of or a consultant to the transition team.
   - Legal issues may involve medical records, informed consent, and contracts to transfer equipment, money, and responsibility to the partner organization(s).
   - As needed, develop a contract between the LPHA and the partner organization(s), with an attorney's assistance. (See section on Transitioning Models.)

Address Transfer Logistics

1. Consider logistics related to the transfer of records, equipment, and patients to the partner organization(s).
   - Notify patients about the changes in service delivery, provide information about the partner organization(s), and instruct patients on how to receive care.
   - Assure patients they will still be able to receive care but that it will be at a different location/organization. Inform patients of efforts to improve the quality of care. Although the intent is to maintain the quality of care, this cannot be guaranteed. At least initially, quality of care may be reduced or challenged.
   - Make the process as simple as possible for patients. Do not create unnecessary barriers to the receipt of care.
   - After patients are notified about the change, obtain releases for record transfer.
   - Once releases are obtained, transfer records or their copies to the partner organization(s). Hire or enlist a records manager, as needed.
   - Assure patients that confidentiality will be maintained throughout the transfer process.

2. Since there are many legal and/or medical risks associated with transitioning services, it may be beneficial to contact persons with expertise in risk management.

3. Inventory equipment, such as exam tables, laboratory equipment, and other items the LPHA may no longer need. Sell or donate the equipment either to the partner organization(s) or to other providers in the community.

4. Formalize a patient enrollment process at the new location.
   - Assess the organization's capacity to take on new patients. Determine if the organization needs to recruit more staff to deal with the increased patient load.
   - Stagger patient enrollment as needed to avoid overwhelming the partner organization(s).
   - Establish protocols for enrollment, and develop a timeline to facilitate the process and minimize obstacles.

Establish Accountability

1. When responsibility for health services provision is transferred from the LPHA to a private provider, concerns arise about the availability and adequacy of services provided by the partner organization(s) and the use of public funds to support these services (Halverson et al, 1997). The LPHA has the key responsibility for ensuring the provision of quality services.

2. There is diminished accountability when a LPHA relinquishes control over a service (Bechamps et al, 1999). However, through contracts, LPHAs are often able to maintain better control of their assurance role. Contracts should support the gathering of information from private providers to carry out monitoring activities. Contracts may include service delivery details and outcome and process objectives. (See the section on Contract Monitoring/Performance Evaluation.)

3. Public health agencies need to be able to measure the performance of public and private providers in terms of: health outcomes, units of service, cost, access, consumer demographics, and consumer satisfaction (Halverson et al, 1997).

4. Both agencies may agree to report to each other on specific outcomes. Privatization initiatives that involve formal accountability systems have proven to be the most successful (Halverson et al, 1997). (See the section on Contract Monitoring/Performance Evaluation.)

5. A monitoring plan should address questions such as these (Management Sciences for Health, 2001):
   - Is the partnership achieving its goals and objectives?
   - Is each partner fulfilling its role?
   - Is the partnership carrying out its activities within budget?
   - Is the community satisfied?
   - Are the partners satisfied?
   - Are the partners adhering to the agreed-upon timeline, or are there reasons to make changes in the timeline?

See Appendix A for references on evaluation, performance, and outcomes measurement and section on Contract Monitoring/Performance Evaluation.

In a Public Health Foundation (PHF) study on privatization and public health, many of the LPHAs surveyed used contracts with private providers to maintain better control of their assurance role. Several of the contracts included outcomes and process objectives to be met by the private provider. Study sites felt that LPHAs should be accountable for maintaining their assurance role. Therefore, nearly all of the 25 sites surveyed retained outreach, case management, and monitoring roles (Bechamps et al, 1999).

Develop a Contingency Plan

1. Unforeseeable circumstances can make a work plan obsolete or no longer feasible. Barriers related to staff, politics, or the community might develop. Partner organizations may reconsider their decision because they feel unprepared or incapable of taking on the LPHA's patient base. Cultural differences between the LPHA and the partner organization(s) may prevent the transition from occurring. LPHAs must therefore include contingency planning in the process.

Any plan to transition services should take into account the time, effort, and information needs of this enormous undertaking. By proactively planning and building the necessary skills and tools for change, the LPHA can promote communication among key stakeholders to facilitate the change process. Involvement of all levels of staff helps to develop a stronger infrastructure, which is capable of supporting the provision of the essential services. Delineating clear and realistic goals from the beginning will decrease demands on staff and resources, and will allow for the transitioning to occur in a reasonable amount of time (Bechamps et al, 1999).

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Transitioning Models

By reading this chapter, you will learn:
1. Examples of the different transitioning models.
2. Criteria/factors used to choose appropriate models.
3. How the transitioning process works and options for different transitioning arrangements.
4. What information should be gathered prior to forming agreements or negotiating contracts.
5. How to develop a formal agreement.

Over the past several years, decisions about whether to transition public health services and what types of transitioning arrangements to use have largely been ad-hoc. Hampered by reduced budgets and increased pressure to perform, local public health agencies (LPHAs) have struggled in a competitive environment. LPHAs have been generally unaware of the experiences of their colleagues in undertaking the same difficult and sometimes painstaking management process.

An examination of the aggregate experiences of LPHAs that have transitioned services reveals notable patterns. These lessons can be helpful for health agencies that are beginning or in the midst of the transitioning process. This chapter provides an overview of transitioning models, the criteria used to select an appropriate model, a description of the steps in the transitioning process, and the tasks involved in developing a monitoring/performance evaluation system for transitioned services.

Most of the transitioning that has occurred nationally has been for direct clinical services and functions linked to these services. This trend is the product of: the advent of Medicaid managed care, the loss of Medicaid revenue to support direct clinical services, the return of LPHAs to their core mission of population-based health services and the movement away from individualized patient care, increasing numbers of uninsured persons, and a sometimes ineffective safety net system. This section therefore focuses on the transitioning of direct clinical services.

Components of Direct Clinical Services
Most direct clinical services consist of several interrelated activities:
- Referrals
- Case management
- Service provision
- Quality assurance/monitoring
- Research

Before evaluating the range of available transitioning models for a particular service, the LPHA should consider the service in terms of its components to decide whether to transition all or only some of the activities. For each service being considered for transitioning, the LPHA should examine each component activity, add additional activities as necessary, review the agency's unique qualifications to perform each activity, and identify how each relates to the agency's core functions.

Types of Transitioning Models
There are two basic types of transitioning models: 1) service-shedding models, and 2) alliance-building models (Halverson et al, 1997).

1. **Service-shedding models**
   These models apply to LPHAs that decide to eliminate all direct clinical services either because the capacity for these services exists in the community or because the service is no longer required. In these cases, the LPHA does not transition services to another provider under official contract terms. Rather, the LPHA *ceases operations entirely or transfers operations* to a private entity.

Characteristics of service-shedding models

- Most prevalent in localities where the demand for direct clinical services provided by the LPHA has declined; may be more prevalent in mandatory Medicaid managed care states (1115 waiver states).
- Applicable when the provision of direct clinical services is not a mandated responsibility for the LPHA.
- Often based on an assessment by the LPHA to ensure that the needs of the community will be met.
- Applicable when the infrastructure exists in the community to support the range of services.

Benefits

- Limits the LPHA's financial commitments for service provision and contract monitoring.
- May increase the accessibility and/or quality of services.
- Allows the LPHA to concentrate on population-based services.
- Increases the accountability of local providers.

Limitations

- Not possible in localities where direct clinical services are mandated responsibilities of the LPHA.
- Limits the LPHA's ability to track the demand for the services or the health outcomes associated with the services.
- May not be politically palatable to the general public, advocacy groups, and others.
- May be associated with loss of state and local funding if services are not provided directly by the government unit.
- May be costly to assign/develop staff to monitor the transition.

Corporate Consolidation or Shared Ownership Model
In 1993, health services in Grundy County, Iowa, were falling apart. In response to recommendations from consultants and a community task force, the county created the Grundy County Health Commission to operate and oversee all curative and preventive healthcare, home healthcare, mental health, and emergency medical services. The LPHA, hospital, and county government share personnel and administrative functions (Lasker et al, 1998).

Service Shedding through Service Elimination
The Dade County (FL) Health Department had been involved in primary care delivery for more than 10 years when, in the mid 1990s, the state adopted a mandatory Medicaid managed care policy. The LPHA was forced to decide whether to continue providing categorical primary care services. After a strategic planning retreat, management decided that the LPHA would not be able to compete against providers who were recruiting Medicaid patients. The LPHA decided to divest itself from most clinical services and use funds for traditional population-based services (Reid et al, 1998).

Service Shedding through Full-Service Contract
In 1995, Mecklenburg County (NC) signed a contract with Carolinas HealthCare System to provide approximately 80% of LPHA services, including all direct clinical services, community services, public health nursing, case management, and health education. The system also provides most associated support services, including administration and medical records. The Carolinas HealthCare System was incorporated as a public authority and had both the ability to issue bonds and the flexibility to operate as an independent private entity. The county signed a 6-year contract for services under a global budget that was equal to approximately 60% of the expense budget. LPHAs retained some mandated services, such as vital records, communicable disease contact tracing, and environmental health services (Lasker et al, 1998).

2. **Alliance-building models**
   In these models, transitions are usually supported by collaborative arrangements for the oversight and delivery of public health services. Alliances can take the form of *informal cooperative ventures, formal cooperative ventures, joint ventures/corporate consolidation, or shared ownership.*

Characteristics of alliance-building models

- Involves organizations with some experience in working with one another.
- More common among smaller and more rural LPHAs that provide a large percentage of direct clinical services compared to the total range of services.
- Applicable to areas with limited state funding for LPHA activities and/or lack of mandate for established local public health organizations.

Benefits

- Enables the LPHA to maintain a leadership role in the provision of direct clinical services.
- Increases the probability that the LPHA will receive quality data on services delivered and health outcomes
- Strengthens the government's position.
- Reduces expenditures for services.
- Provides opportunities for cross-fertilization of services offered to the same client mix.
- Limits public exposure and accountability.

Limitations

- Limits financial savings as the LPHA must maintain at least a portion of the infrastructure related to the transitioned services.
- Increases the need for coordination between the LPHA and the contractor.
- Minimizes the role of population-based public health activities and the local public health entity.
- May require changes in local laws/codes.
- Reduces the LPHA's direct control over services.

Alliance Building through Informal Cooperative Ventures
In 1992, the Madison (WI) Department of Public Health led and oversaw the development of the South Madison Health and Family Center, a comprehensive health center that provides primary care, public health, and family support services. Seven organizations, including the city and county health departments and Planned Parenthood, jointly oversee the Center. The Center is managed through an established governance structure supported by administrative protocols and a coordination office, which monitors roles and responsibilities (Lasker et al, 1998).

Alliance Building through Limited-Scope Contracts
In the mid 1990s, the city manager of Richmond, Virginia, asked the health department to eliminate the provision of direct clinical services. At the same time, a community survey identified increasing health needs of the city's population. In response, the health department collaborated with the Medical College of Virginia to develop a community health center. The health department transferred all clinical staff to the medical school and established an interdisciplinary case management model to integrate the services of both institutions. Eventually, the terms of the contract changed, and the Medical College of Virginia assumed responsibility for the center's operation (Lasker et al, 1998).

Criteria for Selecting a Transitioning Model
Some LPHAs will be able to decide on a model based on established criteria, such as: LPHA mission, legal mandates, budget/fiscal considerations, capacity of community providers, capacity of LPHA, public health needs, and political environment. In this case, the LPHA and partner organization(s) should initiate a formal process with the following steps:

- Develop definitions for the selection criteria — Effective use of selection criteria requires common definitions. Common definitions will allow those involved in the transitioning process to have a shared knowledge base and will facilitate a more informed choice of transitioning model.
- Weight the criteria — Not all criteria carry equal weight. The LPHA and partners should evaluate the criteria and rank and weight them according to their importance in the decision-making process.
- Choose participants — The LPHA and partners must determine who (within and outside the organization) will have a voice in the decision process. The selection of participants usually is based on position and expertise.

- Conduct the analysis — The next step is to complete a questionnaire that differentiates among the transitioning models.
- Communicate the decisions — Once a model has been selected, the LPHA and partners must make a concerted effort to communicate the decision both internally and externally. Many LPHAs make the mistake of implementing the transitioning process "behind closed doors." This can lead to misconceptions and skepticism about the LPHA's decision-making process and outcomes.

Types of Transitioning Arrangements

In both the service-shedding and alliance-building models, the transitioning arrangement can take several forms, ranging from a formal contract to an informal handshake. Other types of arrangements include: *memorandum of agreement/understanding (MOA/MOU), letter of intent, and strategic direction statement.* For most arrangements, the LPHA develops a written document that describes the roles and responsibilities of the parties involved. Contracts and agreements go through a scrutiny process that usually involves defining general terms of the collaboration and involving attorneys to draft and negotiate the agreement. For more informal arrangements, the parties form partnerships, collaborations, coalitions, or task forces. Informal arrangements are usually most applicable to small initiatives characterized by a baseline relationship among the involved parties and minimal financial risk. Many informal arrangements are managed by an administrative body comprised of the member organizations (Lasker et al, 1998). (See section on Developing Partnerships.)

- Contract — Formal agreement awarded by competitive bid or sole source (one party receives the contract without bidding by other organizations). As an arm of the government, an LPHA often requires a formal contract for services if an agreement involves any financial arrangements or specific obligations. A contract can either be "limited scope" or "full scope." In a limited-scope contract, the LPHA contracts out a portion of the activities related to a particular service but retains some activities. In most cases, the LPHA will retain the data tracking and/or quality assurance activities. The rationale for selecting a limited-scope contract rather than a full scope contract centers on both the legal mandates placed on the LPHA and the health agency's unique qualifications to provide the services.
- Memorandum of agreement/understanding — Detailed letter describing the proposed relationship structure. The letter is signed by both parties and serves as a binding legal document. Although it is not a contract per se, attorneys for all parties to the agreement should review the document.
- Letter of intent — Letter describing the intended transitioning relationship. Often, one party sends a letter of intent to another party, rather than both organizations signing one document.
- Strategic direction statement — Non-binding document that simply describes the transitioning arrangement.

LPHAs should carefully consider the choice of a transitioning arrangement. Collaborations are difficult to maintain, with many opportunities for miscommunication. The type of transitioning arrangement will set the stage for the relationship and establish the expectations of the involved parties. Some transitioning models clearly warrant or lend themselves to specific types of arrangements, but, in most cases, there is some flexibility. Other factors that may influence the type of transitioning arrangement include: 1) type and number of service(s) to be transitioned, 2) LPHA's relationship with the partner organization(s), 3) costs of services to be transitioned, and 4) local laws and regulations.

Information Required for Contract Negotiations

Before developing a contract, the LPHA and vendor(s) must gather preliminary information about the services to be transitioned. The information falls into six general categories:

1. Financial factors — Sources of revenue for contracted services; estimated third-party revenue
2. Referral volume for services — Value of services to contractors; cost savings to LPHA and additional expenses from transitioning; state/federal/grant funding requirements; reimbursement rates for services
3. Legal issues — Legal authority to transition services; personnel issues (civil service and union contracts); issues for outside counsel (if possible); terms of federal/state grants and other service obligations; subcontracts affected by transitioning; assurances of privacy of data
4. Service delivery/quality improvement issues — Potential service continuation/expansion/elimination issues; staffing requirements; reporting requirements; data from past 3 years on programs and services (input, output, outcome) and assessments of quality of care; reporting requirements for service activity based on clinical, operational, and financial benchmarks

5. Patient access issues — Access monitoring mechanisms for transitioned services; reporting mechanism and requirements for evaluating quality of care; service requirements for the uninsured
6. Political issues — External political groups that need to be informed and included in the transitioning process (providers, payers, patients, advocacy groups, politicians); internal political issues and plan to manage staff expectations. (See section on Creating Political Will)

Terms and Conditions

LPHAs that choose to formalize a relationship for transitioning services should consider several terms and conditions when developing and negotiating the agreement. The list below suggests terms for inclusion in an agreement (MOU or contract) and recommendations for how these terms should cover the interests of the LPHA. The list is not exhaustive and is meant only as a guide. Any LPHA that enters into a formal transitioning arrangement should engage an attorney to review and approve the terms of the agreement.

- Scope of services — Description of service(s) to be transitioned.
  - Define all transitioned services by CPT (current procedure terminology) code where possible to ensure consistency in service delivery and billing.
- Strategic planning — Process of building a template to guide the future direction of transitioned services.
  - Include a transition plan as an appendix to the agreement.
- Communications/outreach — Communication about the transitioned services to the general public and to specific populations.
  - Define each party's rights to the use of the other's name and logo in any marketing materials or strategies.
- Financials — Financing mechanism for the transitioning arrangement.
  - Include language to address any increase or decrease in the LPHA's funding for the transitioned service(s).
  - Define how the LPHA will pay for the transitioned service(s).
  - Identify where the revenue streams will reside and the length of time each party will retain specific revenues.
  - Include language linking the LPHA's payment for services rendered to the actual performance of the contractor.
  - Include costs associated with monitoring/quality assurance.

Rating — Process of calculating the appropriate premium to charge, given the degree of risk represented by the group and the expected costs to deliver medical services.
Premium — Prepaid payment or series of payments made to a health plan (MCO) by purchasers for medical benefits.
Reimbursement mechanisms for healthcare services — Options include fee for service, discounted fee for service, and capitation payments (global, partial, or carve-out).

- Personnel — Obligations associated with the staffing of the transitioned program.
  - Define accommodations for current LPHA employees; decide whether any or all staff will be given the option to transfer to the contracting organization.
  - Work with the LPHA's human resources department to evaluate any pension or other personnel issues.
- Equipment and supplies — Supplies and equipment related to the transitioned service, including medical supplies/equipment and technical equipment.
  - Define which of the LPHA's supplies and equipment will be provided to the contractor under the terms of the agreement. The costs of the equipment should be factored into the value of the agreement.
  - Decide on a process for the transfer of medical records from LPHA to contractor.
- Oversight committee and management team — Cross-section of persons typically composed of LPHA staff, the contractor, and other outside organizations. The committee oversees and monitors the process and progress of the transitioning arrangement from both an administrative and a service delivery perspective.
  - Define the roles and responsibilities of the oversight committee.
  - Describe the oversight committee's role in decision-making and problem resolution.
- Monitoring/data collection — Process of collecting input, output, and outcome data on the services included in the transitioning agreement.

  - Identify data reports and monitoring procedures that are required by oversight bodies, and determine the need for additional/supplemental reporting information.
  - Describe the process and timing for collecting and exchanging data between the LPHA and the contractor as well as the actual data to be collected, reported, and monitored.
- Terms and conditions — Time allowed for sentinel events, including the termination and renewal of the agreement.
  - Specify the length of time that the agreement is valid and the procedures required to renew the agreement.
  - Specify the procedures for terminating the agreement and the allowable circumstances that substantiate a termination with and without cause.

Developing the Agreement

Developing a formal agreement between an LPHA and a contractor for transitioned services can be a long and sometimes unwieldy process. Any LPHA that decides to formally transition a service or set of services should assign one person or a team to manage the contracting process and the relationship with the vendor(s). The tasks listed below are the core activities in the contracting process. Some of these tasks can be completed informally, but all should be considered. In many cases in which a service is transitioned via a contract, the LPHA remains responsible for the health of the community. Therefore, the process of contracting out a service does not alleviate the LPHA's obligations to ensure the provision of that service.

- Research regulatory requirements — Collect data on local, state, and federal regulatory requirements (including grant requirements) that may affect the transitioning arrangement. Ensure that the service(s) can be legally transitioned and that the requirements of the LPHA can be fulfilled by the vendor or partner.
- Compile documentation — Compile all supporting documentation on the levels and costs of services. Work with program and finance staff to document levels of services and specific expenditures for the past few years.
- Decide on transitioning process — Identify obstacles to and processes for transitioning. Determine appropriate transitioning arrangement(s). Obtain information on the agreement process and timing requirements.
- Meet with consultant/attorney — Hire/meet with consultants/attorneys to help manage the transitioning process. Consult first with the in-house counsel and then "interview" outside consultants to decide whether to manage the transitioning process internally or externally.
- Discuss with partner(s) — Hold preliminary discussions with parties to solicit interest in service provision.
- Issue RFP — Draft and issue a Request for Proposal (RFP) and other documentation, depending on the type of agreement chosen. Use sample RFPs from other LPHAs as templates.
- Select vendor — Evaluate vendor responses based on established criteria, and choose one or more vendors.
- Draft terms — Draft the core agreement terms, and develop a list of general obligations.
- Negotiate terms — Meet with vendor(s) to discuss and negotiate agreement terms. Ask vendor(s) to prepare a list of proposed obligations and responsibilities. Convene a meeting with the LPHA's core management team and the vendor to discuss agreement terms. After the meeting, send information to the attorneys for incorporation into a standard agreement.
- List unresolved issues — Develop a list of outstanding agreement terms that both parties could not agree on. Maintain a list of the LPHA's non-negotiable items.
- Develop monitoring requirements — Develop a monitoring methodology and performance requirements. With the vendor, define and agree upon the data required, reporting format, and process for monitoring, including site visits.
- Prepare final agreement — Draft the final agreement document; review the agreement periodically, and revise as necessary.

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Developing Partnerships

By reading this chapter, you will learn about:
1. The makings of a successful partnership.
2. Preparations required for an effective collaboration and to maintain a strong relationship.
3. Various types of partnerships and potential partners.

All communities face challenging times as they are expected to do more with fewer resources. In addition, with growing interest in health outcomes, many are being held accountable for results that are not in their direct control (Lasker et al, 1997). The development of strategic alliances enables local public health agencies (LPHAs) to contain expenditures and do more as funding is reduced (Atchison et al, 2000). Through pooled resources and expertise, interorganizational relationships have been important in improving the quality, efficiency, and accessibility of public health services (Mays, 2001). Organizations face many economic incentives to participate in partnerships and as a result are able to expand public health activities despite the loss of Medicaid and other revenues. Developing partnerships is a beneficial way to secure external funding for new activities or to transfer responsibilities to other healthcare providers (Mays, 2001). (See Appendix A for references on partnership development.)

Collaboration is a relationship between partners committed to pursuing both an individual and collective benefit. Collaboration is the ultimate commitment between organizations where risks, responsibilities, resources, and rewards are shared (Himmelman, 1996).

Partnership development is a large part of the work of LPHAs and is not unique to the transitioning process. The concepts presented below may not be new but can be helpful in reinforcing what LPHA staff already know about developing partnerships.

Successful Partnerships
The management literature cites common themes of successful partnerships:
- Successful collaborations result from building relationships, developing trust, and appreciating the value of each other's contributions and perspectives (Nelson et al, 1999).
- Successful collaborations usually result from the partners' history of working together (Himmelman, 1996).
- Developing collaborative relationships requires considerable time and patience.
- A collaboration's success depends not on the organizations but on the relationships that develop among the persons involved (Minnesota Department of Health, 2000).

Preparing for a Partnership
To prepare for a partnership, organizations must (Nelson et al, 1999):
- Know their strengths and weaknesses and where they are headed.
- Assess whether a partnership is compatible with their mission and capacity.
- Identify their capabilities in terms of work history, philosophies, principles, and values.
- Acknowledge the competitive advantage of collaborating (e.g., develop a list of possible benefits and challenges that a partnership might bring to the organization).
- Take an objective look at potential partners' programs, skills, resources, activities, missions, and client populations.
- Analyze the rapport between partners; honestly and comprehensively assess potential partners.

Effective Collaboration
Effective collaborations are based on the following steps:

<u>Develop goals and objectives</u>
- Convene planning sessions to create goals, objectives, a joint work plan, and a budget. See section on Developing a Work Plan.

- Develop a clear partnership agreement. Partnerships can be either non-contractual or contractual, depending on the partners' needs, goals, and objectives (Management Sciences for Health, 2001). See section on Transitioning Models.
- Develop protocols for interorganizational communication, information sharing, data exchange, and conflict resolution (Mays, 2001).
- Gather sufficient resources for achieving goals. It might be important for all organizations to be willing to commit monetary and other resources.
- Create an evaluation plan for monitoring organizational and community performance (Mays, 2001). See Appendix A for references on evaluation, performance and outcomes measurement. The plan should address questions such as (Management Sciences for Health, 2001):
  - Is the partnership achieving its stated goals and objectives?
  - Is each partner fulfilling its role?
  - Is the partnership carrying out its activities within the proposed budget?
  - Is the community satisfied?
  - Are the partners satisfied?
  - Are the partners adhering to the agreed-upon timeline, or are there reasons to change the timeline?
- Be willing to change any aspect of the partnership if necessary along the way.

Himmelman (1996) identified some questions to guide the collaborative process:
- Who should be involved in the partnership both within and outside the collaborating organizations?
- What is the shared vision that motivates the collaboration?
- What expectations do each of the organizations have for one another?
- Should ground rules be set before the partnership moves forward?
- What is the mission statement for the collaboration? What are the short- and long-term goals and objectives?
- What skills and assets can each partner contribute?
- How will the work get done and the goals and objectives be met?
- Who will administer and manage the partnership? Who will make key decisions? Who will provide the leadership?
- What sources of funding are required? What are the financial plans for the partnership?

<u>Build relationships</u>
- Maintain strong and effective leadership.
- Ensure a commitment to the work and a foundation of trust and equality.
- Create an environment conducive to working together from the beginning (Management Sciences for Health, 2001).
- Appreciate the strengths and capacities that each organization brings to the partnership, and realize that organizations have different ways of working together.
- Be flexible and willing to compromise (Goldhagen and Chiu, 1998).
- Address cultural issues and appreciate diversity (Nelson et al, 1999); involve organizations that represent communities of color.

<u>Ensure involvement and support</u>
- Obtain support and commitment from the management of each partner organization (Management Sciences for Health, 2001). Acknowledge that self-interest, often related to financial factors, may be the incentive for joining a partnership.
- Create awareness and support among key decision-makers to ensure the visibility and acceptance of the partnership in the community (Mays, 2001).
- Involve the community from the start.

See Appendix A for references on community involvement and support.

<u>Communicate</u>
- Nurture rather than control the partnership (Nelson et al, 1999).
- Interact often, update partners frequently, discuss issues openly, and convey necessary information to each other (Lovelace, 2000).
- Identify both large and small successes accomplished throughout the partnership.

Failed Partnerships

The failure of partnerships can often be attributed to fundamental relationship issues among the organizations/individuals involved. See Appendix A for references on conflict resolution. These issues may relate to:

- No history of working together.
- Suspicions, preconceived notions, mistrust, and cultural divides (Nelson et al, 1999).
- Difficulty with diverse persons and organizations working together.
- Patterns of functioning in a competitive environment and the need for time to develop trust and release competitive tensions (Himmelman, 1996).
- Reluctance to share proprietary information, knowledge, and resources that give an organization its competitive edge (Himmelman, 1996).
- Viewing the other organization as a competitor and not a partner (Minnesota Department of Health, 2000).
- Lack of commitment to the mission or vision of the partnership, lack of strategic planning, and lack of integrated decision-making or support systems.

Partnership Models

Halverson et al (1997) identified several partnership models that LPHAs might consider for transitioning of services. See the section on Transitioning Models for further discussion.

Service-shedding model

Service shedding is appropriate when the public sector role is terminated and operations are transferred completely to private providers. There are two models of service shedding (Halverson et al, 1997):

- Ceasing operations — Occurs when private providers have sufficient capacity and expertise to deliver services.
- Transferring of operations from public to private ownership — Usually involves the purchase or lease of public facilities and equipment.

Alliance-building model

Alliance building means that LPHAs collaborate with private providers to deliver services jointly. This model allows public and private providers to share responsibility for supplying health services to communities. There are four main types of alliance-building models (Halverson et al, 1997):

- Informal cooperative ventures — Based mainly on interorganizational trust and interpersonal relationships rather than formal mechanisms such as contracts.
- Formal cooperative ventures — Center around contractual agreements for the provision of services or sharing of resources.
- Joint ventures — Sharing of responsibility for service delivery among two or more organizations; allows multiple organizations to contribute to the delivery, management and evaluation of health services through contracts and agreements.
- Shared ownership model — Two or more agencies jointly sponsoring a new corporate entity that is responsible for service provision and sharing the ownership of this new organization.

Interorganizational Partnerships

In a recent study, investigators surveyed 60 county health directors in 15 states about their interactions with other types of healthcare organizations, such as managed care, community health centers, and hospitals (Mays et al, 2000). Findings showed that:

- LPHAs partnered with other organizations in four main areas — planning, program administration, service delivery, and community assessment.
- More than 50% of hospitals in the jurisdictions studied had some form of collaboration with the LPHA. Fewer than 40% were formalized by contract; 66% involved patient-referral agreements, 31% involved the joint delivery of clinical services, 29% the joint administration of population-based services, and 11% the joint assessment of community health needs.
- Nearly two-thirds of community health centers collaborated with the LPHA. Two thirds of the partnerships were formalized by contract; the majority of activities were related to patient referral agreements.
- Almost 83% of LPHA relationships with managed care organizations were formalized by contracts. Relationships between managed care and LPHAs predominated in jurisdictions with populations of >100,000.

Case studies of interactions between LPHAs and other healthcare organizations have been documented in the literature and identified through NACCHO focus groups and interviews. Examples of service delivery relationships developed between LPHAs and hospitals, community health centers, universities, health and human service agencies, private providers, and managed care organizations are cited below to illustrate the range of interactions that exist. Many of the LPHAs have engaged in interactions with a number of different organizations/individuals.

Community health centers

Community health centers (CHCs), both federally qualified and supported by state and local funds, have a mission similar to that of LPHAs – to improve community health and integrate primary and preventive services. Therefore, they are likely partners for LPHAs.

- Like LPHAs, CHCs need to develop collaborative relationships to remain viable in the healthcare marketplace.
- The incentives for CHCs to engage in partnerships with LPHAs relate to continuing their role in providing health services to Medicaid populations and securing funding and resources to serve greater numbers of uninsured and underinsured populations (Mays, 2001).

The Boulder County (CO) Health Department transitioned its personal health services (prenatal care, delivery services, well-child care) to CHCs in the county. These services were the most labor and resource intensive, and all required significant county financial resources in addition to Medicaid. The four CHCs in Boulder County had both the willingness and the desire to expand service capacity to low-income families, particularly since the funding mechanism for Medicaid patients provided more favorable reimbursement rates to CHCs than to the health department. Therefore, many of the health department's primary care services were successfully transitioned to the CHCs (Appendix C).

In 1998, Public Health-Seattle-King County (WA) transitioned pediatric services at three sites and family health services at one site. Since most pediatric patients were Medicaid-insured, a local CHC was able to expand capacity with the patient-generated revenue. Collaborative efforts increased information, referrals, and resource sharing between the health department and the CHC, especially for translation services, outreach and Medicaid enrollment, and communicable disease services. This work of system development and resource coordination continues, as the partnership between the CHC delivering primary care and the health department delivering "wrap-around" services expands (Appendix D).

Additional examples of LPHA-CHC relationships include:

- San Angelo-Tom Green County (TX) Health Department (Appendix D)
- Dutchess County (NY) Department of Health (Appendix D)
- Leon County (FL) Health Department (Appendix D)
- Tacoma-Pierce County (WA) Health Department (Appendix C)
- Milwaukee (WI) Health Department (Mays et al, 2000)

Private providers

Private providers who are independent of or part of managed care networks are becoming increasingly important as collaborators.

- As a result of increased Medicaid reimbursement and the growth of managed care, many LPHA patients are receiving care through private providers.
- Because many communities have large numbers of private providers, LPHAs no longer need to offer a variety of direct clinical services.
- Developing public/private partnerships and transitioning services to private providers enable LPHAs to focus on population-based services.
- Since many private providers lack expertise in serving Medicaid populations, LPHAs must make sure that their former patients are receiving appropriate and adequate care.
- If private providers are unwilling or unable to deliver services to uninsured populations, then LPHAs may need to continue offering certain services.

The Mahoning County (OH) Board of Health is focusing on uninsured children and prenatal patients without a medical home. The Board of Health implemented a prenatal voucher program that uses coupons in exchange for services. They developed a list of private physicians who will accept these vouchers. Many of the providers are members of the Mahoning County Child and Family Health Services Consortium, made up of 35 local health and social service agencies. The voucher program targets patients who visit private clinicians, providing them with a wider choice of practitioners. Public health nurses identify women in the first trimester, provide "wrap-around" services throughout the pregnancy, and link them to a medical home (Appendix B).

Given changes in the private healthcare sector, improved Medicaid reimbursement rates for prenatal and delivery services, and the advent of Medicaid managed care, the Pinellas County (FL) Health Department decided to transition some clinical services. As the 1990s progressed, the health department's patients not only became acceptable to the private sector but also increasingly attractive from a fiscal perspective. Private practitioners became more competitive in attracting patients, and with sufficient numbers of private sector providers in the county, the health department decided it was not appropriate to enter into this competition. Therefore, the health department transitioned most prenatal services to private providers, contracted the care of AIDS patients to Pinellas Cares, a hospital-affiliated HIV/AIDS clinic, and transitioned most pediatric primary care services to Medicaid HMOs (Appendix C).

Additional examples of LPHA-private provider partnerships are:
- Orange County (CA) Health Care Agency (Appendix D)
- Springfield/Greene County (MO) Department of Public Health and Welfare (Appendix D)

Hospitals

Hospitals are identifying themselves as LPHA partners. Government-owned hospitals are more likely than privately owned hospitals to participate in public health partnerships (Mays, 2001). There are several incentives for such partnerships:
- Nonprofit hospitals often need to provide community service benefits as justification for tax-exempt status.
- Some hospitals want to provide non-acute-care services, including preventive services.
- The ability to share the costs of resource-intensive services (e.g., inpatient care, uncompensated care) is attractive to many hospitals.
- Partnerships help hospitals promote awareness of their mission and services.

The Memphis-Shelby County (TN) Health Department implemented an integrated delivery system to increase efficiency. Health department planners decided to link their primary care clinics administratively with the four primary care clinics of the regional medical center. The health department signed a contract to hand over the management of the clinics to the medical center. In many ways, the partnership did not evolve easily. Health department staff were concerned that the hospital wanted to partner solely for financial reasons. It took considerable effort to convince the staff that the delivery system would be improved. The partnership was publicized in news releases, articles, and newsletters. The health department immediately saw some efficiencies in the supply ordering process and the billing system. The staff integration went fairly smoothly, but it meant a shift for providers who were less hospital-oriented than the providers at the hospital's clinic (Appendix C).

The Jefferson County (AL) Department of Health formed an alliance with Children's Hospital to provide pediatric care in a newly constructed health department clinic. The health department also initiated a partnership with Cooper Green Hospital, the county's indigent tertiary care facility, for adult care. This latter partnership has proven to be more challenging because the need for adult care is greater, health insurance for the population is scarce, and the number of services and resources available is severely limited (Appendix B).

Additional examples of LPHA-hospital relationships include:
- Southwest Washington (WA) Health District (Appendix D)
- Albany County (NY) Health Department (Appendix D)
- Chicago (IL) Department of Public Health (Appendix C)

Universities and academic health centers

Universities can bring valuable resources to a partnership, and their credibility and name recognition can provide a competitive advantage for LPHAs (Goldhagen and Chiu, 1998). A variety of linkages are possible between LPHAs and academic institutions on projects dealing with teaching, service, or research. The collaboration can be either a casual connection or a formal contractual agreement or affiliation (Keck, 2000).

The Salt Lake City-County (UT) Health Department recognized the need for more comprehensive primary care in its clinics, which meant recruiting many more physicians. The Director approached the Chairs of the University of Utah Medical Center Departments of Pediatrics and Obstetrics/Gynecology to conduct full-time primary care teaching clinics in the health department health center. This relationship has benefited all participants; the health department has freed its staff to work on population-based activities, and the University has increased its patient base and accommodated a growing number of residency programs (Lasker et al, 1998).

Additional examples of LPHA-university partnerships include:
- Duval County (FL) Health Department (Goldhagen and Chiu, 1998)
- Richmond (VA) Health Department (Lasker et al, 1998)

Other agencies

Health and human services organizations might be the most appropriate partners in communities where they are well represented. These organizations often have missions similar to that of the LPHA and expertise in serving low-income and other at-risk populations.

In 1995, the Montgomery County (MD) Health Department expanded the Care for Kids Program, which it had created in 1992 to provide both well and sick care to low-income children not eligible for medical assistance. The department contracted with an HMO, an organization of CHCs, and private physicians. In 1999, the county contracted with the Primary Care Coalition to administer the program. The Coalition is a nonprofit organization of community health and human service providers formed to increase access to primary care for low-income residents. The Coalition has evolved into a broker between the health department and community providers, contracting with service providers more expeditiously than the county bureaucracy allows. Specialty medical services for children are now provided through partnerships with specialists. To provide maternity care for low-income women not eligible for medical assistance, the health department contracts with a local hospital that had provided prenatal care to the department's high-risk maternity patients for several decades. Family planning is provided through a contract with Planned Parenthood (Appendix C).

Managed care organizations (MCO)

In reaction to political and marketplace changes and the increasing presence of managed care in the community, LPHAs have identified different ways of collaborating with MCOs. By sharing human and capital resources, LPHAs and MCOs can address shortages in resources and realize the gains of collaborating on activities such as service delivery, disease surveillance, health education, and community outreach (Roper and Mays, 2001). (See Appendix A for references on managed care; See the section on Technical Assistance for resources on managed care.)

LPHAs and MCOs have not traditionally worked together and therefore often fail to realize that they share many goals and can rely on each other's expertise.
- Now that mandatory Medicaid managed care has penetrated the healthcare environment, MCOs are serving vulnerable populations who were traditionally served by LPHAs. MCOs can draw upon the experience of

LPHAs in serving these populations.
- By collaborating with MCOs, LPHAs can reduce their role as service providers and maximize their public health dollars by providing population-based services.

As LPHAs lose their patient base to managed care in many communities, they can contract with MCOs to provide services to LPHA patients.
- If a health plan agrees to provide services to LPHA patients, they may receive capitated reimbursement from the public health agency in exchange (Mays et al, 1998).
- In many cases, it might be more cost efficient for the MCO to contract with the LPHA to provide certain services (e.g., case management) (Reid et al, 1999). Money received from the provision of these services can be used to subsidize population-based activities.

In Minnesota, the Prepaid Medical Assistance Program (PMAP) purchases healthcare for Medical Assistance (Medicaid) and General Medical Assistance (low-income adults who do not qualify for Medicaid) clients under a managed care model. Under this plan, Medical Assistance dollars are shifted from counties to health plans to pay for covered services; health plans provide services to people who traditionally received services at LPHAs. LPHAs have to decide whether to continue to provide clinical services, join a capitated provider network, and/or enter into a contract with MCOs. LPHAs that choose to contract with health plans need to (Minnesota Community Health Services Advisory Committee, 1995):
- Base their decision on a community assessment
- Negotiate contracts with health plans
- Be able to describe their expertise in working with the Medicaid population
- Be prepared to address potential conflicts of interest
- Communicate effectively with health plans

By contracting with one another for these services both organizations can realize benefits (Reid et al, 1999). For example:
- The National Committee for Quality Assurance, the accrediting body for MCOs, has strong accreditation standards related to the provision of preventive health services. The process of achieving these standards is an excellent opportunity for MCOs to collaborate with LPHAs.
- MCOs are required to develop practice standards related to the prevention and early detection of illness and disease. MCOs can contract with LPHAs to help meet their health status goals.
- By pursuing partnerships with MCOs, LPHAs can achieve assurance goals and supplement revenue streams to support population-based services.

The models of collaboration discussed earlier — service-shedding and alliance building — also apply to MCOs. Each is associated with benefits and drawbacks for both MCOs and LPHAs.
- A major drawback of the service-shedding model is that public health organizations have difficulty maintaining their assurance function when complete control is handed over to an MCO.
- Alliance-building models preserve a level of responsibility for the public sector in the management and oversight of service delivery, despite the transfer of service provision to MCOs.

Partnership Development with MCOs
(Minnesota Community Health Services Advisory Committee, 1995)
Many of the steps to successful partnership development with MCOs are similar to those for partnerships with other organizations. However, there are some specific steps to keep in mind when working with MCOs.

Prepare for the partnership

- Hold meetings between medical directors and senior staff at MCOs to build trust and identify areas of expertise of both the MCO and the LPHA (Leviss and Hurtig, 1998).
- Identify areas of common interest among the LPHA and health plan, and take into account the differing philosophies and cultures.
- Evaluate the LPHA's strengths and weaknesses, and choose the most appropriate type of collaboration with the MCO (Leviss and Hurtig, 1998).
- Review the LPHA's public health goals/plans and the internal preventive health/public health goals of the health plan.
- Research other collaborations between MCOs and LPHAs.

Initiate the partnership

- Invite the most appropriate persons from the MCO, LPHA, and community to the table, and ensure that everyone can devote time to work together.
- Engage healthcare consumers in the discussion of how services will be provided.
- Agree not only on overall goals of the partnership but also on strategies, tactics, and timelines, including how to deal with potential conflicts of interest.
- Develop strategies and roles for each participant, and assess their capacity and readiness.
- If deemed necessary, structure collaborations in the form of a contract, a memorandum of understanding, etc., to clarify responsibilities and roles (Leviss and Hurtig, 1998). (See section on Transitioning Models.)
- Understand the difference between the collaboration's goals and the individual organization's goals, and separate them appropriately when problems arise.
- Find a common language.
- Agree on how the collaboration will be governed and how political and funding issues will be addressed.
- Locate resources (including staff support), and agree on how the resources will be used.
- Decide how to include purchasers and providers.
- Address issues related to competition, and be willing to share credit for any accomplishments.
- Be mutually accountable; develop monitoring and evaluation criteria.

Sustain the partnership

- Provide frequent training to LPHA staff in new managed care policies; develop procedural guidelines to help them understand the changing healthcare environment (Leviss and Hurtig, 1998).
- Invest LPHA resources in information and billing systems improvements to track patient information, revenues, and expenditures (Leviss and Hurtig, 1998).
- Establish a managed care office in the LPHA (Leviss and Hurtig, 1998).

Partnerships or collaborations bring together persons with different perspectives to share resources and skills and to identify new and better ways of thinking about health issues (Lasker et al, 1997). Through the exchange of information and sharing of resources, the capacity for mutual benefit and common purpose can be enhanced. (See Appendix A for additional references on partnership development.)

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Funding Ideas to Support Population-Based Activities

By reading this chapter, you will learn more about:
1. Current public health funding sources and expenditures.
2. The shift from clinical to population-based services.
3. The importance of assessing the costs of providing specific services.
4. Creative ways to identify new funding sources to support population-based services, as other revenue sources are lost.

Funding Sources

Funding for local public health agency (LPHA) services is varied. According to preliminary national data from NACCHO's *Infrastructure Study* (NACCHO, 2001), on average:

- 44% of an LPHA's total budget comes from local government (city, county, town).
- 30% is derived from the state government, including federal pass-through funds.
- 19% comes from service reimbursement (Medicaid, Medicare, patient, and regulatory fees).
- 3% comes from the federal government, including direct grants.

Urban Institute's New Federalism Project

As part of its New Federalism project, in 1998, the Urban Institute studied the changes occurring in 13 state public health systems (Alabama, California, Colorado, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, Wisconsin). Findings showed that (Wall, 1998):

- Texas and Wisconsin rely on local funds for more than half of their revenues. Of approximately 140 LPHAs in Texas, only half receive any state funds.
- Decentralized states are most reliant on local funds.
- Only 9% of LPHA budgets in Alabama and 14% in Florida are derived from local tax revenues, reflecting a high level of state control over public health.
- The percentage of LPHA budgets derived from local sources partly reflects county and city taxation policies and the importance attached to public health by local governments.
- LPHAs that are adept at maximizing regulatory fees and public insurance revenues are less reliant on local tax support.
- LPHAs in Alabama and Florida are most likely to deliver personal health services.
- LPHAs in the South have traditionally considered clinical service delivery as central to their mission, mainly because of the shortage of private providers in rural areas.

Public Health Expenditures

Evaluating the costs of public health service delivery is an important internal management tool and a way to negotiate for more funding. With better financial data, public health advocates can argue more effectively for increased support for the 10 essential services (Leviss, 2001). In 1994, the Department of Health and Human Services (DHHS) Office of Disease Prevention and Health Promotion commissioned a series of studies of public health investments (Atchison et al, 2000). Subsequently, the Public Health Foundation (PHF) worked with states and LPHAs to develop a methodology to collect data on expenditures related to the 10 essential services of public health (Eibert et al, 1996).

The studies found that reliable data on public health expenditures can help in the allocation of scarce resources and establish a closer connection between the mission/priorities of public health and actual investments in public health. Quantifying local public health expenditures according to the 10 essential services can be very useful for resource allocation (Mays et al, 2000).

Expenditures Studies

The first of the PHF expenditure studies included nine states (Arizona, Illinois, Iowa, Louisiana, New York, Oregon, Rhode Island, Texas, Washington). Findings showed that (Eibert et al,1996):

- Public health expenditures can be defined, measured, and monitored according to the essential services framework.
- Overall, 55% of LPHA dollars are spent on personal health services, such as maternal and child health and primary care.
- Personal health services consume the largest share of the average LPHA's staffing and funds; population-based services represent 24% of spending.
- Excluding personal health services, both state and local health departments spend the largest amount on "diagnosing community problems."
- State sources represent 50% of LPHA expenditures for population-based services, local sources (appropriations and fees) account for 16%, federal funds for 32%, and Medicaid reimbursements and other funds for 2%.

This study documented a lack of reliable information in state health departments about local public health expenditures. Therefore, PHF collaborated with NACCHO and the National Association of Local Boards of Health (NALBOH) to study expenditures in three local health departments: Onondaga County Health Department (NY), Northeast Tri-County Health District (WA), and Columbus Health Department (OH) (Barry et al, 1998). Health department staff were unanimous in their belief in the importance of characterizing expenditures by essential services. Expenditure data can be used to:

- Support long-term strategic planning at the local level to set priorities and identify resource needs.
- Identify gaps in essential services and areas requiring more focus and resources.
- Educate boards of health, staff, the public, and legislators about public health.

In the final study, ASTHO, NACCHO, NALBOH, and PHF worked with the Maryland Department of Health and Mental Hygiene and 24 LPHAs in MD (ASTHO, NACCHO, NALBOH, and PHF, 2000). This study showed that:

- The essential services framework can be used to characterize state and local public health agencies at a statewide level.
- The state has to be ready before engaging in a measurement of expenditures.
- Maryland's expenditures are primarily oriented toward personal health services.

Shift from Clinical to Population-Based Services

Revenues generated from categorical services and fees generated from the provision of clinical services to Medicaid beneficiaries often support the delivery of population-based services and work on the essential services (Leviss, 2001). For LPHAs that provide clinical services, Medicaid has been an important revenue stream. Although Medicaid provides only about 7% of a typical LPHA's budget (NACCHO, 2000), LPHAs have historically relied on Medicaid revenues to support population-based services, subsidize less profitable services, and provide care to the uninsured (Leviss, 2001).

The substantial shift of Medicaid-funded services into managed care plans has resulted in a reduction of clinical services and an associated loss of revenue. To maximize limited public health resources, there is a shift among LPHAs from a focus on clinical to population-based services (Mays et al, 2000). Changes in healthcare financing have caused public providers to reduce operational costs to remain financially solvent. While resources for personal healthcare increased from a variety of federal sources in the 1980s and 1990s, funding for population-based activities decreased as national expenditures for population-based activities fell from 1.2% of all health expenditures in 1981 to 0.9% in 1993 (Lumpkin et al, 1998).

A study by Lumpkin and colleagues (1998) examined the impact of Medicaid resources on the public health responsibilities of LPHAs in Illinois. The impact on core public health services was found to be substantial and to negatively affect the agencies and their role in the community. The study also examined whether:

- Medicaid resources enable core public health activities in the LPHAs studied.
- The loss of Medicaid resources reduced the capacity of the LPHAs to carry out the core public health functions.
- Additional resources are needed to maintain the provision of core public health functions if Medicaid revenues are lost.

The investigators identified all Medicaid revenues "at risk of loss" to the LPHAs as a result of Medicaid managed care and assessed the potential impact on core public health functions if these revenues were lost.

- Illinois LPHAs projected a reduction in core public health services that would be greater than the value of the services lost.
- As part of their safety net function and to prevent certain populations from falling through the cracks, the LPHAs estimated that they would continue to provide 10%-20% percent of the previous levels of clinical services even without reimbursement.
- The core public health activities that would be the most affected by lost revenue were "preventing epidemic/disease spread, promoting and assuring healthy behaviors, and assuring the quality and accessibility of care to the community."

Assessing the Cost of Population-Based Services

To decide which services LPHAs should provide, expand, minimize, or eliminate, it is important to:

- Know the costs of providing specific services. With knowledge of the amount spent on public health activities, it is easier to advocate for resources and determine how resources should be allocated (ASTHO, NACCHO, NALBOH, and PHF, 2000). Collecting data on the cost of service provision helps not only to identify areas of efficiency but also to demonstrate the value of public health to the community (Leviss, 2001).

By knowing the cost of delivering an individual unit of service, LPHAs can (Leviss, 2001):

- Compare the LPHA with other community providers
- Compare the cost of one service to another
- Identify areas of efficiency and inefficiency
- Analyze the LPHA and its infrastructure
- Understand the demand for particular services
- Advocate for local, state, and national support for funding of core public health functions
- Demonstrate the value of public health to stakeholders

- Examine the LPHA's financial situation, see what types of funding exist, and determine what is still needed to support population-based activities and the essential services.
- Develop a financing system that supports the essential services.
- Estimate how much will be saved or lost by transitioning a particular service to another healthcare provider.

The privatization of health services has an effect on LPHA revenues and expenditures. The PHF study (Bechamps et al, 1999) identified cost savings and other fiscal concerns as a primary reason for privatization of services. Six of the 25 LPHAs surveyed reported savings as a result of privatization and thus additional money to support population-based services.

- Identify funding streams to replace potentially lost Medicaid revenue (Leviss, 2001). Do not overlook the flexibility of more traditional sources of funding, such as block grants, which can often be used for activities outside of service delivery.
- Identify additional funding sources to support population-based services. Be creative; funding sources to support these services are scarce.

See Appendix A for additional references on expenditures/financial resources.

Funding Population-Based Services

As LPHAs lose revenue sources, they can turn to other ways to support population-based services.

Existing funding sources

- Take advantage of the flexibility of existing funding sources, such as the MCH block grant, which can cover costs of providing population-based services (Wall, 1998). These funds may be able to be diverted to support services such as outreach, case management, and assessment.
- Use special Medicaid administrative match program funds that support non-clinical activities such as outreach, enrollment, and education for Medicaid-eligible residents. Federal Medicaid matching funds have proven to be a rich source of funding for LPHAs. The funds may help finance a new program or the expansion of an existing program (HRSA, 2000). Visit www.cms.gov for more information.

In an attempt to defer revenue loss, the Southwest Washington (WA) Health District took advantage of Federal Medicaid Administrative Match (FMAM) funds, which more than covered the health department's shortfall. FMAM income was used to establish a fund to help during the transitioning process (Milne, 1997).

New funding sources

- Identify new federal, state, and local funding streams. For example, LPHAs in Maryland will be receiving funding from state tobacco settlement funds to carry out essential services (Atchison et al, 2000).
- Possibilities include increasing the collection of fees and fines from regulatory activities (e.g., day care, lead poisoning prevention, inspections, vital records) (Leviss, 2001).
- Seek grants from private corporations and foundations. (See resources on foundations in the section on Technical Assistance.)
- Request additional tax levy dollars for new programs and mandated services from the local government (Leviss, 2001).
- Increase or introduce charges for services to paying clients. Patient fees typically operate on a sliding fee scale (Leviss, 2001). Other options are initiation of non-Medicaid family planning fees and fees for other programs such as WIC to support activities (Slifkin et al, 2000). These steps require development of a business perspective to market services, collect revenues, remain cost competitive, and increase efficiency (Guarino, 1997).

The Bergen County (NJ) Health Department integrated a business perspective into the agency's practices to "achieve organizational efficiency, demand responsiveness, competition, market-value awareness and accountability (Guarino, 1997)." The administration felt that the public health system should be defined in terms of value and performance to ensure the health department's visibility to the public. With this new business perspective, internal procedures and work practices improved. Marketing strategies and business planning were incorporated into the provision of care. The health department began to seek competitive vendor contracts and involvement in managed care networks. The budget now follows an outline, which includes:

- Communication of the purpose of the health department as a public structure in the community
- Service value of current and future activities
- Impact of activities on community health
- Breakdown of the costs of doing business

- Strategize how to obtain additional funding from the state health department. This requires communicating the importance of population-based services to the necessary persons.

In Minnesota, New Jersey, New York, and Washington, the state offers matching funds to localities to encourage a focus on core services (Wall, 1998). New Jersey law requires the distribution of State Public Health Priority Funds to all applying health departments that meet the minimum population criteria of 20,000. These funds have been prioritized for use in building LPHA infrastructure capacity.

- Advocate for a direct appropriation, such as a special tax set-aside, from local, state, or national legislators to support public health activities.

The Hillsborough County (FL) Health Care Plan, a comprehensive managed care plan for indigent residents who do not qualify for other healthcare coverage, was funded by a half-cent sales tax allocated by the county. Participating network providers include the health department, hospitals, and community health centers. The Hillsborough County Public Health Unit administers the plan. The program provides an integrated system of health and human services and controls the costs of indigent care by providing primary and preventive services and reducing inpatient and emergency care. Outcomes include increased access to primary care and lower per-patient costs.

Collaborations/partnerships

- Develop new strategic alliances and collaborations with other organizations in the community to ensure the health of the public (Leviss, 2001). Developing partnerships also helps LPHAs contain expenditures and do more with fewer resources (Atchison et al, 2000). (See Appendix A for references on partnership development.)
- Contract with MCOs to support the provision of population-based services to Medicaid patients (Wall, 1998). Medicaid managed care provides LPHAs with new funding opportunities. MCOs are required to provide certain preventive services, such as immunizations and family planning. LPHAs can play a role in providing these services under contract with an MCO (Leviss, 2001). When creating provider networks, some states give preference points in the competitive bidding process to managed care plans that work with LPHAs (Wall, 1998). LPHAs may continue to provide case management and other enabling services while they subcontract with private providers to deliver the related clinical services. The money from the contract can then support population-based activities.

In California, health plans are required to contract with LPHAs to provide population-based services, such as family planning, STD and HIV testing, immunizations, and tuberculosis services, unless the plan can demonstrate its ability to provide these services (Wall, 1998).

Since there are few sources of funding to support population-based services, it is important that LPHAs are creative in how they market themselves. As many LPHAs take on new roles and responsibilities, staff members develop new competencies and expertise, which can be marketed to funders. Local conditions can also influence the types and amount of funding available. For example, an LPHA may have access to community foundations and local business resources. In addition, local health officials continually emphasize the importance of maximizing the flexibility of existing funding streams to support population-based services.

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Creating Political Will

By reading this chapter, you will learn more about:
1. How to create the political will to undergo a transition of clinical services to community partners.
2. How to identify and appeal to political stakeholders.
3. How to communicate effectively with political stakeholders and the media.

Local public health agencies (LPHAs) that transition services to community partners consistently note the importance of "political will." That is, to engage in an action, a community requires determination and a commitment from its people and organizations. Political will can be a critical factor in changing the public health structure of a city or county. Many LPHAs have been quick to recognize that they must work closely and maintain relationships with political powers and elected officials because decisions to transition services involve financial and other resources in which these groups may have a stake. Working with both state and local governance can result in increased backing, financial support, and decision-making authority for LPHAs. The literature also shows that successful, innovative programs generally require the awareness and support of key decision-makers (Mays et al, 1998). Several LPHAs confirm that having local players champion their cause was key to their accomplishments. These are some suggestions for creating the political will needed to transition LPHA services to other healthcare providers.

Assess the Political Environment

- Be aware of community politics. Assess the perspectives of community residents and politicians on service delivery, barriers to service, community resources, needs, and other important areas to be affected by the transition.
- Learn about the political process in the community. Find out the steps required to get the transitioning plan approved.
- Remember that the political situation varies by state, region, and locality. Consider relationships among key players, especially between the local board of health, LPHA, and county commissioners. Local values may also need to be addressed.

In Minnesota, local government control has always been a central concept. County boards are often the ultimate decision-makers in matters pertaining to public health. Health officials therefore work closely with county commissioners. LPHAs have found that informing county commissioners about important issues and soliciting their support need to be part of the process (Lind and Finley, 2000).

Identify Political Stakeholders

- Identify stakeholders as soon as possible, and involve them in the planning process. The earlier they are involved, the more personal investment they will have in the LPHA's plans and the more they will advocate for the LPHA's issues and needs.
- Consider involving the key political contacts in the community, such as the local board of health, county commissioners, and mayor. Assess whether any of these contacts will be a powerful advocate or champion.
- Work actively with the local board of health. In some communities, the board of health has final decision-making authority. Even if the board's power is minimal, members can explore issues publicly and thoroughly and provide opportunities for education and information sharing (Gebbie, 1997).
- Target citizens who are likely to know where the power lies in the community. Speak with directors of human service and government agencies, legislative aides, grassroots activists, religious leaders, business leaders, persons active in service clubs, senior citizen activists, and leaders of communities of color (University of Kansas, 2000).

What are the advantages of involving influential people?

- They can alert the LPHA to the community's concerns.
- They can let the LPHA know how the community will react to the transitioning initiative.
- They may have a historical perspective that will affect the initiative.
- They may be able to garner participation in and acceptance and support for the initiative.
- They may lend credibility to the cause.
- They may be able to garner support from persons who might otherwise be against the LPHA's ideas (University of Kansas, 2000).

- Think about which group or individual stakeholders can exert political pressure. Consider working with religious leaders, local government and political figures, school administrators, teachers, PTA members, school board members, persons involved in political campaigns, local media representatives, and local business persons.
- Work with the state health department. The state health department is a political stakeholder that should not be overlooked. It may control contracts, budgeting, and funding that can affect an LPHA's transitioning plans. The state health department may also be able to offer support, from data needs to personnel. The state's role in the transition plans will necessarily be larger if the LPHA is part of a centralized system operated by the state health agency. In this case, the LPHA will need to consult the state before implementing the transitioning plan.

The Minnesota Department of Health provides a videoconference orientation on the state public health system to all new county commissioners and community health board members. The health department also coordinates ongoing written and electronic communication and provides consultation to county boards on a variety of issues (Lind and Finley, 2000).

- Contact local politicians. If they are not helpful, consider approaching state politicians. State representatives and members of Congress may also offer their influence and support. Visit the Web site of the National Conference of State Legislatures (NCSL), www.ncsl.org, or the Legislative Action Center on NACCHO's Web site, capwiz.com/naccho/home, for information on how to contact elected officials.

Appeal to Political Stakeholders

- Determine the interests of political stakeholders. These may not necessarily include public health. Find ways of relating LPHA goals and activities to their needs (University of Kansas, 2000).

How to strengthen the support of county commissioners for public health activities
(Lind and Finley, 2000):

- County commissioners care about what their constituents care about. To influence locally elected officials' decisions, public health professionals must actively engage the community in aspects of public health and demonstrate how public health affects the entire community. Design educational efforts for county commissioners and communities to enhance the understanding of broad-based, community-focused public health. Emphasize the long-term cost-effectiveness of public health programs.
- Help people understand that public health is more than direct services. Provide tangible results of public health efforts, including prevention.
- Many local government issues, such as economic development, are seen as more pressing than public health. Help elected officials see that these issues often are connected closely to public health.
- Many commissioners understand and support environmental health activities. Strengthen the connection between environmental health and other aspects of public health. Use environmental health as a starting point to engage commissioners.
- County commissioners receive an abundance of information. Determine the most efficient, clear, and concise way to communicate with them.
- Work with the state health department to enhance the credibility of messages to county commissioners.
- Do not forget the county administrator, who is often a "gatekeeper" to the county board.

- Educate stakeholders. This may require starting with general information on public health.

The City Manager for Ft. Worth (TX) prepared a special briefing for the city council on what the service transition would mean to citizens and clients of health clinics.

Health officials at the Boulder County (CO) Health Department began their educational efforts with an introduction to the IOM's 1988 report, *The Future of Public Health*. Staff provided elected officials with background on how the health department was drawn into its safety-net role and on their current vision for public health.

- Share information about the benefits of transitioning, including continuity of care, more affordable and accessible health care, and increased LPHA efficiency. Develop projections; document escalating costs. Collect as much data as possible to make the case while being honest about the costs of transitioning.

Boulder County (CO) LPHA management spent much time making sure that political stakeholders understood the driving forces behind each decision. Informing, educating, and motivating political players may help to avert conflict. If political stakeholders understand the basis for the transition plan and have been allowed adequate discussion, their support may come more readily.

Health officials in Leon County (FL) did not want any surprises. Before the transitioning decision became public, management proposed their plans to the coordinating council, county commissioners, county administration, and state health department. Stakeholders were briefed on the rationale behind the plans and on how the LPHA was assuring continued care.

- Contact influential community members, and ask for their participation. It is always helpful to have the support of community spokespersons. Use the LPHA's constituents as a pressure group to enlist the support of decision-makers.

The Chicago (IL) Department of Public Health identified supportive persons and groups. When the transitioning contract went before the city council, health department staff made sure that community spokespersons were there to show their support.

In Shelby County (TN), regional health councils address community diagnosis, health priorities, and strategic approaches. The health department worked with these councils, composed of county residents, to voice support.

- Involve LPHA staff as appropriate. Encourage them to meet with decision-makers and discuss topics such as outcomes, dollars saved, and level of service provision.
- Make every attempt to keep promises to political stakeholders, but do not promise things over which the LPHA has no control. If necessary, start small to gain credibility and trust. Hesitant stakeholders may be receptive to a partial transition.

The Tacoma-Pierce County (WA) Health Department first restructured administratively to show they were capable of success. When the health director later approached elected officials about transitioning the agency's clinical services, they were more willing to support the change.

Communicate with Stakeholders

- Before initiating and throughout the transitioning process, keep political powers apprised of plans.
- Meet with political stakeholders in person. Personal contact is usually helpful in gaining support. Make personal calls to county commissioners and state legislators (Gebbie, 1997).

The Fort Worth (TX) City Manager reported that health department representatives met with each council member in their districts. The outreach teams, consisting of public health nurses and community health aides, presented their assessment of issues and problems facing the residents of the district and the programs in place to address those issues. The plan is to keep elected officials aware of public health and the positive impact on voters. These teams are a continuing resource for elected officials.

- Keep communication materials brief and succinct. Consider developing a brochure to disseminate to stakeholders.

The Chicago Department of Health developed a report on the implications of its service-delivery strategy. The 3-page document provides the rationale for the decision and is easily updated.

- Maintain open channels with key policy makers:
  - Add legislators and other policy makers to the mailing list for the agency newsletter.
  - Periodically call elected officials and staff to keep them up-to-date and to ensure that the agency's agenda is part of their agenda.
  - Invite policy-makers to meetings and special events.
  - Be responsive to requests from policy-makers.
    (Hirano and Christensen, 2001)
- Interact with the media. Treat the media as a potential partner.

Helpful hints for working with the media

- Encourage the local media to be an integral part of the process. Media representatives who feel a sense of ownership will be more likely to publicize the initiative.
- Enlist the help of a seasoned public relations or media veteran.
- Appoint spokespersons for newspaper, television, and radio interviews.
- Prepare fact sheets.
- Keep the media informed about LPHA activities.
- Provide examples of local impact.
- Make coverage "user-friendly."
- Develop a list of media contact names and phone numbers.

Tips on making a story newsworthy

- Create a sense of urgency.
- Put a human face on the story.
- Involve celebrities (e.g., mayor, well-known business and community leaders)
  (National Civic League, 2000).

- Contact national organizations for resources on communicating with political stakeholders.

Resources

International City/County Management Association (ICMA) is the professional and educational organization representing appointed managers and administrators in local governments throughout the world. www.icma.org

National Association of Counties (NACO) acts as a liaison with other levels of government, works to improve public understanding of counties, serves as a national advocate for counties, and provides counties with resources on innovative methods to meet local challenges. www.naco.org

U.S. Conference of Mayors is the official nonpartisan organization of cities with populations of 30,000 or more. Each city is represented in the Conference by its chief elected official, the mayor. www.usmayors.org

National Conference of State Legislatures (NCSL) is a bipartisan organization dedicated to serving the lawmakers and staffs of the nation's states, commonwealths, and territories. The mission is to improve the quality and effectiveness of state legislatures, foster interstate communication and cooperation, and ensure legislatures a strong, cohesive voice in the federal system. www.ncsl.org

National Association of Local Boards of Health (NALBOH) represents the interests of local boards of health and assists them in assuring the health of their communities. www.nalboh.org

Association of State and Territorial Local Health Liaison Officials (ASTLHLO) is comprised of representatives from each state and territory whose responsibility is the support and oversight of local public health units. ASTLHLO enhances communication, provides a support network, and provides an opportunity for local health liaison officials to promote and influence national public health policy.

- Plan a community celebration when transitioning has concluded. Invite political stakeholders.

The development of political will requires collaboration across sectors to educate stakeholders and change community norms about service delivery. Health officials must not only guide their agencies through complex decision-making and transitioning processes but also foster relationships with political stakeholders and bring together a variety of organizations and resources. LPHAs have found that working with political stakeholders is instrumental to the transitioning process; the support of key groups and individuals often equals success.

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Workforce Development

By reading this chapter, you will learn more about:
1. How to prepare the public health workforce for work in the essential services and population-based activities
2. How to use in new capacities staff that formerly provided clinical services
3. How to locate skilled public health professionals
4. How to find and utilize new technologies and other educational resources

The 1988 Institute of Medicine (IOM) report, the Future of Public Health, concluded that the nation's public health system was incapable of meeting its responsibilities. Issues such as emerging diseases and poor access to health care for the indigent and enduring public health problems like teen pregnancy and substance abuse threaten the capacity of the public health system to engage in its mission of health promotion and disease prevention. The IOM report also found that the public health workforce lacked a firm grounding in the key concepts of public health. The IOM defined three core functions of public health – assessment, assurance, and policy development – on which to base efforts to refocus and educate public health workers and repair the public health system. These core functions paved the way for the development of the 10 essential services of public health.

Recent changes in the public health system have created new demands on an already evolving workforce. As traditional public health functions are transitioned to private providers, LPHAs are making decisions about the training needs of their employees. Skills of LPHA staff generally focus on the provision of clinical services. With the recent focus on population-based activities, it is now crucial to have a workforce skilled in epidemiology, planning, partnership development, and oversight of contract-service providers. Public health employees need to be trained in the 10 essential services and provided with technical assistance on their new responsibilities. Research has shown that retraining is almost always necessary to transition employees into new positions (Bechamps et al, 1999).

LPHAs should follow these workforce development steps.

Develop a Training Plan

- Provide a basic course in public health ("Public Health 101") that includes workshops on population-based strategies, social marketing, media advocacy, and information technology. Because so few LPHA personnel are trained in public health, all employees (not just those who previously provided clinical services) should be oriented to public health practice and the 10 essential services.

The Bergen County (NJ) Department of Health held workshops on the development of public health systems, core public health functions, the role of public health in the community, and the principles of a learning organization, including systems concepts, team learning, and competence-based training. Management integrated a business perspective into training sessions and educated staff about finance and business practices (Guarino, 1997).

- Train staff as soon as possible. The sooner retraining occurs, the easier the transition and the better equipped staff will be to carry out the LPHA's new mission (Bechamps et al, 1999). The LPHA should provide ongoing continuing education to ensure that all public health workers keep up with trends, changes, and advances in the field (Milne, 2000).

A health official in Elyria, Ohio, foresaw the need for training and attention to staff needs. "Four years ago, in anticipation of change, we made a state public health nursing course available to all clinic nurses to enable a transition from clinic to neighborhood programs."

- Emphasize the new working relationships between LPHA staff and personnel in community-based organizations; acknowledge their dissimilar philosophies and work styles.
- If the LPHA lacks training expertise, bring in outside experts, such as information technology specialists, contract analysts or attorneys, community organizers and developers, and public relations/media relations specialists, to conduct training sessions. (See section on Technical Assistance Resources.)

Staff of the Tacoma-Pierce County (WA) Health Department underwent a 6-month training session that covered assessment, community engagement, population-based activities, and social marketing. Trainers were brought in from outside because LPHA staff lacked the required training skills. According to health department officials, the results justified the investment.

- Identify interdisciplinary content for new employee orientations and workforce updates Topics should include: orientation to the values, history, and world view of public health; assessment; epidemiology; analytic thinking; communication skills; community development; policy development; politics; and organizational effectiveness. (Gerzoff and Gebbie, 2001).
- Consider the use of innovative distance-based learning technologies (e.g., web-based instruction, satellite downlinks). Traditional approaches do not adequately prepare employees for the new work of public health (DHHS, 1997). Distance learning provides consistency, avoids duplication, and can be extremely cost-effective. Other benefits are:
  - Decreased staff travel and release time
  - Increased number of participants
  - Promotion of collaborative relationships through information exchange
  - Quick and wide dissemination and updates of information

The Public Health Foundation's Web site (www.phf.org) contains an online distance-learning clearinghouse, TrainingFinder.org. This free service is a comprehensive database of distance-learning course listings designed to increase training opportunities for the public health workforce.

Use Staff Differently/Locate Skilled Public Health Professionals

- Consider how staff will fit into the new service delivery model. LPHAs are finding creative ways to reorganize assignments based on new responsibilities and priorities.

Albany County (NY) Health Department's restructuring of its personnel system has contributed to increased capacity. Three nursing positions attached to clinics were reassigned to population services (e.g., TB and STD prevention) and community issues (e.g., domestic violence, teen pregnancy). With the entire nursing staff cross-trained for multiple functions and programs, nurses can take on several roles instead of being dedicated to a single office or program.

The Tacoma-Pierce County (WA) Health Department created a new set of full-time equivalent (FTE) positions. Management provided training opportunities and a series of courses. Staff competed for new jobs and were assigned positions based on skill level.

- Remember that many staff members involved in the provision of individual clinical services derive satisfaction from this part of their jobs. Some LPHAs have encouraged community partners to hire these staff members so that they can continue to provide direct services.

- Recruit skilled public health professionals, such as trained epidemiologists, biostatisticians, health policy analysts, and educators. Consider these recruiting methods:
  - Foster relationships with academic institutions and faculty.
  - Create opportunities for existing staff to increase their skills in the organization.
  - Pay for employees to enhance their professional and technical skills through external education and training.
  - Incorporate private-sector recruiting techniques (e.g., sign-on bonuses, counteroffers, referral awards for hard-to-fill positions, temporary pay differentials to compensate for added responsibilities or special projects).
  - Recruit via the Internet.
  - Ask staff to help with recruiting.
  - Exhibit at job fairs.
  - Offer internships.

  (Thielen, 2001)

Because recruitment and retention of qualified staff are problems in rural areas, these areas might need to rely on telecommunications. "Telehealth" is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. For example, small, rural LPHAs that lack resources to hire an epidemiologist can use this technology to obtain epidemiologic services when needed (National Advisory Committee on Rural Health,1999). For more information, contact the Office for the Advancement of Telehealth, http://telehealth.hrsa.gov.

Explore Available Resources

- Check with the state public health agency about training resources, including course offerings, personnel, and funding.

The Minnesota Department of Health conducts videoconferences and onsite workshops for public health nurses to enhance skills in population-based practice. A series of training sessions taught nurses to determine: 1) the health status of communities, 2) populations at risk, 3) strategies and interventions to effect change at the community, systems, and individual levels, and 4) evaluation criteria for interventions. More information is available at http://www.health.state.mn.us/divs/chs/phn/partnerships.html.

- Consider other partners from the public, voluntary, and private sectors. According to *The Public Health Workforce: An Agenda for the 21st Century*, a report of the Public Health Functions Project (DHHS, 1997), "partnerships and collaborations enhance the relevance of education and training and provide potential financial support resulting in a more effective and efficient educational program." Potential partners include MCOs, business and industry, schools of public health and other health professions, state health departments, professional associations, community-based organizations, foundations, federal government, and other key stakeholders groups. (For more suggestions, see the section on Developing Partnerships.)

- Recognizing the challenges that LPHAs face in determining how to retrain their employees, organizations such as the American Public Health Association are working to assess the training needs of the public health workforce and define expected skills and competencies. Acquiring employees with these new skills, or retraining current employees, is especially important for LPHAs, which often rely on data to influence policy and programs. By orienting new employees to the profession of public health, emphasizing the essential services, providing continuing education, and taking advantage of technology, such as distance learning and telehealth, LPHAs should be in a better position to meet the challenges of a population-based public health system.

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Labor-Management Cooperation

By reading this chapter, you will learn more about:
1. Benefits of labor-management cooperation.
2. Barriers to labor-management cooperation.
3. Organizational structures that support successful worker participation.

Contrary to the prevailing view that unions block workplace innovations, when given the chance for genuine involvement in strategic, operational and working level decision-making, unions can and do work as allies with public management to elicit and sustain commitment that is essential to teamwork and improving productivity.

Jerome M. Rosow, President, Work in America Institute
(Department of Labor, 1996)

The most valuable asset in LPHAs is the workforce, the frontline workers. A federal *Task Force on Excellence in State and Local Government through Labor-Management Cooperation* saw dramatic and compelling evidence that the public sector is achieving high performance through greater employee participation (Department of Labor, 1996). The task force found that "labor-management cooperation, which engaged employees in decisions around service planning and implementation," typically resulted in:

- More efficient service — Service frequently became more efficient; new or expanded services were often offered, and all were more responsive to citizens.
- More cost-effectiveness — Money was saved and better spent.
- Better quality of work life — Employees experienced more involvement and opportunities to contribute and learn skills; they gained greater job security and found increased respect.
- Improved labor-management relations — Workplaces were characterized by less conflict, faster conflict resolution, more flexible contracts, and emphasis on mutual responsibilities for service improvement.

As LPHAs confront the challenges facing the public sector today, they need to treat frontline workers and the unions that represent them as part of any viable solution. The task force report offers nuts-and-bolts advice to state and local governments on how to build and sustain cooperative, service-focused relationships with employees. It also presents case studies of joint labor-management efforts by state and local governments.

According to the report from the *Task Force on Excellence in State and Local Government through Labor-Management Cooperation:* "…labor-management cooperation that is specifically focused upon employee participation and service improvement represents a fundamentally different approach from more traditional labor-management relations. In traditional relationships, employee involvement in problem-solving is limited or absent and the organization is characterized by hierarchical service delivery and decision-making systems. Workplace problems and conflicts are likely to be more difficult to identify and resolve. In a successful and stable labor-management partnership, labor and management agree to assume and allow new roles for managers, workers and their representatives in workplace decision-making. This means that employees participate on a daily basis in decisions about services in areas traditionally reserved only for supervisors and managers. In exchange, the workers and their representatives are committed to responsible improvement to public services" (Department of Labor, 1996).

The task force identified a variety of obstacles to labor-management cooperation that must be faced and overcome to achieve success. These include:

- Difficulties in convincing everyone of the need for change and the need to enter into new relationships
- Unaddressed personal or institutional concerns, such as fears of layoffs
- Internal inability to agree or develop cohesion
- Political considerations
- Intentions to contract out no matter what

The task force saw examples of agencies and jurisdictions that overcame these obstacles to establish and achieve workplace excellence and more effective relationships.

Why do unions participate in labor-management efforts? In addition to giving frontline workers the opportunity to use the know-how they have developed over the years, labor-management cooperation also gives the union input on issues critical to workers but not usually covered in collective bargaining -- issues of public services' quality, cost, and timeliness that bear directly on workers' job security. Meaningful and successful labor-management cooperation occurs when:

- The union and management acknowledge each other's legitimate roles and functions;
- There are mutual interests and goals on which joint action is possible;
- The parties recognize that conflicts will occur and are not inherently bad and that joint initiatives should value resolution of conflict above avoidance of conflict;
- There is an atmosphere of basic respect, trust, and value for all employees and the diversity they bring to the workplace;
- Information is shared openly and candidly;
- The parties exhibit patience and perseverance.

Above all, success requires:

- A commitment by the union and management to organizational success and a willingness to assume responsibility for achieving it;
- A willingness of management to share authority, including strategic decision-making authority, and to accept the union and frontline workers as valuable partners;
- The readiness of workers and the union to exercise authority responsibly and re-think long-cherished beliefs;
- The recognition by employers of the importance of employment security and the need to make every effort to maintain it (AFSCME, 1996).

The federal task force also identified organizational structures that support successful worker participation. These include:

- Organizations that have fewer supervisory layers and use teams instead of supervisors to make key decisions.
- Joint labor-management committees that set the agenda and pace for partnership initiatives and include union leaders and program managers.
- Project teams that evolve from the labor-management committee process and bring together workers and managers from different parts and levels of the organization to resolve problems and make improvements.
- Employee involvement in teams and committees where worker representatives are chosen by their co-workers, even in government agencies without collective bargaining agreements, to enhance trust and acceptance in the process.

Finally, the task force found that the same skills, people, and trust that allow workers and management to work together on a service improvement project eventually produce positive benefits in other areas, such as improved bargaining or conflict resolution. With flexible and strategic leadership on both sides, trust and skills can be transferred to other parts of the organization and to other services or processes. Public services as well as public sector employees and managers all benefit.

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Contract Monitoring/Performance Evaluation

By reading this chapter, you will learn more about:
1. Preparing a performance evaluation plan
2. Identifying and selecting performance measures
3. Data requirements, submission, and review

Performance Measurement

The following discussion on contract monitoring and performance evaluation outlines a detailed, comprehensive process. The degree to which a local public health agency (LPHA) will be able to follow these steps depends on:

- The formality of the agreement between the LPHA and the partner organization. All formal contracts should include a detailed performance evaluation plan. If an LPHA has a less formal transitioning agreement, then the monitoring plan can be less formal as well.
- The capacity and resources of the LPHA and partner organizations to engage in a performance evaluation process.
- Whether or not money is exchanged among the involved parties.
- The number, type, and scope of services being transitioned.
- The relationship of the LPHA with the partner organization and their history of collaboration.

Performance measurement yields several benefits to both the LPHA and the contracting or partner organization (AHRQ, 2001). Performance measurement:

- Serves as an important management tool to learn if the program is accomplishing its intended goals
- Promotes the effective use of resources.
- Helps enforce contractual requirements.
- Provides information needed to hold health plans, providers, and contractors accountable for the services they offer; provides a basis for offering incentives.
- Allows comparisons of program performance.
- Facilitates the tracking of trends.
- Provides an objective basis for ongoing quality-improvement initiatives.
- Facilitates communication and reporting to constituencies and stakeholders, including funders and legislative and executive officials.
- Helps reward staff by monitoring performance.

The following steps will make the performance evaluation process more manageable for both the LPHA and the partner organization:

- Develop an evaluation plan jointly to encourage interest and investment in the process by all participants.
- Ensure that the evaluation plan is reasonable and useful to both the LPHA and the partner organization.
- Collect baseline data for comparison purposes.
- Require contractors and collaborators to provide only the core data needed to evaluate the quality and quantity of services being delivered. Limit the number of measurements and do not collect data that will not be used.
- Make the data collection easy enough and the time frames short enough so the collection can be repeated on a frequent basis.
- Limit the number of required reports from contractors and collaborators. Include data already being reported to funding and regulatory agencies.

Performance evaluation plan

All transitioning arrangements – whether formal or informal or for one small service or many large services — should have a performance evaluation plan. A performance evaluation plan implies the "regular collection and reporting of data to track work produced and results achieved" (Turnock and Handler, 2001). The plan will be useful not only for monitoring and oversight of transitioned services but also for other activities, such as (AHRQ, 2001):

- Program management — To oversee program operations and ensure that goals are addressed adequately and resources are used efficiently.

- Accountability — To demonstrate success in meeting goals and objectives.
- Quality improvement — To track the impact and quality of interventions.

The LPHA should prepare a performance evaluation plan before finalizing any agreement or contract. The LPHA should share the plan with and get the approval of the partner organization. The plan should include:

- Mission statement, including short- and long-term goals and objectives
- Steps and timing of the monitoring process
- Data/indicators that will be used to monitor services
- Format of reporting requirements
- Ways in which performance measurement will improve management and resource allocation
- Consequences of substandard performance

The George Washington Center for Health Services Research and Policy has developed purchasing specifications that provide options for language on key contracting issues with MCOs. These include language on quality measurement and improvement and data and reporting.
www.gwu.edu/~chsrp/

Capacity for performance monitoring

Part of the planning process is to assess the capacity and resources of the LPHA and partner organization for performance monitoring. Resources include the expertise of the staff responsible for conducting and overseeing the evaluation and the costs involved.

- Staffing — The LPHA and partner organization should assess (AHRQ, 2001): 1) staff members' experience and expertise in performance measurement and data management, 2) the need for training in data collection and analysis, and 3) the need to hire additional staff or contractors. The responsibility for monitoring the transitioned services should be delegated to LPHA personnel who have an understanding of the transitioned service. The level of services to be transitioned and the expertise of staff in both the LPHA and the partner organization may warrant the hiring of new staff or contractors with experience in performance evaluation. Before hiring new staff, however, be sure to consider the user support resources available for different performance measurement sets.
- Costs — Performance measurement is associated with many unavoidable costs. The LPHA and partner organization should estimate the level of internal and external resources needed to support the oversight function. Costs will depend on the jurisdiction and the size of the transitioned service. Some costs to consider are (AHRQ, 2001):
  - Staff resources
  - Senior-level oversight and involvement
  - Staff training
  - Outside expertise
  - Software and other materials for measures not in the public domain
  - Data collection and validation
  - Data analysis and preparation of results
  - Report preparation and dissemination

  It is important to remember that performance measurement initiatives may actually identify cost-effective quality improvement measures and thus reduce costs in the long-term (AHRQ, 2001).
- Advisory support — A key resource will be an advisory group of stakeholders to oversee the performance evaluation process, including the decision about which performance measures to use and data to collect. Include LPHA staff, especially persons responsible for overseeing the contract or agreement, and staff from the partner organization. Also include persons with expertise in data collection and data analysis and an understanding of the contracted service. Add members as needed for specific expertise or input.

Reporting requirements

Some data requirements will be specific to the transitioned program or service, but others will reflect federal and state mandates regarding the provision of healthcare services to Medicaid and State Children's Health Insurance Program (SCHIP) recipients. The LPHA will need to work with the appropriate state departments involved in regulation of healthcare services (e.g., Department of Commerce, Department of Health, Department of Human Services) to identify reporting requirements for Medicaid and SCHIP services. Whenever possible, indicators

should include data and reports that funding agencies and other government organizations already require of the partner organization. This will limit the number of reports the contractor has to produce and increase the likelihood that reports to the LPHA will be completed in a timely manner and that data will be accurate. The following types of data may already be collected:

- Encounter data
- HEDIS data
- Quality reports
- Provider reimbursement information
- Provider network information
- Third-party recovery information

Performance measures

Once data requirements have been determined, the LPHA, in consultation with the advisory group and the partner organization, needs to decide what other data need to be collected to adequately monitor the performance of the contracted service. An endless amount of data can be collected from organizations performing the transitioned services. Data collection can be expensive, so choose performance indicators carefully. Since the process of developing performance measures is time consuming and resource intensive, it is important to use existing performance measures and tools whenever possible. Performance measurement tools must include clearly defined terminology or specifications that are (AHRQ, 2001):

- Objective — Quantifiable and capable of external verification.
- Standardized — Able to be understood and applied in the same way regardless of who is involved.
- Comprehensible — Able to be understood without specialized training or expertise.

The following steps will be helpful in identifying performance measures (AHRQ, 2001):

- Review existing performance measures in general use (see below).
- Search AHRQ's CONQUEST compendium of performance measures (see below).
- Consult with peers.
- Consult with professional organizations.
- Review the literature.

The following performance measures are in general use by Medicaid, SCHIP, and Title V programs and can be adapted by the LPHA.

Consumer Assessment of Health Plans (CAHPS)

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). It is a survey instrument that measures perceptions of the experience of healthcare. For more information, see the Consumer Assessment of Health Plans: Fact Sheet. AHRQ Publication No. 00-PO47, April 2000. www.ahrq.gov/qual/cahpfact.htm

Agency for Healthcare Research and Quality Quality Indicators (AHRQQIs)

These measures, derived from hospital-discharge data, can provide warnings of potentially inadequate care. www.ahrq.gov/chtoolbx/measure3.htm.

Health Plan Employer Data and Information Set (HEDIS)

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS Quality Standards provide an annual national benchmark to measure clinical performance in eight categories (AHRQ, 2001):

- Effectiveness of care
- Availability and accessibility of care
- Satisfaction with the experience of care
- Use of services
- Health plan stability, including disenrollment rates and physician turnover
- Costs of care
- Informed healthcare choices, including new member orientation/education and language translation services
- Health plan descriptive information.

State Medicaid agencies use HEDIS measures to assess the performance of their contracted MCOs. Several state Medicaid agencies also use HEDIS measures to assess the performance of their Medicaid fee-for-service and primary care case management plans. Most states use all or part of the HEDIS set to monitor SCHIP performance.
www.ncqa.org

Title V Maternal and Child Health Performance Measures
HRSA has developed a set of broadly defined public health performance measures to be collected by states annually.
www.mchdata.net

Conquest
For information on additional performance measures, check CONQUEST — the COmputerized Needs-oriented QUality Measurement Evaluation SysTem, AHRQ's computerized compendium of performance measures. CONQUEST allows users to collect and evaluate healthcare quality measures to find those most suited to their needs. CONQUEST can be used as (AHRQ, 2001):

- A source of information on performance measures in the database
- A source of information on specific conditions, the populations they affect, and measures developed to measure performance in treating them
- A tool for comparing and evaluating the measures

www.ahrq.gov/qual/conqix.htm

It is also critical to decide what aspects of the partner organization's performance in delivering the contracted service/s needs to be measured. This is where an examination of the mission statement and goals and objectives can be useful. Performance measures can assess (AHRQ, 2001):

- Use or utilization — The number of times a treatment or procedure is performed and the outcome. Demographics of individuals utilizing these services are important as well.
- Access — Extent to which needed healthcare services are available to eligible or enrolled persons in a timely manner.
- Health services delivery — Extent to which people receive various health services; can also include cost and units of service provided.

Two tools developed by AHRQ may be useful for program management and quality improvement:

National Guideline Clearinghouse (NGC) is an electronic resource of established, evidence-based guidelines for a variety of health conditions.
www.guideline.gov/index.asp

Evidence Reports and Technology Assessments review the relevant scientific literature on certain clinical care topics to use as a basis for clinical guidelines and other quality-improvement activities.
www.ahrq.gov/clinic/epcix.htm

- Perceptions of the experience of care — Patients' perceptions of the experience of care and satisfaction with providers and health plans; often assessed by use of the Consumer Assessment of Health Plans (CAHPS)
- Quality of care — Aspects of the quality of healthcare delivery, such as appropriateness, access, acceptability, timeliness, and satisfaction.

There is no standardized definition of healthcare quality. One of the most widely used definitions was developed in 1990 by an IOM Study Committee. According to the IOM, quality of care is the "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." This definition emphasizes the relationship among healthcare quality and outcomes, desired results, and use of current and evidence-based medical knowledge (Lohr, 1990).

Uniform Data System (UDS)
This is an integrated reporting system used by BPHC grantees (e.g., community health centers, migrant health centers, healthcare for the homeless programs). To ensure compliance with legislative mandates and report on program accomplishments, BPHC requires a core set of information to be collected annually. UDS provides data on services, staffing, and financing.
www.bphc.hrsa.gov

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
This is the standards-setting and accrediting body in healthcare. The Joint Commission develops standards and evaluates the compliance of healthcare organizations against these benchmarks. The standards address an organization's level of performance in key functional areas and develop performance expectations for activities that affect the quality of patient care.
www.jcaho.org

Foundation for Accountability (FACCT)
This organization is dedicated to helping Americans make better healthcare decisions. FACCT creates tools that help people understand and use quality information, develops consumer-focused quality measures, supports public education about healthcare quality, and supports efforts to gather and provide quality information.
www.facct.org

Many factors are involved in choosing which performance measures to use either for monitoring and oversight or for another purpose. When making decisions about performance measurement tools, the following considerations may be helpful (AHRQ, 2001):

- Think long term to define realistic expectations and resource requirements. Collecting and reporting performance measurement data for the first time is always challenging. Consider making the first year a pilot year, where measurement results are not publicly released. Second-year results are more likely than first-year results to reflect actual performance, and providers can have a practice year without any adverse consequences (AHRQ, 2001).
- Consider all available measurement tools. Adopt an entire measurement set, or pick and choose among one or several to provide a complete assessment (AHRQ, 2001).
- Use fewer rather than more measures, at least in the first few years, to demonstrate the feasibility and usefulness of performance measurement activities without spending all of the agency's resources (AHRQ, 2001).

Determining how the results of the performance measurement will be used is important in determining the appropriate data to collect. The following are important considerations (AHRQ, 2001):

- If results will be used to make comparisons, decide ahead of time what will be compared. Comparisons can be made only when data elements, data collection, and data analysis procedures are rigorous and precise.
- To track trends over time, be sure to collect baseline data before starting the transitioning process.
- To compare results with an established benchmark or find out how the service ranks with others, use measures for which national databases and/or benchmarking information exist.

Data sources
The LPHA, in consultation with the advisory group and the contracting organization, needs to determine if data sources are available or can be made available for the performance evaluation process. Data are generally obtained from three sources: 1) administrative data, including claims and encounter data and enrollment files, 2) medical records, and 3) member surveys (AHRQ, 2001).

- Administrative data — All health programs, plans, and systems maintain administrative data. Their application to performance measurement requires an understanding of the data and an assessment of the data's limits, completeness, and accuracy. Since administrative data are collected regularly, their use in performance measurement will decrease both the time and the costs involved in data collection (AHRQ, 2001).

- Encounter and claims data — These are types of administrative data. Some states use encounter or claims data as the basis for calculating HEDIS measures and collect these data as a part of normal operations (AHRQ, 2001). Claims data are likely to be complete for services/procedures that are individually reimbursed and less likely to be complete for those that are not. The completeness of encounter data also varies (AHRQ, 2001). The accuracy and consistency of the data must also be considered.
- Medical records — All providers maintain records on patients' conditions and treatments. In some cases, medical records data have been transferred into databases, facilitating their use for performance measurement. Medical record audits are a useful tool for evaluation but are very costly (at least $20-$25 per chart) (AHRQ, 2001).
- Survey data — To determine the usefulness of a survey for performance measurement, it is necessary to assess the procedures used to develop the survey instrument, select the sample, and administer the survey. CAHPS is a survey instrument that is frequently used to measure perceptions of the experience of healthcare. Additional patient satisfaction surveys are also available (AHRQ, 2001).

Considerations pertaining to data sources for performance measurement include the following:
- Locating data that are readily available, comparable, complete, and accurate may be difficult (AHRQ, 2001).
- For statistical reasons, the number of cases studied must be large enough that information can be reliably applied to others (AHRQ, 2001).
- Data availability issues are important to any performance measure, especially in small geographic regions. Relying on data sets that are incomplete or inaccurate will invalidate performance measurement results. However, relying solely on existing and readily available data may limit the possibilities. This is why it is important to include those in charge of data in all planning activities (AHRQ, 2001).

In Mecklenburg County (NC), the local service delivery was transferred from a county health department to a hospital-based integrated delivery system. To assure that public health services remained available, accessible, and adequate to meet the needs of county residents, a local evaluation and monitoring system was established. The LPHA and several other organizations formed a consortium to evaluate the delivery system and community health outcomes. The organizational structure is monitored by evaluating on scope of services, personnel involved, staffing patterns, program funding, and management. Service process measures detect changes in service quality, utilization of services, appropriateness of care, and continuity of care. Community health outcomes are monitored in the county's population over long periods of time and focus on trends in a few indicators over time (Keener et al, 1997).

Data submission and review

Once the data requirements have been determined, the LPHA, in consultation with the advisory group and partner organization, should:
- Develop targets and acceptable ranges for data submission.
- Develop a standard format for data submission (including defined intervals for submission and software requirements).
- Specify acceptable methods of data submission (e.g., e-mail).

The LPHA, in consultation with the advisory group and partner organization, should then:
- Determine the persons/groups who will receive and review the data.
- Detail the tasks of each reviewer in the monitoring process and the required analytical reports.
- Determine where the data analysis should be submitted, the type(s) of evaluation meetings, the frequency of the meetings, and the meeting participants.

Other items to consider when developing a performance evaluation report is whether this information will be shared with stakeholder groups and audiences other than the LPHA. Careful planning is required to ensure that performance measurement reports achieve their intended results. Since each audience has its own characteristics, needs, and potential uses for the information, thorough knowledge of the intended audience is essential in the design of performance measurement reports. Designing a single report for multiple audiences may create problems. A well-planned dissemination strategy needs to be a part of every performance plan and should be developed early in the process (AHRQ, 2001).

Follow-up

The LPHA, in consultation with the advisory group and partner organization, should:

- Develop mechanisms for tracking issues requiring follow-up.
- Determine the consequences associated with performance that is below expectations.
- Determine what type of review and analysis will be performed and what follow-up steps will occur. For example, if the data identify a 50% decline in the number of patient visits based on the established target, what process is in place to address this decline?
- Determine whether meeting or not meeting established targets holds financial consequences for the contractor. In many states and localities, governments have developed performance-based contracts that tie a contractor's performance of a service to the payment for that service.

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Technical Assistance Resources

The following resources are provided to help LPHAs throughout the decision-making and transitioning processes.

Note: Despite the availability of these and other resources, an LPHA may need to hire an outside consultant. In addition to providing experience in a particular area, consultants can facilitate decision-making by being neutral and unbiased. To locate a consultant, contact professional associations or large local corporations, which often have community service programs and can provide a range of management and technical expertise. Or, call a local university or college Department of Human Resources, Training and Development, or Business Administration.

Community Health

Asset-Based Community Development (ABCD) Institute
Produces resources and tools for community builders involved in capacity-based initiatives, helping them identify, nurture, and mobilize neighborhood assets. Activities are based on the belief that community assets are key building blocks in sustainable urban and rural community revitalization efforts. Community assets include the skills of local residents; the power of local associations; the resources of public, private, and non-profit organizations; and the physical and economic resources of localities.
www.nwu.edu/IPR/abcd.html

Center for the Study of Social Policy's Peer Technical Assistance (TA) Network
Helps states and localities improve outcomes for children, youth, and families through interrelated governance, financing, and service-delivery changes. Made up of 60 peer consultants with expertise in: innovative approaches to child and family service delivery; neighborhood strategies to improve outcomes for families and children; promotion of children's mental health through comprehensive systems of care; promotion of educational success by linking schools, health and social services, and community supports; cross-agency budgeting and financing; new forms of local governance; and management information systems.
www.cssp.org/peer.html

Civic Practices Network (CPN)
Collaborative and nonpartisan project bringing together diverse organizations and perspectives. Provides training manuals, best-practice guides, and evaluation tools; identifies successful projects around the country.
www.cpn.org

Coalition for Healthier Cities and Communities
Network of partnerships and organizations that develops and distributes resources to support healthy communities initiatives.
www.healthycommunities.org

Community Health Assessments: Tools of the Trade
Compendium of resources for improving health and creating community-focused health-delivery systems. Provides background papers, guidelines, model surveys, annotated bibliographies, and online directories; offers consulting services.
www.hcwp.org/resources/commhealth/index.asp

Community Toolbox
Practical guidance for improving community health and development. More than 3,000 downloadable pages of skill-building information on more than 150 topics.
ctb.ukans.edu

Healthy People 2010 & Environmental Health
Online companion resource to Healthy People 2010 for tracking environmental health objectives. Provides easy access to national environmental health objectives, plus web links to help states and communities use the objectives for Healthy People planning efforts and environmental health improvement projects.
www.phf.org/EH

Institute for Alternative Futures (IAF)
Think tank that provides techniques, creates networks, and develops practices to help communities and organizations develop their own image of the future and effective strategies to shape that future.
www.altfutures.com

Interaction Institute for Social Change (IISC)
Non-profit organization providing training, consulting, and facilitation services to community leaders, non-governmental organizations, and other not-for-profit groups. Works with individuals and organizations committed to social justice and civic responsibility; builds sustainable partnerships between corporations and community-based organizations.
www.interactioninstitute.org

International Healthy Cities Foundation (IHCF)
Committed to a participatory, multi-dimensional approach to urban health issues. Provides a forum where diverse sectors of the community meet to create working alliances.
www.healthycommunities.org

Minnesota Institute of Public Health
Works with individuals and organizations to safeguard and protect public health. Creates materials and offers training and consultation to help others build and maintain safe and healthy communities.
www.miph.org

National Civic League (NCL)
Nonprofit organization that works with communities to foster cross-sector collaboration and grassroots problem-solving. A Guide to a Community-Oriented Approach to Core Public Health Functions provides information on engaging the community in the three core public health functions.
www.ncl.org

State Healthy People 2010 Tool Library
Contains Healthy People tools and materials from states that can be viewed and downloaded. Materials are organized by the seven "action areas" in the Healthy People 2010 Toolkit.
www.health.gov/healthypeople/state/toolkit

Cultural Competency

Center for Cross-Cultural Health (CCCH)
Clearinghouse and source of information, training, and research on the role of culture in health. Designed to help healthcare providers and institutions meet the health needs of ethnically, linguistically, spiritually, and culturally diverse patients. Services include training, workshops, and conferences; on-site consultation; reference archive; and quarterly digest.
www.crosshealth.com

National Center for Cultural Competence (NCCC)
Aims to increase the capacity of healthcare and mental health programs to design, implement, and evaluate culturally and linguistically competent service-delivery systems. Activities include: training, technical assistance, and consultation; networking, linkages, and information exchange; and knowledge and product development and dissemination.
www.georgetown.edu/research/gucdc/nccc/index.html

Federal Government

Centers for Disease Control and Prevention (CDC)
Lead federal agency for protecting health and safety at home and abroad, providing credible information to enhance health decisions, and promoting health through strong partnerships. Serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities to improve the health of the people of the United States. Offers numerous educational and training opportunities, such as the Public Health Training Network, a distance-learning system that uses a variety of instructional media to meet the training needs of the public health workforce.
www.cdc.gov/phtn

Centers for Medicare and Medicaid Services
Administers Medicare, Medicaid, and the State Children's Health Insurance Program. Source of information on these three programs, the Health Insurance Portability and Accountability Act of 1996, and fraud/abuse. Web site includes resources for consumers and health professionals.
www.cms.gov

Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC)
Provides resources, links, and funding related to primary care services, particularly as it relates to underserved populations. Offers resources on programs to increase access to health care, decrease health disparities and create and expand community health centers. Web site includes information on cultural competence, searchable databases, best-practice guidelines, clinical protocols, and information on BPHC programs such as the President's Initiative to Expand Health Centers, Health Care for the Homeless, Healthy Schools, Healthy Communities, and Minority and Women's Health.
bphc.hrsa.gov

Health Resources and Services Administration (HRSA) Bureau of Health Professions
Provides information on funding opportunities for clinicians, health professional educational and training programs, and resources on the health care workforce. The programs of the Bureau help to assure access to quality health care professionals in all geographic areas and to all segments of society. The Bureau strives through its programs to increase the diversity of health professions students, focus on the primary care disciplines, and expose students early and throughout their training to clinical practice in underserved areas.
bhpr.hrsa.gov/

HRSA Field Directors
See Appendix F for directory.

National Center for Health Statistics (NCHS)
Vitsal and health statistics agency maintains data based on populations cllection and data collected from vital and medical records. Provides a variety of nationwide and state health data relevant to assessing health status and access to care. Many NCHS data sources are synthesized in the annual CDC publication, "Health, United States."
www.cdc.gov/nchs

Public Health Leadership Institute (PHLI)
A 24-month, distance-learning leadership development program funded by CDC and offered by the Center for Creative Leadership and the University of North Carolina at Chapel Hill's Kenan-Flagler Business School and School of Public Health. The mission is to strengthen the leadership competencies of senior public health officials and build inter-organizational teams to improve community health status.
www.phli.org

Foundations/Funding

Community Health Partnership Initiative (CHP)
Created in 1999, with support from the Bureau of Primary Health Care (BPHC), to encourage alternative/non-federal financing of primary care for underserved populations. Services include: 1) assessment of the access needs of vulnerable populations and the effectiveness of healthcare systems in meeting those needs, 2) identification of opportunities to integrate services/systems of care to improve access, continuity, appropriateness, and quality of care, 3) identification and application of "models that work," 4) clarification of the value, applicability, and constraints of federal programs in improving access to and improving services for vulnerable populations, 5) provision of technical assistance for community-based providers in developing partnerships that optimize the care of vulnerable populations, 6) assistance in development of strategic plans to increase primary care capacity, and 7) assistance to communities in exploring possible participation in federal programs to meet the needs of vulnerable populations.
www.communityhealthpartners.org

Council on Foundations
Supports foundations by promoting knowledge, growth, and action in philanthropy. Web site includes a directory of foundations, information on legal and government affairs, and links to grantmakers.
www.cof.org

Grantmakers In Health (GIH)
Helps foundations and corporate giving programs improve the nation's health by building the knowledge, skills, and effectiveness of grantmakers and the field of health philanthropy. Foster communication and collaboration among grantmakers and with others.
www.gih.org

The Foundation Center
Supports and improves institutional philanthropy by promoting public understanding of the field and helping grantseekers succeed. Collects, organizes, and communicates information on U.S. philanthropy, provides education and training on the grantseeking process, and ensures public access to information and services through our World Wide Web site, print and electronic publications, five library/learning centers, and a national network of cooperating collections.
www.foundationcenter.org

Legal Issues

Electronic Resource Center, Management Sciences for Health
Provides information on forming a contractual partnership. Includes an article on "Forming Partnerships to Improve Public Health," which discusses how to prepare for and implement a partnership and form a partnership agreement.
erc.msh.org

National Health Law Program (NHeLP)
National public interest law firm dedicated to improving health care for America's working and unemployed poor, minorities, elderly, and persons with disabilities. Helps legal services programs, community-based organizations, the private bar, providers, and persons who work to preserve a healthcare safety net for uninsured or underinsured populations. Offers training conducted on issues such as the State Children's Health Insurance Program (SCHIP) and Medicaid managed care. Services include: 1) reviewing materials, including draft contracts for managed care, 2) preparing comments on regulations, policies and legislative proposals, 3) drafting opinion letters, 4) advising on individual eligibility cases, 5) assisting in development of advocacy strategies, 5) providing citations, memoranda, and articles for policy development or court cases, and 6) monitoring and analyzing legislation.
www.healthlaw.org

Public Health LawNet
Web site sponsored by CDC's Public Health Law Program. Contains information on public health laws, discussion groups, education and training, funding opportunities, and other resources developed by CDC and partners.
www.phppo.cdc.gov/phlawnet

Managed Care

American Association of Health Plans (AAHP)
A national trade association representing more than 1,000 Health Maintenance Organizations (HMOs), preferred provider organizations, point-of-service plans, and other health plans. Has an extensive roster of educational programs, including the Executive Leadership Program and Minority Management Training and Outreach Program. Provides information on patient care, conferences and training, and health care for consumers.
www.aahp.org

HRSA Managed Care Technical Assistance Center (MCTAC)
Offers technical assistance and training to help health departments negotiate and operate within the Medicaid, Medicare, and commercial managed-care delivery systems to ensure financial viability and improve the quality of care. Offers a variety of workshops and training sessions to meet customers' needs. The range of expertise of MCTAC's consultants – most of whom are senior executives from managed-care organizations – includes: public health and managed care, contract review and negotiations, contracting for prevention services, marketing, management information systems, strategic planning, positioning, and networking.
www.jsi.com/hrsamctac

Maternal and Child Health

CityMatCH's Data Use Institute
Training model to enhance the use of data by LPHAs and partners for urban maternal and child health. Curricula combine skills-building workshops, self-instructional materials, and a didactic and case studies-based short course. Education and training take a range of forms and are reinforced by local practice projects.
www.citymatch.org

Title V Information System
Electronically captures data from annual Title V Block Grant applications and reports submitted by U.S. states, territories, and jurisdictions and provides information on key measures of maternal and child health. Developed by the Maternal and Child Health Bureau and the National Center for Education in Maternal and Child Health, the database allows users to search and sort data on the health status of the nation's mothers and children.
www.mchdata.net

National Public Health Organizations

American Public Health Association (APHA)
Oldest and largest organization of public health professionals, representing more than 50,000 members from more than 50 occupations. Actively serves the public, members, and the public health profession through programs, publications, annual meetings, awards programs, educational services, and advocacy. Medicine and Public Health Initiative (M/PHI) involves an ongoing working alliance between the American Medical Association and APHA that began in 1994. M/PHI promotes joint strategic planning and stimulation of collaborative efforts at the national, state, and local levels and brings together leading organizations and individuals concerned about health and healthcare to develop an agenda of action that engages public health and medicine in reshaping health education, research, and practice.
www.apha.org

Association of Maternal and Child Health Programs
The national organization representing state public health leaders and other interested individuals and organizations working to improve the health and well being of women, children, youth and families, including those with special health care needs. AMCHP accomplishes its mission through the active participation of its members and vital partnerships with government agencies, families and advocates, health care purchasers and providers, academic and research professionals and others at the national, state and local levels.
www.amchp.org

Association of Public Health Laboratories
Promotes the highest quality laboratory practices and works to ensure quality laboratory testing of public health significance. Also conducts several fellowship programs within laboratories and the National Laboratory Training Network, a collaborative effort of APHL and CDC, providing high quality, low cost continuing education for testing personnel in medical, public health and environmental laboratories throughout the U.S. and its territories. The programs and workshops address emerging infectious diseases as well as other high priority lab topics such as management, quality assurance, current testing and personnel regulations, and safety issues.
www.aphl.org

Council of State and Territorial Epidemiologists
An association of public health epidemiologists in states and territories working together to detect, prevent, and control conditions of public health significance. Epidemiologists working in public health agencies are responsible for monitoring trends in health and health problems, and devising prevention programs that enable the entire community to be healthy. Public health assessment includes surveillance, epidemiologic studies, program evaluation, and performance measurement. Members have surveillance and epidemiology expertise in a broad range of areas including communicable diseases, immunizations, environmental health, chronic diseases, occupational health, injury control and maternal and child health.
www.cste.org

National Rural Health Association (NRHA)
National membership organization designed to improve the health and healthcare of rural Americans and to provide leadership on rural issues through advocacy, communications, education, and research. Provides a forum for the exchange and dissemination of ideas, information, research, and methods to improve rural health. Offers educational events, publications, and resources that focus on the unique needs and problems of rural America.
www.nrharural.org

Public Health Foundation (PHF)
National, non-profit organization dedicated to achieving healthy communities through research, training, and technical assistance. Provides health agencies and other community health system organizations with objective information on health improvement planning, understanding and use of data, and performance improvement. Develops tools and resources for public health planning, program development, progress tracking, and evaluation. Also provides public health professionals of all disciplines a place to search the most comprehensive database of distance learning opportunities. The site provides information to assess and meet the development needs of the public health workforce, while further advancing state-of-the-art training and utilization of public health competencies.
www.phf.org and www.TrainingFinder.org

Public Health Research Laboratories (PHRL)
Aims to strengthen the public health system by providing domestic and international support in public health research, training, education, and technical assistance. Specializes in statistical and epidemiologic consultation and in training of public health workers in the use of Geographic Information Systems (GIS).
www.phrl.org

Outcomes/Monitoring

DATA2010
An interactive database system developed by the National Center for Health Statistics. Contains the most recent data for tracking Healthy People 2010 objectives. Mainly includes national data, but state-based data are provided as available.
www.cdc.gov/nchs/hphome.htm

Health Forum
A new enterprise created through the union of The Healthcare Forum and the American Hospital Association's publishing and data and information subsidiaries. Provides information on building healthy communities. One product is the Outcomes Toolkit, an interactive CD-ROM and Internet-based performance-planning tool.
www.healthforum.com

Improving Health in the Community
An Institute of Medicine (IOM) guide describing the use of community indicators and performance monitoring to improve community health. Includes CDC's Healthy Days Measures among the suggested community performance indicators. CDC's Web site has links to several state and county health departments and private and nonprofit organizations that have used the Healthy Days Measures as community health status indicators.
www.cdc.gov/nccdphp/hrqol

The Public Health Competency Handbook
A research-based resource that outlines the critical competencies required to put the Essential Public Health Services into practice at both the organizational and employee levels. Includes forms, surveys, and assessments that can be customized and modified for individual agencies. For ordering information, e-mail cphp@sph.emory.edu.

Providers

American Hospital Association (AHA)
National organization representing and serving hospitals and healthcare networks and their patients and communities. Provides education for healthcare leaders and is a source of information on healthcare issues and trends. Products and services of the AHA Resource Center help healthcare leaders gain access to timely, quality health services information.
www.aha.org

National Association of Community Health Centers (NACHC)
National trade association serving and representing America's community, migrant, and homeless health centers. Web site includes searchable information on legislative actions and regulations that affect CHC operation, technical assistance resources for navigating the healthcare environment, and funding and educational opportunities.
www.nachc.com

National Association of Public Hospitals and Health Systems (NAPH)
Represents safety net hospitals and health systems. Through advocacy, research, and education, addresses a range of issues that affect public hospitals and the persons and communities they serve, including changes in the healthcare system, management and operation of safety net hospitals, and organization and delivery of healthcare services to the uninsured.
www.naph.org

Primary Care Associations and Primary Care Offices (PCAs and PCOs)
The Office of State and National Partnerships (OSNP) facilitates, coordinates, and develops Bureau of Primary Health Care (BPHC) relationships with PCAs and PCOs. PCAs are private, nonprofit membership associations that represent BPHC-supported community health centers and other community-based providers of primary care to the underserved. PCOs are federally supported offices in state governments that identify and address the needs of the medically underserved. See Appendix E for a Directory.
bphc.hrsa.gov/OSNP/

Quality Improvement

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
Accredits healthcare organizations and programs in the United States. The mission is to improve the safety and quality of care provided to the public through the provision of healthcare accreditation and related services that support performance improvement. Sponsors a variety of education programs and provides relevant publications for healthcare professionals. Offers standards-related educational support for the organizations it accredits, and advances provider understanding of concepts in performance measurement and improvement.
www.jcaho.org

Research Institutions

Academy for Health Service Research and Health Policy
Provides a professional home and technical assistance resources for research and policy professionals. Stimulates the development, understanding, and use of the best available health services research and health policy information by public and private decision makers. A WebBoard is dedicated to the discussion of workforce issues among researchers, policymakers, and others. Examples of WebBoard topics are: data collection and analysis; policy and program information; sources/quality of health workforce data; methods of measuring supply, demand, and need; and supply requirements, distribution, and diversity.
www.academyhealth.org

California Center for Health Improvement (CCHI)
An independent, not-for-profit, prevention-focused health policy center and a resource for policy-makers and community residents on policy interventions for improving population health.
www.cchi.org

CCHI's Health Policy Coach Web site presents prevention-focused policies at the federal, state and local levels and provides nonpartisan information and a network of policy coaches to help transform ideas into action.
www.healthpolicycoach.org

Center for Health Services Research and Policy (CHSRP)
The major health services research center for the George Washington University Medical Center. Conducts health services research and policy analysis on health policy issues. Identifies, monitors, and analyzes emerging issues in federal and state health law and policy and evaluates the effects of changing federal policies on health care. Web site contains a database of purchasing specifications.
www.gwu.edu/~chsrp

Health Research and Educational Trust (HRET)
Focuses on the critical issues affecting healthcare finance, delivery, and access, as well as community health. Produces practical information and products that help healthcare providers, trustees, and the persons they serve improve the health status of communities.
www.aha.org/hret

New York Academy of Medicine
Independent academic institution committed to improving the health of urban populations, particularly the urban poor, and to the continuing development and scholarship of healthcare professionals. Tools include collaborative empirical and scholarly research, healthcare policy development, advocacy, and education. Offers a rich array of symposia and colloquia and a respected curriculum of continuing medical education opportunities for professionals. Has one of the most complete medicine and health sciences libraries in the nation.
www.nyam.org

Search Institute
Nonprofit, independent research organization that promotes long-term organizational and cultural change to support the healthy development of children and adolescents.
www.search-institute.org

Schools of Public Health

Association of Schools of Public Health (ASPH)
The only national organization representing the deans, faculty, and students of the accredited schools of public health and accredited programs in public health in the United States and Puerto Rico. Represents the primary system that trains personnel to operate the nation's public health, disease prevention, and health promotion programs. The mission is to improve the public's health by advancing professional and graduate education, research, and service in public health.
www.asph.org

University of North Carolina-Chapel Hill (UNC-CH) School of Public Health
Runs the Management Academy for Public Health, a joint effort of UNC-CH's School of Public Health and Kenan-Flagler Business School, which strengthens the management skills of senior- and mid-level managers in local and state public health departments in Georgia, North Carolina, South Carolina and Virginia. The Southeast Public Health Training Center assesses workforce needs and helps build development programs in six southeastern states: North and South Carolina, Virginia, West Virginia, Kentucky, and Tennessee. Academic institutions and public health agencies in each state partner with the School of Public Health.
www.sph.unc.edu

North Carolina Institute for Public Health
Service initiative of the University of North Carolina at Chapel Hill School of Public Health. Provides specialized training, consulting, research, and technical assistance to organizations and agencies that practice health care and public health in the state.
www.sph.unc.edu/nciph

University of California at Los Angeles (UCLA) School of Public Health Technical Assistance Group
Provides services for the planning, implementation, and evaluation of public health programs. Offers the technical expertise of the school's faculty. Services include: 1) training of public health professionals and community health workers in the skills they need to promote health in their communities, 2) consultation on the planning, implementation, and evaluation of public health programs and projects, 3) hands-on technical assistance; and 4) research services, including proposal development, design, measurement, and data collection/analysis strategies.
www.ph.ucla.edu/php/tag.htm

University of Iowa Center for Public Health Practice
Promotes the linkage between the academic and research activities of the College of Public Health with public health practitioners at the local, state, federal, and international levels. Places special emphasis on: ensuring maximum practitioner participation in educational programs, developing effective practice-site relationships, and supporting communities through technical assistance and research.
www.public-health.uiowa.edu/cphp

University of Washington School of Public Health and Community Medicine's Northwest Center for Public Health Practice (NWCPHP)
Works with state partners to create a regional network for public health workforce development. Tailors workforce development activities to multiple skill levels and disciplines for public health workers at the state and local levels. Shares training materials and courses; develops and shares opportunities for peer support, mentorship, and leadership in public health practice; and implements a multimedia approach to training based on the needs of each partner state.
healthlinks.Washington.edu/nwcphp

State and Local Government

Association of State and Territorial Health Officials (ASTHO)
National non-profit organization representing the state and territorial public health agencies of the United States, the U.S. Territories, and the District of Columbia. Members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy, and to assuring excellence in state-based public health practice. Engaged in a wide range of legislative, scientific, educational, and programmatic issues and activities on behalf of public health, and a source for research, publications, consulting assistance, meetings, and seminars. Offers direct consultation on issues related to state public health and primary care systems organization and financing, data availability, and performance measurement
www.astho.org

International City/County Management Association (ICMA)
Seeks to enhance the quality of local government and to support and assist local government managers and administrators. Develops and disseminates publications and reference materials to improve local government management. Serves as a clearinghouse for the collection, analysis, and dissemination of information and data about local government.
www.icma.org

National Association of Counties (NACO)
Provides extensive legislative, technical, and public affairs services to members. Acts as a liaison with other levels of government, works to improve public understanding of counties, serves as a national advocate for counties, and provides counties with resources for innovative methods to meet the challenges they face. Assists counties in the development of services and projects related to information technology, information systems, and technical standards and provides resources to information and technology vendors. Provides county officials with the latest legislative and research information, technical assistance, training, and examples of successful programs, policies and procedures. Offers resources for lobbying efforts.
www.naco.org

National Association of State Medicaid Directors (NASMD)
Bipartisan, non-profit organization of representatives from state Medicaid agencies. Serves as a focal point of communication between states and the federal government. Maintains an information network among the states on issues pertinent to the Medicaid program.
medicaid.aphsa.org

National Conference of State Legislatures (NCSL)
Bipartisan organization dedicated to serving U.S. lawmakers and their staffs. Committed to improving the quality and effectiveness of state legislatures, fostering interstate communication and cooperation, and ensuring legislatures a strong, cohesive voice in the federal system. A source for research, publications, consulting assistance, meetings, and seminars. Through direct consultation, specialists on legislative organization and management, rules and procedures, committee operations, personnel policies, strategic planning, and related institutional issues work with leaders to make operations more efficient and effective.
www.ncsl.org

National League of Cities (NLC)
Acts on behalf of local governments to influence national policy and build understanding and support for cities and towns. Through a range of programs and services, assists local leaders in their jobs as policymakers and public servants.
www.nlc.org

State Associations of County and City Health Officials (SACCHOs)
These are small, independent organizations that represent local public health at the state level. SACCHOs often host meetings of local public health officials and are involved in local public health issues at the state level. Work closely with state departments of health and other state and national public health organizations. See Apprendix G for a Directory.

US Conference of Mayors
The U.S. Conference of Mayors is the official nonpartisan organization of cities with populations of 30,000 or more. There are 1,139 such cities in the country today. Each city is represented in the Conference by its chief elected official, the mayor. The primary roles of the Conference of Mayors are to promote the development of effective national urban/suburban policy; strengthen federal-city relationships; ensure that federal policy meets urban needs; provide mayors with leadership and management tools; and create a forum in which mayors can share ideas and information.
http://www.usmayors.org/

State Health Status

State Health Facts Online
Free, up-to-date, and easy-to-use health data on all 50 states, provided by the Kaiser Family Foundation. Includes data on health policy topics, such as population demographics, health status, and health insurance coverage. The Kaiser Family Foundation also has child health, Medicare and women's health data.
www.state.healthfacts.kff.org

Behavioral Risk Factor Surveillance System (BRFSS)
National population-based survey, including access, health insurance coverage and health risk factor data collected by age and race. Enables public health professionals to monitor progress in achieving the nation's health objectives.
www.cdc.gov/brfss/

Technology/Information

Data Skills Online
Self-instructional, web-based tool providing state and local public health professionals with analytic and technology skills focused on quantitative and qualitative data collection and analysis. Currently available tools include: Subscribing to a List, Browser Basics and Searching, Overview of Primary Data Collection Instruments, and Designing Questionnaires.
www.sph.unc.edu/toolbox

Partners in Information Access for Public Health Professionals
Collaborative project designed to provide public health professionals with timely, convenient access to information resources produced by CDC, the National Library of Medicine, and the National Network of Libraries of Medicine; helps them obtain tools needed for information access, trains them to use the technology required for effective access, and trains them to identify and use pertinent information resources and services.
nnlm.gov/partners/

Workforce

American Federation of State, County and Municipal Employees (AFSCME)
Provides services in workplace issues, legislation and political action, communications and leadership training, and union building.
www.afscme.org

Center for the Health Professions
Helps healthcare professionals, health professions schools, care delivery organizations, and public policy makers respond to the challenges of educating and managing a healthcare workforce. Programs address supply and distribution, skills and training, cultural competency and diversity, and leadership, partnership, and vision.
futurehealth.ucsf.edu/home.html

Healthy People 2010 Companion Document
Helps states and communities address the national workforce development objectives for the health professions and public health agencies. Guide contains strategies, examples, and resources to increase under-represented minorities in the health professions and assure a competent public health workforce. Includes brief summaries of workforce issues, strategies, and planning options.
bhpr.hrsa.gov/healthworkforce

Illinois Center for Health Workforce Studies (ICHWS)
Examines the supply, distribution, training, diversity, and competence of health professions in Illinois. Studies focus on medicine, nursing, dentistry, public health, pharmacy, occupational therapy, physical therapy, and genetic counseling. A resource for those interested in state and national workforce policy.
www.uic.edu/sph/ichws/index.html

National Public Health Leadership Network
Strives to refine and expand state and regional efforts to facilitate, demonstrate and evaluate increased capacity of public health leadership, through state and regional leadership programs dedicated to meet the local grassroots needs by developing and enhancing individual and organizational leadership and management for improving and promoting the health of communities. Through the development of leadership skills and shared vision, the institutes/programs facilitate creative, integrated, collaborative approaches to the achievement of the Public Health Core Functions and Essential Public Health Services. A collaboration between ASPH, CDC and St Louis University, the state/regional programs are developing an extensive network of public health leaders with an increased capacity to strengthen the relationship among public health practitioners, health care service providers, academia and communities.
www.slu.edu/organizations/nln/index.html

New England Alliance for Public Health Workforce
The New England Alliance for Public Health Workforce Development has launched its website at: http://www.bu.edu/publichealthworkforce. The site features the Alliance's calendar, a course database, and information for local public health practitioners. You can sign up for their listserv online to get their monthly newsletter, featuring highlighted events and trainings.
www.bu.edu/publichealthworkforce

Washington, Wyoming, Alaska, Montana, Idaho (WWAMI) Center for Health Workforce Studies (CHWS)
Conducts policy-relevant research in collaboration with federal and state agencies. Provides consultation to local, state, regional, and national policy makers on workforce issues; develops analytical methods; and contributes to the understanding of workforce issues and findings.
www.fammed.washington.edu/chws/index.html

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Appendix B: Focus Group Summaries

Note: All of these focus groups were conducted in October 1999 and April 2000. The situation presented is what was occuring during this time, and the circumstances might have changed since the interview was conducted. Feel free to contact the local health department directly using the contact information provided to seek additional information.

Jefferson County Department of Health, Alabama

Conducted: October 1999

Decision

The Jefferson County Department of Health is an example of a local public health agency (LPHA) that engaged in a strategic planning process related to the total range of service delivery and decided not to transition primary care services entirely out of the agency.

Decision-Making Process

With expected changes in funding due to the advent of managed care, the Jefferson County Department of Health realized the need to expand community involvement, increase its responsiveness to clients, and ease the financial burden of providing primary care. The LPHA began to question whether the agency had the proper balance in services and was ready for the future. The LPHA was spending the majority of its resources on assurance, mostly related to primary care delivery in eight locally supported healthcare centers. The agency realized the need to retool the budget and develop different ways of ensuring the delivery of primary care without necessarily transitioning out of primary care. The most important consideration was: if the LPHA gets out of the business of primary care, is there the capacity or infrastructure in the community to cover the need?

The expected change in funding due to Medicaid managed care created the need to provide cost-efficient care while ensuring access to persons in need, especially those who would not be served by other providers. Medicaid payments in Alabama are the lowest in the country, decreasing the likelihood that the private sector would fill the need. Furthermore, 50% of children who qualify for CHIP and Medicaid do not apply. Therefore, many persons who qualify are not covered.

Spurred by the 1988 Institute of Medicine (IOM) report calling on health departments to emphasize assurance, assessment, and policy development, the agency decided to engage in a strategic planning process to reformulate its mission and position itself for the future. The health department looked at how care was traditionally provided and considered three different scenarios: 1) not providing primary care at all and focusing only on core public health functions, 2) maintaining the status quo with minor adjustments in the mix of primary care and core public health services, or 3) decreasing primary care services.

As part of the strategic planning process, each LPHA Division set goals, evaluated costs, reviewed core public health functions, and assessed which, if any, services could be provided more efficiently by others. They then provided comments and recommendations to the Director based on the three scenarios. The head of each Division was also asked to develop goals and objectives to meet assurance, assessment, and policy development goals within a specified budget.

The health department used a process called “Q sort” to assess the importance of each of its programs. Top-level managers and service-center directors were given 80 cards, one for each area of LPHA service. The participants sorted the services based on perceived relative importance and ranked them according to priority. Individual results were combined and presented to the entire agency. High-priority activities included health statistics, web access, and immunizations. Low priorities included animal control, lab and x-ray, and mental health. The results of the Q sort prompted a restructuring of the agency in which community services were separated from personal health services and resources were redistributed accordingly. This change has occurred gradually over the last 5 years.

Transitioning Process

After assessing both internal and external factors, the LPHA decided to pursue the second scenario, which was

to maintain the status quo as long as funding was available and no credible community partners emerged to support the primary care infrastructure. However, the health department still wanted to change the way services were provided.

Concurrently with the health department's strategic planning process, Children's Hospital of Alabama was conducting a formal assessment of its services. The hospital expressed the intent to expand primary care to high-risk populations. To avoid competition and facilitate collaboration, the health department formed an alliance with Children's Hospital to provide pediatric care in a newly constructed health department clinic, the McNair Health Center. Planning for the McNair Health Center took about one year; community leaders worked with LPHA architects and administrators to finalize the building design and select the administrator.

For this health center, the LPHA experimented with the idea of a medical home where patients would always see the same doctor, waiting times would be short, and the clinic would not have to contend with large numbers of patients. To accomplish this, the LPHA needed to hear from clients about ways to be more efficient and user friendly. Initial input was obtained through a town meeting and a marketing survey. The health department also convened a Community Advisory Council comprised of persons who had used the agency's services. The Council is now active in the community's healthcare. Focus groups were used to explore concerns that emerged from the Council's meetings. One result was a redesign of maternal and child health services based on community concerns about continuity of maternity care, providers' bedside manner, access to resources, enrollment in Medicaid, and patient satisfaction.

The neighborhood clinic concept was a new one for the community. The location was closer to where the patients lived, and they did not have to spend 4 hours per visit. Another departure for clients was a phone triage system for after-hours calls. This system encouraged parents of patients to call, ask questions, and make a determination about the medical situation without having to go to the emergency room or wait for walk-in services at a clinic.

The neighborhood clinic also required a shift in mindset for the staff. Previously, when patients came to a clinic, the aim was to do as much as possible for them since there was no way of knowing when/if they would return. Now, staff members are streamlining their approach and paying more attention to patients' requests and needs. With the physician-oriented health system, patients do not have to contend with lengthy waiting times, and rates of kept appointments have increased to 80%-90%. The changes have also resulted in improved billing and overall efficiency, including a streamlining of the assessment process and responsiveness to trends in community health.

For adult care, the health department initiated a partnership with Cooper Green Hospital, the county's indigent tertiary care facility. This partnership has proven to be more challenging because the need for adult care is greater, health insurance is nonexistent, and available services and resources are severely limited.

Dwindling resources are providing the impetus for increased collaboration among community providers. Although the health department wants to continue to provide primary care services, it must proceed in a different direction -- through public/private partnerships. Four years ago, the Cooper Green Hospital was nearly forced to close because of projected shortfalls in funding. The health department was concerned about who would assume the charity care that Cooper Green was providing. The health department convened a Coordinated Council for Indigent Care that included representatives from the LPHA and the county, local medical society, and hospital association. One outcome was the replacement of the county's maternity program with a consortium of area hospitals and providers.

Outcome Measurements: Process and Results

Outcomes are measured through internal audits, such as opinions, peer reviews, position reviews, and costs per visit, and external audits, such as those by the Joint Commission.

As part of the decision to stay in primary care, the health department purchased an electronic medical records system that all partners have agreed to use. This system allows the agency to develop an extensive data collection system that can be queried for different elements and used to analyze quality of care. The agency's ability to assess its success is based on the collection of data through this process. The data can be used to

support all public health functions. Fundamentally, if the health department has data, it can maintain its assessment function and provide data for policy development. By tracking visits, diagnoses, and outcomes, the system can also support the agency's assurance function. If the agency decides at some point to transition all primary care services, it can still obtain medical information from a variety of sources to fulfill the health assurance and assessment functions. A proposed countywide medical data repository will enhance this role.

Challenges

The health department is still clarifying the division of labor among providers and organizations. There is also the challenge of working with a variety of organizations that have different interests, missions, and ways of operating even as they work towards the same goal.

The LPHA has asked for more accountability from the health centers. A recent substantial reduction in force due to funding shortfalls has resulted in a deliberate attrition of high-cost services. Each center underwent a self-evaluation, including a review of policy mandates, revenues, and costs, to determine whether services could be provided elsewhere for less. They also assessed traditional population-based services and clinical protocols. In addition to cutting numbers of staff, the health department has had to train remaining staff. For example, nurses have taken on new responsibilities, such as drawing blood for laboratory tests and doing nutritional assessment, that were previously performed by employees affected by the cutbacks.

The health department has an ongoing commitment to ensuring quality primary care. Although divesting primary care is an option, the agency is very cautious. The LPHA wants to assure the availability of quality care that is stable and viable long-term if provided elsewhere. At this point, no partners have expressed a strong commitment to this role. As healthcare costs continue to rise and funding sources remain stable or decline, the continuing challenge is how to balance personal health services with core services without jeopardizing funds for core services.

Advice

The LPHA staff and partners had these words of advice to other agencies that are making strategic decisions about service provision:

- Remember that public providers cannot do it alone.
- Develop an understanding of internal and external resources.
- Evaluate the mission, and weigh the costs of change.
- Be a facilitator in advocating for the agency's role in the community.
- Have strong leaders who can keep the health department relatively strong.
- Be a leader in encouraging the private sector to the table.
- Be aware that critical external pressures provide the impetus to come to the table; without a crisis, the agency would not have responded.
- Look for ways to collaborate; take advantage of external situations that arise.
- Strategic planning and forecasting had an impact; anticipate a crisis and plan accordingly.
- Persevere.

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Monterey County Health Department, California

Conducted: January 2000

Decision

The Monterey County Health Department (MCHD) underwent a strategic planning process to make decisions about the provision of primary care services for low-income residents and to strengthen the healthcare safety net for Medicaid beneficiaries, the uninsured, and the underinsured.

Decision-Making Process

MCHD operates three Federally Qualified Health Centers (FQHCs) in designated underserved areas that provide primary care to low-income populations. The clinics are designated FQHC "Look-Alikes" in that they meet all FQHC requirements but receive no Section 330 grant funding. MCHD partnered with the school district, the county hospital, and the local non-profit community hospital to establish the clinics, with the goal of creating a safety net for the medically underserved. From the outset, MCHD intended to involve other providers who would eventually assume ownership of the clinics. However, this has not occurred.

MCHD has faced several challenges in operating the clinics. The first relates to clinic governance requirements. The board of an FQHC is required to be representative of the community. Therefore, 51% of board members must be clinic patients and demographically representative of the community served. Recruitment and retention of interested community members have been ongoing challenges. It has been consistently difficult to obtain the meeting quorum required for voting on agenda action items. At the time of last year's annual FQHC recertification application, MCHD reviewed the bylaws and the new governance requirements of the Bureau of Primary Health Care. It was determined that significant revisions would be required to comply with these new requirements.

A second challenge relates to the clinics' annual financial deficits. The Medicaid population represents 60% to 80% of the patients served, and the remaining services are provided without cost-based reimbursement. The majority of non-Medicaid patients are uninsured, and the commercial insurance plans reimburse at low rates. Although there are areas of considerable affluence in the county, safety net providers have been relatively unsuccessful in securing local resources to support and sustain the healthcare safety net. Finally, given that a division of county government operates the clinics, funding opportunities in the private sector and from state and federal programs are limited. The passage of the Safety Net Preservation Act (HR2341) would help ensure that the clinics continue to receive sufficient Medicaid funding.

The third challenge is the difficulty in recruiting and retaining primary care physicians. California has rigorous credentialing standards that are especially burdensome for publicly owned community clinics. The private sector is able to provide incentives to physicians, but MCHD cannot. In an effort to stabilize primary care physician services and specialty care, MCHD recently negotiated an arrangement with Natividad Medical Center (the county hospital) for physician services and medical oversight functions.

The clinics are located in Salinas, Seaside, and Marina. The Alisal District in East Salinas is the most populated community in the city and home to many recent immigrants from Mexico and Central America. Over the past decade, the diversity of patients on the Monterey Peninsula has increased and the demographics of the surrounding communities of Seaside and Marina have shifted, due mainly to the closing of Fort Ord. Whereas these communities were historically populated by primarily Caucasians and African Americans employed by or retired from the U.S. Army, recent estimates show that more than 60% of the current population is made up of Latinos who are moving to the area to fill the growing number of jobs in the tourism and agriculture industries. In the burgeoning California economy, competition for employment is fierce, availability of childcare is scarce, and affordable housing is nonexistent. MCHD clinics provide the only access to primary care for the Medicaid population in Marina. In Seaside, only one private provider accepts Medicaid.

Transitioning Process

Given the limited financial resources available and the need to increase the focus on population-based services, MCHD clinics are in the process of transitioning from a program administered by public health services staff to the formation of a separate and distinct Primary Care Division. Coincidentally, the Interim Director of Health is consulting with FQHC policy experts to craft revised bylaws, and efforts will soon begin to reconstitute the Community Health Center Board to satisfy new FQHC "Look-Alike" requirements.

Outcome Measurements: Process and Results

Health status and access measures are measured via a community assessment process called Tellus, which includes surveys of individuals and uses secondary data. With the recent inception of Medicaid managed care in a County Organized Health System model, additional data on services are reported to the State Department of Health Services and the Center for Medicaid and Medicare Services (formerly known as HCFA). MCHD also makes use of school district student health data, patient satisfaction surveys, an active complaint policy, and other methods for client feedback.

Challenges

The client base is largely first- and second-generation immigrants and is very diverse in geographic origin. Families have relocated from Mexico, South America, Asia, the Philippines and Pacific Islands, Russia, Pakistan, India, and Ethiopia. Most clinic clients speak only Spanish, and many others have very limited English language skills. The populations served are often poorly educated with high levels of illiteracy.

Aside from their immigrant status, patients present challenging medical and social problems. Many have received inadequate or no preventive healthcare, and most have chronic health conditions that require intensive case management and specialty referral. A fear of discovery by the Immigration and Naturalization Service inhibits clients' willingness to complete the paperwork required by state healthcare programs. Many patients are without telephones and have migratory employment.

Transportation poses another significant hurdle, especially since the county lacks an efficient mass transit system. Natividad Medical Center, the county hospital, is far from two of the three clinics that, combined, provide nearly 75% of services. Only emergency care and obstetrical services for pregnant women are available to the Medicaid population at the local non-profit hospitals. To develop and sustain a system of care for low-income residents, MCHD clearly must strengthen its relationship with Natividad.

Advice

For other health departments making strategic decisions about service provision, MCHD staff has the following advice:

- Network and collaborate with other local health departments who are experiencing similar challenges.
- Engage partners from local government, community hospitals, and school districts.
- Find a partner agency that shares the LPHA's mission and serves the same population.

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New Mexico Department of Health

Conducted: April 2000

State Public Health Structure

New Mexico is an example of a centralized public health system in which local public health agencies (LPHAs) are operated by the state department of health and function directly under the state's authority. LPHA staff are considered employees of the state.

The New Mexico Department of Health (DOH) is divided into six Divisions: Behavioral Health Services, Laboratory Services, Public Health, Long-Term Services, Administrative Services, and Health Improvement. Of these, the largest is the Public Health Division, which encompasses Immunizations, Chronic Disease Prevention, Injury Prevention and Emergency Medical Services, Epidemiology, and the Women, Infants, and Children (WIC) program. The DOH Secretary is approved by and serves under the governor, along with the Division Directors and other upper management. At the Divisional level, programs are administered by bureaus, which address: Health Systems, Primary Care, Family Health, Infectious Disease, Epidemiology, Information Management, Chronic Disease, Injury Control, and Program Support.

Technically, New Mexico does not have a system of LPHAs. The only autonomous LPHAs are the Albuquerque Environmental Health Department and the Bernalillo County Health Department, both of which focus mainly on environmental health services. At the regional level, the administrative units are the four District Offices, each of which has a health officer, director, and program managers. The District Offices supervise the work of the Local Health Offices (LHOs), which provide public health services and programs at the local level. Each county has at least one LHO; statewide, there are 52. New Mexico has no local health boards and no county health commissioners. Therefore, there is little local involvement in the state-operated LHOs. The only responsibility that counties have to the LHOs is to provide buildings to house LHO programs and services.

Budget and Administrative Functions

District Offices have some autonomy, but all contracts and agreements require state approval. The four District Office directors report to the Public Health Division, which also determines the District Office budgets; District Offices and LHOs have no authority over or input into their budgets. Moreover, the last two appropriations acts have barred the moving of programs/services from one budget line to another, thus limiting flexibility to shift funds according to local needs.

LHOs receive only minimal funding from their jurisdictions. Some counties provide in-kind services, such as space and maintenance, but others do not. Many counties have indigent funds that are used mainly to support local hospitals. Some counties have added public health options (e.g., prenatal care, substance abuse treatment, prescriptions) for these funds. If LHOs go above their projected general revenues, they are not allowed to keep the excess. With little success in getting MCOs to pay for specific services, the majority of funds continue to come from the state.

Historically, budgets for public health have been appropriated by the state legislature to the DOH, then to a particular division in the DOH, and then to the District Offices and LHOs. The movement towards performance-based budgeting may affect this system. The DOH is currently involved in the development phase of this type of budgeting, in which funds are allocated based on whether the DOH (through its Divisions) meets specific performance measures.

Staffing issues are addressed by the DOH as well. The state personnel office determines salaries, which unfortunately are not very competitive. The hiring process is almost entirely state-driven. This state-driven system, in which budget, personnel, policies, and procedures all generate from the DOH state office, is a source of considerable tension that stymies any movement toward change or innovation.

Service Delivery System

New Mexico's LHOs have a long history of providing personal health services, such as well-child checks, family planning, WIC, immunizations, adult healthcare services, blood pressure and cholesterol screening, and prenatal care. During the time that service provision centered mainly on direct services, few population-based services were provided. In the late 1980s, however, clinic services — starting with prenatal care and progressing to other personal health services — were reduced.

The trend toward the transitioning of direct services to other parts of the healthcare system has not extended to rural areas, mainly because of a scarcity of providers. In one rural county, the LHO is one of the few providers and operates as an important safety net provider. The county tried to transition some services to private providers, but the providers were not ready.

Other LHOs have come to the realization that they cannot do it all, especially with diminishing resources. This realization has resulted in a transitioning of clinical services to other community providers. With the reduction in personal care services, LHOs are trying to organize communities around "bigger issues of public health." If a patient has insurance, the LHO does its best to refer the person to another provider. However, the LHOs in many counties still serve as important safety net providers.

The number of providers available in a community has a direct impact on the ability of LHOs to transition clinical services and concentrate more on population-based services. In rural areas, LHOs have tried to increase capacity and fill gaps through provider agreements and contracts. Although the capacity of community health centers (CHCs) has grown in recent years, CHCs remain relatively disconnected from the public health system.

The state's local service delivery system is supplemented by contractors who are funded by the DOH but are relatively autonomous. The DOH contracts with private-sector organizations, hospitals, clinics, treatment centers, schools, mental health providers, and universities to provide services at the local level. Often there is little coordination and communication between the contractors and the District Offices and LHOs.

In the absence of community health boards, communities are working to have a voice in public health activities. In about two thirds of counties, the concept of local health councils is taking hold. Health councils are usually made up of private providers, community members, and representatives from businesses, schools, and social service agencies. Public health professionals are major players on health planning councils, but funding is a problem. Additional problems center on definition of a mission and lack of ability to affect the allocation of resources.

Transitioning of Services

Unfortunately, transitioning has met with little success in many areas. Staff vacancies and low morale are persistent problems. LHO staff members are troubled by conflicting messages; they are told to stop providing clinical services but are encouraged to have a caring perspective. LHOs are confused about their mission and the future of public health at the county level. In many places, public health is seen as the most stable structure in the community, and community members trust public health providers more than they do private providers. Persons who leave the LHO for a private provider often return to the LHO. It is difficult to tell them that the LHO no longer provides direct services.

Another dilemma has resulted from the allocation of resources based on decisions of the state legislature. Unfortunately, at the county level, decreasing the number of clinical services that are provided does not necessarily result in an increase in population-based services. LHOs do not have the flexibility to use savings or revenues from one service to support another. This lack of autonomy is a deterrent to efficiency because LHOs are not necessarily rewarded for their efforts. If they end up saving money in one service area, the DOH often takes the money and uses it for something completely unrelated. In addition, as LHOs move out of clinical service delivery, the legislature has started to wonder what the LHOs are going to do. In many cases, the solution, again, is to take away money from direct services and use it to pay for something else.

There is little political support for moving dollars from clinical services to population-based services. Few politicians believe the state should be spending money on population-based services when citizens lack adequate access to care. Politically, it may be risky to move out of primary care if there are few providers in the community to take over. Also, some of the legislative leadership questions whether public health is duplicating the services of Medicaid managed care. Unfortunately, many state legislators care about healthcare only if it is a concern among their constituents. Also, LHOs feel that there is no consistent voice at the highest levels of the DOH to convince legislators about the importance of population-based services.

Evaluation

New Mexico has some of the poorest health status indicators in the county. For example, 22%-35% of residents are estimated to be uninsured or underinsured. This number is likely much higher, however, given the large population of undocumented immigrants. The state has the worst prenatal care rate in the nation. Although New Mexico has undertaken efforts to develop "state of health" reports and county health profiles, the DOH generally lacks consistent and adequate data collection systems. Another ongoing difficulty is the need to determine how to measure population-based services and assess if programs are affecting disease rates. Because of a lack of resources to evaluate programs, the same interventions continue to be used without any evidence of their effectiveness. The DOH wants to move toward evidence-based programs but lacks funds and support for this activity. The DOH has started to provide technical assistance to communities to plan interventions and develop more opportunities for data collection, which may improve the situation.

Advice

State and local staff offer the following advice to other programs:

- Do not rush the transitioning process.
- Maintain quality in the services that the LPHA maintains.
- Find resources for evaluations.
- Obtain clear guidance on the best methods for assessment and data collection.
- Seek technical assistance, as needed, for data analysis. Learn how to use local data for community planning and capacity building.

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Mahoning County District Board of Health, Ohio

Date: December 1999

Decision

The Mahoning County District Board of Health (BOH) decided to defragment care and provide patients with a single source of care while achieving the goal of cost-effective healthcare that covers the uninsured, mainly pregnant women and children.

Decision-Making Process

Deciding to transition out of providing direct clinical services was motivated not by the financial situation of the BOH but by a concern that patient care was fragmented and inefficient. The BOH was also mindful of the Healthy People 2000 goal to increase access to primary care. They realized that, with the continuing categorical funding structures, they were not achieving this goal.

In 1996, the BOH began a strategic planning process to examine patients' needs and wants. Although most patients were pleased with nursing and other medical services, the parents of well-child patients reported that care was fragmented. They wanted one source of care rather than a system that required seeking care in a variety of places. At about this same time, Medicaid managed care (MMC) came to Ohio. The BOH decided that it was best not to compete for MMC contracts because the financial risk did not seem appropriate and they did not want to gamble with public dollars. Given that the county was about to revert to mandatory MMC, the BOH felt pressure to make changes in its structure and services. The BOH was to lose approximately 50% of pediatric patients and 80% of prenatal patients to MMC and thus a great deal of Medicaid revenue. The families who would remain with the BOH were those without health insurance. Therefore, the advent of MMC was a big impetus for the BOH to reengineer its maternal and child health programs. The county refocused its energies from funding clinic service delivery to forming partnerships with local organizations and insuring people without access to care.

In their strategic planning, the BOH used and continues to use the Maternal and Child Health Bureau's "Public Health Pyramid" to help determine the distribution of resources among the various public health services. The BOH realized that they were spending most of their money on the top half of the pyramid, i.e., on direct care and enabling services, and little on the bottom half of the pyramid, i.e., population-based services and public health infrastructure. With the "pyramid" approach, the ideal is to contribute the majority of resources to the larger, bottom half of the pyramid, which includes population-based services, such as health education and promotion, outreach, and screening, as well as infrastructure building, such as community health assessment and planning, monitoring of health outcomes, policy development, and quality assurance. Mahoning County identified the need to broaden the base of the pyramid and reallocate resources so that more money is spent on the core public health functions of assessment, assurance, and policy development.

Transitioning Process

The Mahoning County Child and Family Health Services (CFHS) Consortium, made up of 35 local health and social service providers including the BOH, was formed in the early 1980s to assure that low-income children and pregnant women had a specific source of ongoing primary care that was coordinated with both preventive and episodic healthcare. The Consortium provides an excellent networking opportunity for organizations to share activities and collaborate when appropriate. The BOH decided to consult the Consortium about their service delivery system. The Consortium endorsed looking outside the county's usual method of service delivery, which focused on the operation of clinics.

In late 1997, in an effort to defragment care, the BOH (with assistance from the Consortium) partnered with a foundation funded by Anthem Blue Cross/Blue Shield of Ohio. The Foundation operated the Ohio Caring Program for Children, which provided health insurance to uninsured children. The program, operated like a Preferred Provider Organization (PPO), entitled a child below 185% of poverty to a medical insurance card, which in turn paid for primary and specialty outpatient care. The goal was to unify care and encourage families to find a medical home, i.e., to obtain preventive, outpatient, primary care, and urgent care in one location. This was a marked departure from the traditional method of service delivery in the county. Instead of providing well-child and prenatal care directly, the BOH established this public/private partnership. The Board used $150,000 of its $400,000 Children and Family Health Services (CFHS) grant from the state health department (a

legislative appropriation made up primarily of Federal Maternal and Child Health Block Grant funds), to provide health insurance to 350 infants and children. The BOH and County Medical Society recruited 100 physicians in the community who were willing to accept this insurance and agreed to be a medical home for these children.

As a result of this insurance expansion program, the county was able to expand access to and choice of primary care providers. Beneficiaries of the Caring Program were able to find medical homes in the private sector, while the CFHS-funded clinics could focus on providing immunizations, enrolling people in the health insurance program, and providing other outreach and quality-assurance activities.

With the advent of the State Children's Health Insurance Program (SCHIP) and its coverage to 80% of the children in the Caring Program, the Foundation decided to disband the program. The BOH has turned its focus to uninsured children and prenatal patients without a medical home. The BOH recently implemented a prenatal voucher program, which uses coupons in exchange for services. The BOH developed a list of physicians who will accept these vouchers, which equal a fixed amount to the provider for services. The program reaches out to patients who visit private providers and the clinics traditionally funded with CFHS money and enables patients to have a greater choice in selection of healthcare provider. By identifying women in the first trimester, a public health nurse provides patients with wrap-around services throughout pregnancy and links them with a medical home.

Outcome Measurement: Process and Results

The prenatal voucher program has a built-in evaluation component using birth certificate, medical record information, and patient satisfaction surveys. Items such as the number and type of visits and self-reported health status are tracked. The BOH has partnered with a neonatologist-health services researcher to establish data collection for prenatal care and outcomes. The BOH is committed to continuing the voucher program, given promising preliminary results. They will also be assessing the infant mortality rate to determine the effectiveness of the wrap-around services. For maternal and child health, quality service is not considered to have been provided unless the health of the population changes.

Ohio State University is conducting an assessment of the CFHS process statewide. A package of indicators will measure how well children in CFHS are doing, whether they are being immunized, the ultimate impact on health status, and other traditional health measures. In addition, the Federal Maternal and Child Health Bureau has issued performance standards.

The BOH's Epidemiology Unit continuously monitors programs. However, more time needs to be spent on more aggressively marketing the program's findings.

The decision to redirect CFHS funds to population-based services was also supported by an assessment process – Healthy Valley – begun in 1996. The process involved 200-300 community partners and identified five youth-oriented priorities: 1) exercise for wellness, 2) health screening, 3) substance abuse among youth, 4) unintended pregnancy, and 5) violent death. The ongoing Healthy Valley assessment process, based on the Assessment Protocol for Excellence in Public Health (APEX*PH*), will be used to evaluate the impact on community health and ensure that the BOH is broadening the base of the "pyramid" by focusing on population-based services and infrastructure.

Challenges

There is still a traditional clinic approach in many parts of the county. Rural areas lack private practices to partner with, so the BOH needs to maintain multiple approaches to providing care.

Both fortunately and unfortunately for the BOH, the politicians do not have health on their radar screen. On the positive side, the BOH is an independent governmental entity, and politicians such as the county commissioners do not serve as an obstacle to the BOH in its endeavors. However, due to their lack of involvement and concern, the politicians often do not understand or support public health measures in the county.

No consumer organization in the county speaks for the community on public health issues. Consumers of the healthcare system therefore lack a collective voice. There have been relatively few opportunities to include consumer input in the assessment of the county's healthcare system.

Tension has resulted among organizations that have served on the Consortium. With all of the changes in the healthcare system in the county, there has been conflict with the hospitals over the shift in the level of accountability expected from them. While most see the greater good, many organizations originally stood to lose money, at least in the short term. There was also tension in the CFHS Consortium when Planned Parenthood was brought to the table, given the religious views of a few.

Funding is also a challenge. Money to support the base of the "pyramid" – population-based services and infrastructure – is lacking. The BOH's Epidemiology Unit is in the "fledgling stage" and is underinvested in the core function of surveillance. This is slowly beginning to change, however, as the importance of a continuous level of surveillance is increasingly appreciated. The BOH has been trying to refocus its resources on population-based services, but it has been a difficult process and they have only just begun.

Lessons Learned

The consortium model has been successful in Mahoning County. The excellent communication network that has developed among the providers has enabled the county to look at issues regarding the health of the community on a regular basis and identify ways to collaborate. Substantial referral networks have been developed, and, given the wide range of health and social service organizations that participate, the definition of health has been broadened to include nontraditional public health concerns. There has been a change in the focus of the Consortium over the years. Years ago, it was just a collection of agencies that met once in a while. Now, it is a true partnership that is resulting in a higher quality of care for patients. The Consortium's shared vision takes the focus off individual agencies. The members realize that the health of the community cannot be improved alone; reliance on each other as a collective whole is necessary.

When the BOH started the reengineering process, they were spending large amounts of money on direct services. Now they are providing more financial support to partners to provide services, which enables the BOH to concentrate on core public health functions.

Advice

Board of Health employees and members of the Consortium have the following advice for other local public health agencies that might be making strategic decisions about service provision:

- Keep an open mind. Change is difficult; keep the focus on what the public needs.
- Give the process time to evolve.
- Organizational cultural change is involved; it is a leadership responsibility to help staff throughout.
- Make sure consumers have a choice.
- Seek visionary leadership. Develop a vision for where the agency wants to go, put it into action, and be willing to take the heat.
- Continue to persevere by: 1) taking advantage of herd immunity by forming coalitions to diffuse the heat, 2) electing firm, respected leaders, 3) collecting data to support the change, and 4) focusing on community instead of individual organizations.

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Appendix C: Case Study interviews

Note: All of these interviews were conducted in April 2000. The situation presented is what was occuring during this time, and the circumstances might have changed since the interview was conducted. Feel free to contact the local health department directly using the contact information provided to seek additional information.

Boulder County Health Department, Colorado

Date: April 2000

Community/LPHA Profile

Jurisdiction Size:	281,428
LPHA Annual Budget:	$9,243,285
Metro, Urban, Rural:	Metro (80%), Rural (20%)
Ethnic/Racial Makeup:	African-American (1%), Native American/Alaska Native (0.6%), Asian-American (3.2%), Latino (7.6%), Caucasian (87.6%)
Percentage of Uninsured Residents:	11.4%
Percentage of Medicaid Beneficiaries:	3.6%

Decision to Transition

Boulder County Health Department (BCHD) is a unit of county government. A local Board of Health serves as a buffer between the political process and the operation of BCHD. The relationship between BCHD and the state is collegial and contractual, but the health department is an independent entity.

BCHD started its most significant transitioning process in 1993 and has continued to transition traditional personal health services (e.g., prenatal care, well-child care, well-senior care) to community partners. These services were the most labor- and resource- intensive, and all required significant county resources beyond Medicaid subsidies. The health department based the decision to transition services on four factors. First, four community health centers (CHCs) in the county had both the willingness and the desire to expand service capacity to the low-income families served by BCHD, particularly since the funding mechanism for Medicaid patients provided more favorable reimbursement rates to CHCs than to the health department. To maximize resources for expanding capacity to care for the county's indigent population, it was desirable to attract these additional resources. BCHD wanted to increase not only its capacity but also that of the entire county. Second, although BCHD originally served as a "provider of last resort," by 1993 the health department was actually fragmenting services and working against the concept of "community-oriented primary care." For example, BCHD provided prenatal and delivery care but had to locate a physician if a patient became sick. Similarly, a baby could be integrated into the health department's well-child program 60 days postpartum, but the mother needed to find another source of primary care.

Other factors supported the decision to transition. After completing both the internal and external assessments of the Assessment Protocol for Excellence in Public Health (APEX*PH*) process and instituting a 3-year work plan, it was clear that the health department was not addressing a range of core public health issues. The planning process was fundamental to the decision to transition several personal health services.

Although BCHD transitioned many highly visible health services to community partners, management decided to continue providing other services, such as those for the special needs population, EPSDT, WIC, treatment for communicable diseases and substance abuse, and specialty services for persons with HIV/AIDS. The community lacked the capacity to take on these services.

Transitioning Process

BCHD's principal partners were its governance (local Board of Health and County Commissioners), three hospitals, and the four CHCs that were going to be accepting resources and undergoing expansion. Involving them in other BCHD programs was instrumental. Management worked to ensure that all stakeholders understood the driving forces behind the decision, i.e., Medicaid managed care, managed care, the economics of health care, and the determinants of health. To increase support for the process, management engaged in extensive discussions with staff and Board of Directors, describing advantages and disadvantages for patients, the public health system, and CHCs.

The transitioning process involved considerable discussion and joint planning. Because the situation looked different in each part of the county, it was neither an easy process nor a "one-size-fits-all" effort. In each area of the county, the partners formed a steering committee to discuss advantages and disadvantages of certain options, such as how to move staff and ensure continuity of care during and after the transition. This required educating patients about the transition. BCHD prepared scripts to ensure the consistency of messages. BCHD also trained staff in their new roles and responsibilities by providing workshops on population-based strategies and other relevant topics.

Challenges Involved in Transitioning

- Resistant staff — Some staff, especially nurses and other staff who provided clinical services, did not want to work for a CHC and were unhappy with the decision. This was a major challenge for the health department. Staff members had a great investment in and strong commitment to their patients. Some were concerned about the quality of the CHCs. It was a time of tremendous uncertainty for them. Consciously supporting staff through the organizational change and dealing with grief and loss were major parts of the transition process. It most often went well; sometimes it did not.
- Length of the transitioning process — The county has nearly 300,000 residents in three principal arenas, each of which moved at a different pace. This resulted in a lengthy transitioning process and a perception that the agency was in a state of persistent change.
- Independence of the CHCs — Each CHC was characterized by different skills and management systems.
- Need to redefine public health — BCHD was trying to create a shared vision of what public health could be if it was not inhibited by the provision of personal care services. A major constraint was that persons involved in local public health activities are often not trained in public health.
- Need to retain funding levels — Local funders need to understand that, when services are transitioned to community partners, the public monies that subsidized these services are still needed for public health work and should not be redirected to roads, bridges, and law enforcement.

Impact

As a result of the transitioning of services, BCHD was able to acquire a professionally prepared health planner, who has substantially upgraded BCHD's capacity for community assessment, program evaluation, and health communications. Recent assessments have demonstrated that BCHD is providing children with a medical home and that pregnant women are receiving effective prenatal care in the community. To ensure that access continues to improve, BCHD is regularly monitoring hospitals. A community assessment process also showed that seniors have good access to care. Because BCHD is better able to do effective and visible planning, more residents are engaged and involved in health-related partnerships.

Although the transition has been painful at times, especially for clinic staff, it has energized the agency and increased staff morale. A strategic planning process is expected to identify areas of unmet needs, which may include expanded programming for chronic disease, oral health, and injury prevention. BCHD has also developed and implemented a promising unintended pregnancy program.

Lessons Learned/Words of Wisdom

- Understand the importance of retaining financial resources (MCH funding, county funds) to provide new programming. This will allow hiring of staff with the competencies needed for the new work of public health.
- Understand what assurance means. Be sure to monitor the ongoing adequacy and quality of personal health services. Conduct well-planned surveys.
- Learn from models that work and LPHAs that have already gone through the process. Obtain support and consultation from colleagues in the state or around the nation.
- Any LPHA that cannot offer comprehensive primary care is providing fragmented care and needs to plan for improved capacity for comprehensive services. The LPHA may have an important role in wrap-around services.

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Chicago Department of Public Health, Illinois

Date: April 2000

Community/LPHA Profile

Jurisdiction Size:	2.75 million
LPHA Annual Budget:	$135 million
Metro, Urban, Rural:	Metro (100%)
Ethnic/Racial Makeup:	African-American (40%), Asian-American (5%), Latino (20%), Caucasian (35%)
Percentage of Uninsured Residents:	24%
Percentage of Medicaid Beneficiaries:	25%

Decision to Transition

The Chicago Department of Public Health (CDPH) is independent of the state public health system and is part of Chicago's municipal government. This is in contrast to most other Illinois local public health agencies (LPHAs), which are part of county governments.

CDPH has shifted resources in varying degrees from provision of direct services. CDPH contracted out alcohol- and substance-abuse services to a community-based agency with a long history of providing these services and contracted with a drug store chain to offer pharmacy services in the department's clinics. For primary care services, CDPH has entered into other arrangements. In most cases, community-based organizations and local hospitals have taken over CDPH clinics. In some situations, partner agencies provide services in clinics operated by CDPH. Three clinics became part of the county health services system, which operates public hospitals and a network of primary care facilities. Laboratory services were turned over to the state.

The decision process began about 10 years ago as a result of strategic planning. The cost of delivering direct medical care began to increase significantly at the same time that third-party reimbursement was decreasing and the number of uninsured patients was increasing. CDPH continued to provide an array of traditional public health services for which no reimbursement or grant funds were available. Management began to look at ways to decrease costs and share the burden by partnering with community providers who had the same mission and could provide services more efficiently and effectively. The mayor was a proponent of privatization and more efficient government.

Transitioning Process

Once the decision was made to transition services and partner with other providers, word spread quickly, and interested providers contacted CDPH to explore options. Although a strategic decision was made to partner with other providers, each opportunity was studied independently. Stakeholders were also identified on a case-by-case basis, and communication occurred frequently about benefits and costs. CDPH consulted with community leaders, elected officials, and union members before deciding to transfer complete responsibility from CDPH to another provider. Because of a cumbersome administrative process, some contracts took years to put into place.

Challenges Involved in Transitioning

- Opposition from staff and unions
- Community concern that transitioning represented a retrenchment or withdrawal of CDPH's commitment to serve the community

Impact

CDPH evaluates the quality of services provided by contractors and includes strong monitoring provisions in contracts. In one situation, a contract was pulled. CDPH actively seeks feedback from the community on the quality of contractors. Some data suggest that the new arrangements have been beneficial for both CDPH and patients. More patients are being seen, and more services are being provided.

With the deliberate move to de-emphasize the provision of primary care services, CDPH had to redefine its role.

The agency is now more focused on assuring primary care services by maintaining financial commitments to underserved areas. As a result of this change in emphasis, CDPH has been able to expand staffing for community- and population-based services. For example, CDPH now has door-to-door outreach in immigrant communities and a clinic located in a public housing development that provides primary care services plus job training and self-esteem-building workshops. CDPH officials believe the agency is more effective in improving the public's health because more resources can be devoted to core public health functions. CDPH is changing its identity from a network of clinics to a public health department working at the community and city levels to protect public health.

Lessons Learned/Words of Wisdom

- Do not leap into transitioning. Think it through, and study the environment intensively.
- Engage and consult community-based providers to discuss possible arrangements that will be beneficial to the LPHA, the provider, and the community.
- Obtain community support. Make sure the community knows that the LPHA is not abandoning residents.
- Be resolute in decision-making even when faced with opposition. Be prepared to justify the rationale, but then lay out the timeline and proceed.
- Communication has to occur both inside and outside the health department. Rumors of "privatizing" can be very damaging to staff. The LPHA also needs to manage the message.
- Leadership is fundamental to change. Get the health officer and first level of management behind the decision.

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Erie County Health District, Ohio

Date: April 2000

Community/LPHA Profile

Jurisdiction Size:	80,000 (up to 100,000 in summer)
LPHA Annual Budget:	$4.4 million
Metro, Urban, Rural:	Urban (65%), Rural (35%)
Ethnic/Racial Makeup:	African-American (8.7%), Native American/Alaska Native (.2%), Asian-American (.4%), Latino (1.7%), Caucasian (90.7%)
Percentage of Uninsured Residents:	N/A
Percentage of Medicaid Beneficiaries:	29%

Decision Not to Transition

Erie County Health Department (ECHD) is generally independent of the state. It responds to local needs and requests but has some mandated programs from the state. The state funds ECHD to provide some direct services through a Child and Family Services (CFS) grant and a Title X Family Planning grant. ECHD's relationship with the state is tied to these grants.

Last year, funding for direct services was significantly cut in the CFS grant. As a result, ECHD is no longer subsidized to provide Medicaid services. ECHD had spent most resources on direct care but is now shifting resources from other areas to continue funding these services. ECHD is also starting to provide some population-based, enabling, and infrastructure services, made possible by the grant.

Management decided to continue to provide direct services because there was not much forewarning to do otherwise. Staff may explore other options later, although the ultimate decision-maker is the local Board of Health and the community, which still has an expectation that ECHD will provide direct services. In Erie County, few providers accept Medicaid patients, and the health department is the provider of last resort for many residents. ECHD will continue to provide family planning and immunization services indefinitely, as clients would have difficulty obtaining these services elsewhere. ECHD provides 65% of the immunizations in the community.

ECHD conducted a community needs assessment through a private entity and is trying to interpret the data and develop implementation plans. The assessment revealed that community members were concerned about access to providers.

Potential Partners

ECHD has considered eliminating some direct services but is trying to find an appropriate route, possibly through a partnership with a local hospital that runs a clinic. The clinic is not a free clinic but has become a provider of last resort and may be a place to transition services. A second hospital in the county might also be interested. Unfortunately, interest among private providers is lacking.

The Future

ECHD is assessing what the future holds with regard to direct service provision. Management sees direct services growing, but funding sources are unclear. ECHD hopes to find medical homes for some clients but will probably continue providing services directly to others.

ECHD has not yet been able to provide many population-based services but is planning to increase this service component. ECHD publishes a quarterly newsletter, publishes the annual report in the newspaper to focus on health issues in the community, and airs a series of 13 public service announcements every quarter to disseminate information on topics of interest and concern.

Some local public health agencies (LPHAs) in Ohio stopped providing direct services because of Medicaid managed care, but the Medicaid managed care program is now collapsing in the state. Few providers will accept these clients. Many LPHAs are now being asked to provide services but are unable to do so because of their radical organizational changes. ECHD also worries that welfare reform is increasing the population of

underinsured and uninsured. The county has many seasonal employees who work for minimum wage with no benefits. Few providers in the area will care for these persons.

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Lake County Health Department and Community Health Center, Illinois

Date: April 2000

Community/LPHA Profile

Jurisdiction Size:	617,975
LPHA Annual Budget:	$35 million
Metro, Urban, Rural:	Urban (93.5%), Rural (6.5%)
Ethnic/Racial Makeup:	African-American (7%), Native American/Alaska Native (.3%), Asian-American (3.3%), Latino (9.9%), Caucasian (79.3%)
Percentage of Uninsured Residents:	11.4%
Percentage of Medicaid Beneficiaries:	5%

Decision Not to Transition Services

County health departments in Illinois are sub-units of local governments. They are neither freestanding entities nor part of a centralized system. The state health department acts as a liaison, funder, and regulator of LPHAs.

The Lake County Health Department (LCHD) was a provider of episodic care. That is, staff members treated persons who presented with symptoms of illness. LCHD had an array of grant-funded programs, but the funds were not adequate for provision of the full continuum of services. As a result, gaps were leading to sporadic and fractionalized care.

In 1996, LCHD conducted the Illinois Plan for Local Assessment of Need (IPLAN), a derivative of APEX*PH* that set the stage for the decision-making process. When the community identified access as a problem, LCHD was prompted to look more closely at its jurisdiction. This assessment uncovered a major change than the demography of the community, i.e., an increase in the county's Hispanic population, a significant portion of whom were uninsured or underinsured. Although the county had lower incidence rates of most diseases in the state, these new pockets of poverty were resulting in tremendous disparities in health status. At the same time, doctors were refusing to accept clients from this population group. Of the more than 1,000 doctors in the county, virtually none accepted Medicaid. Moreover, the seven hospitals in the jurisdiction reported high levels of emergency room (ER) use for non-ER care.

LCHD directors looked at these external issues and reassessed the agency's values. They agreed on the importance of carrying out public health core functions but could not assure access to services in the community. The largest nearby hospital had complained about ER usage, but, when asked to become a community health center (CHC), the hospital declined.

These factors helped LCHD decide to become more involved in providing the full continuum of primary care services. There were three options: 1) maintain the status quo, 2) become a conventional clinic without state affiliation, or 3) become a Federally Qualified Health Center (FQHC). The latter turned out to be the best alternative. One advantage of becoming an FQHC is that reimbursement for services is cost-based. The state worked on behalf of HRSA to find medically underserved areas, and three cities in the district qualified. LCHD decided to formally seek FQHC designation.

LCHD continued to reach out to area hospitals to become CHCs and ultimately convinced them of the need. LCHD, the county United Way, and all hospitals in the jurisdiction formed the Lake County Community Health Partnership, a formal not-for-profit entity. This organization played a significant role in LCHD's decision process and it has now become the largest service provider in the community. LCHD also worked very closely with elected officials. The affiliation with the state was instrumental in opening doors to the federal government.

Challenges

- Hesitation/reservation among participating hospitals — There is a long-standing antagonism between hospitals and other providers. Hospitals are not sure whether to look at others as safety net providers or competition.
- Time commitment — The time requirements for this effort were extraordinary.
- Space — This is still a major obstacle and a principal factor in lengthy waiting times.

Impact

Health officials believe that LCHD is better able to assure continuity and quality of care. FQHCs are subject to standards, procedures, and other requirements, including measures of customer satisfaction. According to management, becoming an FQHC has resulted in care that is much more thorough and comprehensive. Staff members have an enhanced capability to provide population-based services through partnerships. They are constantly evaluating data, related not only to direct services but also to the health status of the entire community. Although LCHD cannot expect to see dramatic differences in morbidity and mortality at this point, access-to-care measures point to improvements. Plans for more in-depth evaluation are in place and ongoing.

Utilization rates have also improved. The number of visits increased by 23% in the last 2 years, and 20%-30% of the total Medicaid or uninsured population are registered as clients. Overall immunization rates have risen from 65% compliance to >80%, the result of increased resources from new partnerships. LCHD can expand its reach without affecting its resources.

Lessons Learned/Words of Wisdom

- Partnering is a necessity. It facilitates dialogue with stakeholders in the community.
- Protect against territorialism. The LPHA must be prepared to give up part of itself.
- Have internal dialogue with staff. When privatization of service is mentioned, staff fear for their jobs when, in fact, more staff members may be needed.
- Be aware of the political environment. Recognize the need to work closely with political powers and elected officials.

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Lincoln-Lancaster County Health Department, Nebraska

Date: April 2000

Community/LPHA Profile

Jurisdiction Size:	237,403
LPHA Annual Budget:	$10 million
Metro, Urban, Rural:	Urban (90%), Rural (10%)
Ethnic/Racial Makeup:	African-American (2.4%), Native American/Alaska Native (.7%), Asian-American (2.4%), Latino (3.1%), Caucasian (91.3%), Other (0.1%)
Percentage of Uninsured Residents:	10%
Percentage of Medicaid Beneficiaries:	9%

Decision Not to Transition

Lincoln-Lancaster County Health Department (LLCHD) is a city/county health department that enforces several state regulations and statutes. It is a traditional health department providing the full scope of public health services plus additional services such as animal control, air pollution monitoring, and Medicaid enrollment.

LLCHD has not outsourced any services and in fact has an active public clinic. LLCHD also operates an influenza immunization clinic and provides WIC services. It is one of two local not-for-profit organizations with which the state health department contracted to provide these services. Health officials believe that WIC services are essential and that it is their mission to provide them. LLCHD also does considerable primary care outreach, especially to indigent populations and those enrolled in Medicaid.

Questions were raised a couple of years ago about the direction of LLCHD. The local Board of Health completed a strategic planning process to redefine the health department's role. Health officials decided that it was the county's mission to continue providing clinical services. LLCHD also completed a 2010 health plan. Survey respondents agreed that the community would achieve optimum health only if LLCHD continued to provide services directly.

LLCHD is part of Community Health Partners of Lincoln (CHP). This group includes the county medical society, Lincoln Medical Education Foundation (LMEF), a large rehab hospital, Community Health Endowment, Public Health Foundation of Lincoln, a city council representative, a county commission representative, and the three area hospitals. CHP also initiated a comprehensive health assessment. Members concluded that LLCHD is doing what it should be doing.

Impact

LLCHD has a great ability to work on population issues, which are a major initiative within the agency. LLCHD runs a program called Healthy Homes in which outreach workers promote health in various communities. LLCHD operates a health education information office and maintains an epidemiology division that performs population-based assessments and risk surveys. LLCHD is following the Surgeon General's initiative on health disparities and the top 10 health indicators for the *Healthy People 2010* process.

LLCHD management sees direct care remaining a key focus of the agency's operation. Hospitals are experiencing less revenue as a result of recent budget cuts. They are therefore not the cooperative partners of the past and are less supportive of CHCs. Management fears that health departments that privatized may now be in trouble. Those who transitioned services will need to reinstate these services because no other entities are stepping up to the plate.

Lessons Learned/Words of Wisdom

- Health departments should stay a steady course in an ever-changing environment. Assess the environment, and understand how policies may affect the LPHA. Stay alert to the latest developments, such as the Children's Health Insurance Program (CHIP) and Medicaid, to understand the impact of these programs.

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Memphis and Shelby County Health Department, Tennessee

Date: April 2000

Community/LPHA Profile

Jurisdiction Size:	868,825
LPHA Annual Budget:	$41,600,00
Metro, Urban, Rural:	N/A
Ethnic/Racial Makeup:	N/A
Percentage of Uninsured Residents:	N/A
Percentage of Medicaid Beneficiaries:	20%

Decision to Transition

Memphis and Shelby County Health Department (MSCHD) is a division of county government funded jointly by the city of Memphis and the county of Shelby. Its duties and authorities are delegated from the state health officer, but MSCHD is not part of the state government. MSCHD has contractual relations with the state.

Historically, MSCHD has been a major provider of health services. Since the late 1960s, it has run six primary-care clinics scattered throughout medically underserved parts of the county. Until 1997, MSCHD was spending $8 million-$10 million per year on the operation of its primary-care network. Shelby County directly funds health services through: 1)MSCHD primary-care clinics, 2) the county hospital, and 3) two nursing homes. These components are loosely affiliated, but there is no formal network.

Concerns arose when TennCare, the state's Medicaid managed care program, began to pose threats to the hospital and nursing homes. Changes in disproportionate share hospital (DSH) and graduate medical education (GME) payments added to the financial pressures. At the same time, the mayor became interested in privatizing the county hospital to achieve better integration of county-funded services and to establish more formal relationships among the three service delivery entities. Thus, MSCHD began a planning process 3-4 years ago to create an integrated service delivery system. The primary-care clinics would be linked administratively with the four primary-care clinics of the regional medical center. In 1999, MSCHD signed a contract to hand over the management of the clinics to the regional medical center. Over time, staff will become hospital employees.

MSCHD still provides personal care services such as immunizations, WIC, and STD prevention. There are no plans to transition these services because the programs are working well. The community would be at a loss without these services.

Stakeholders involved in the decision-making process were the hospital president, MSCHD, the mayor's health policy advisor, and the University of Tennessee because it staffs the hospital and subspecialty clinics. Planners also spent time educating the county commissioners. Commissioners wanted two assurances — that the quality and level of services would not diminish and that hundreds of persons would not be laid off.

The county participated in Community Diagnosis, a needs assessment process required by the state. A council representing a cross section of the community reviewed health data, identified health problems, and made recommendations. The council identified two priorities: better integration of delivery systems and improved maternal and infant health. This process helped formulate the idea to focus on the broader community rather than on only county-funded services.

There were other reasons to transition services. The county government became concerned about controlling the growth rate of expenditures. By contracting with the medical center, costs would be fixed over time. "Privatizing" services would create some automatic efficiencies in that linking the primary care services would result in economies of scale. Furthermore, by contracting with a private entity, MSCHD officials hoped they would have more flexibility than that which exists in a government environment.

Transitioning Process

The partnership with the hospital did not come easily. MSCHD staff were concerned that the hospital wanted to partner solely for financial reasons; they needed to be convinced that the delivery system would be

improved. Other partners were the mayor's office, the University of Tennessee, and the state health department, with which the agency contracts for population-based services. The state was concerned about lapses in data collection and service provision.

On some levels, the transition went smoothly. Very little changed at first, especially from the patients' perspective. The partnership with the hospital was publicized in news releases, articles, and newsletters for the integrated delivery system and during events at the primary-care clinics. MSCHD immediately saw some efficiencies in the supply-ordering process and billing system. However, two data systems are still running at the clinic because they are not 100% compatible. The staff integration went fairly smoothly, although it meant a shift for providers who were less hospital-oriented than the providers at the hospital's clinic. The health department is trying to work on physician contracts to find a way to create incentives for physicians.

Challenges Involved in Transitioning

- Financial challenges — The LPHA is essentially creating a new business. The agency was unfunded and undercapitalized and had to identify grant sources.
- Human resources challenges — The process requires integrating staff and gaining their trust. Change is always difficult, especially for civil servants. Staff were concerned that the medical center would take over the clinics, turn everything upside down, and lay off employees.
- Accountability — The process requires building in new accountabilities.
- Evaluation — LPHAs and partners need to develop indicators and benchmarks.

Impact

Although patients are still not quite sure what the change means, over time they should see improvements in referrals, case management, continuity of care, and clinical coordination. Continuity of care for most clinical systems that are publicly funded exists only between 8am and 5pm, Monday to Friday. There is also a new emphasis on providing community-oriented primary care by studying the epidemiology of the community and addressing needs in a coordinated way.

The medical center conducts frequent patient satisfaction surveys, which MSCHD continues to monitor. One advantage of the new system is that clients registered at one clinic are automatically registered in all clinics, resulting in a larger network of care for patients. Both the health department and the medical clinics had quality assurance programs and are blending the two to create a new one. The goal is to ensure that the primary care clinics are well managed and that community objectives are being achieved.

Less involvement in direct services will free MSCHD staff and resources to concentrate on population-based services. MSCHD is performing some high-level epidemiologic work and preparing to become the community's first source of health information on many topics. Costs of providing primary care have stabilized because it is now a fixed item in the contract with the hospital. Services are more efficient and more available to the community.

Lessons Learned/Words of Wisdom

- Understand the importance of identifying stakeholders before making a change. Involve them early in the planning process.
- Be clear about goals, and stay focused. Continually come back to the goals.
- Recognize that change takes time, is incremental, and requires frequent reinforcement.
- Communicate with staff. Spend time training them on core values. Incorporate values into the integrated delivery system.
- Obtain the backing of key leadership in the community.

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Montgomery County Department of Health & Human Services, Maryland

Date: April 2000

Community/LPHA Profile

Jurisdiction Size:	852,174
LPHA Annual Budget:	$20,842,760
Metro, Urban, Rural:	Metro (80%), Urban (10%), Rural (5%), Other (5%)
Ethnic/Racial Makeup:	African-American (15.3%), Native American/Alaska Native (0.3%), Asian-American (11%), Latino (10.3%), Caucasian (73.4%)
Percentage of Uninsured Residents:	9.4%-17.6%
Percentage of Medicaid Beneficiaries:	9.5%

Decision to Transition

Montgomery County does not have a separate health department. Instead, Public Health Services is a division of the Montgomery County Department of Health and Human Services (MCDHHS). The county health officer is nominated by the county but is legally appointed by the governor and paid by the state health department.

Over the past several years, many primary care services, such as maternity and well-child care, have been transferred to private-sector partners. MCDHHS still provides immunizations; communicable disease control; TB, STD, and AIDS clinical services; preventive dental care for children; emergency dental care for adults; and dental care for AIDS patients living in a four-county region. MCDHHS receives a state grant for family planning, which is provided through a contract with Planned Parenthood, and a grant for breast and cervical cancer screening, which is provided through contracts with community providers. MCDHHS is case managing some pregnant women and children but has established partnerships with private providers for children's medical specialty services.

Before the state implemented mandatory managed care for Medicaid patients in 1997, Medicaid patients comprised roughly half of the clients seen for maternal and child health services, and the county received state reimbursement for services to these clients. County services were essential, as no private obstetrical providers in the community accepted Medicaid patients, and pediatric Medicaid providers were scarce. County funds supported services to the other clients, who were predominantly low-income, foreign-born residents ineligible for Medicaid.

Although the implementation of Medicaid managed care in 1997 hastened the privatization process, MCDHHS had already adopted the Institute of Medicine's (IOM's) definition of the core functions of public health. As it was difficult for MCDHHS to provide all unmet service needs, management concentrated on developing strategies to ensure needed services by establishing networks with the private community, which had the ability to absorb the clients. In 1992-93, the health officer approached the private community about moving children into private care. Family planning was transitioned in 1995 to Planned Parenthood. When Medicaid managed care was introduced in 1997, the county had already moved children's primary care services out, but the loss of Medicaid revenue pushed the county to transition maternity care and children's medical specialty services.

Before the 1997 Medicaid changes, the County Council had adopted a resolution that health and human services should be provided by the private sector whenever possible and that the county should be the provider only when services were not available in the private sector. There was some rationale for keeping certain services; sometimes comparable providers were not available, such as for HIV/AIDS and TB management. On the other hand, there was very little that was unique in the medical management of maternity or child services. Ultimately, the decision was the result of synergy between the IOM report's recommended mission, which MCDHHS was trying to move toward, the County Council's resolution on privatization, and the Executive Branch and Council's desire to downsize government.

Transitioning Process

Decisions to privatize programs were made in the context of the IOM report and the availability of services in the community. The feasibility of privatizing each program was analyzed and implemented individually. The process took several years.

Stakeholders/partners included the five community hospitals, with which the department works closely, the medical society, and a coalition of community providers, called the Primary Care Coalition. The Primary Care

Coalition is a nonprofit organization that began as a coalition of community health and human service providers to increase access to primary care for low-income residents. It has evolved into a broker between MCDHHS and community providers, contracting with service providers more expeditiously than the county bureaucracy allows.

Challenges Involved in Transitioning

- Working within rigid county procurement policies and contract regulations.
- Helping private-sector providers develop the capacity to take on MCDHHS clients.
- Maintaining adequate staff, despite the pressure to reduce staff when clinical services cease, for functions outlined by IOM.
- Monitoring the quality of care provided by partners and contractors.
- Assuring quality of care. The Department now has a consultant to develop quality assurance tools for different types of contracts. Staff are conducting on-site audits and giving the providers self-auditing tools. The Department is writing into contracts the right to review data and to have access to other reviews and outcomes and performance measures.

Impact

The transition has expanded clients' options for care. Clients visit former health center sites for eligibility determination and are then referred to the appropriate community provider. Services for children have improved, with access now to both well and sick care. Through the partnership with the Primary Care Coalition, access to care for low-income adults has also improved. By changing from clinical services to case management, public health nurses have increased their ability to assess families' needs and ensure receipt of needed services. Public health nurses work increasingly with public and private social service providers. The community health nurse has also played a role in capacity-building by developing partnerships with private service providers and providing direct services to selected ethnic populations.

As a result of the transition of direct clinical services to the private sector, MCDHHS is able to focus on assessing the community's health, developing policies and strategies to improve identified health problems, and assuring that effective strategies are implemented. MCDHHS hired an epidemiologist to evaluate county data; these data are now driving a number of policy and budgetary issues. A community advisory committee has been created to develop a strategic health plan to identify and address health issues for different county areas. Health problems for minority populations are being identified and addressed through community coalitions. Case management has been expanded to ensure that clients receive needed services. Collaboration with mental health, substance abuse, and social service providers has increased.

Lessons Learned/Words of Wisdom

- The best time to begin this process is when the economy is flush and there is no political pressure to cut the budget. Frame it as a reorganization initiative rather than a money-saving initiative. It is preferable to base the change on public health principles rather than on efforts by elected officials to downsize government.
- Be able to sell a good rationale for not downsizing staff. Look at additional services the community will need, such as case management.
- When downsizing in a union environment, seniority dictates job placement, which can result in a mismatch between the needs of the position and the staff person filling it.
- Staff are not anxious to change from clinical care to assessment, case management, and care coordination.
- The private sector is likely to be ill-prepared for management of problem-oriented public health patients and will need assistance in case management.
- It is not clear that any money is saved in this process. However, the process does increase capacity and, if done correctly, improves health outcomes.

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Pinellas County Health Department, Florida

Date: April 2000

Community/LPHA Profile

Jurisdiction Size:	890,000
LPHA Annual Budget:	$30.5 million
Metro, Urban, Rural:	Metro (40%), Urban (60%)
Ethnic/Racial Makeup:	African-American (8%), Native American/Alaska Native (0%), Asian-American (1%), Latino (1%), Caucasian (90%)
Percentage of Uninsured Residents:	17.5%
Percentage of Medicaid Beneficiaries:	under age 65 (8.1)%, over age 65 (5.7%)

Decision to Transition

Pinellas County Health Department (PCHD) receives about 8% of its funding from the Board of County Commissioners and about 10% from the Pinellas County Juvenile Welfare Board. A physician oversees clinical activities, and there are two environmental divisions. PCHD is a subordinate of the state health department. Buildings and equipment are the property of Pinellas County, but staff members are state employees.

PCHD has transitioned most prenatal care services to private providers, contracted AIDS patient care to Pinellas Cares (a hospital-affiliated HIV/AIDS clinic), and transferred most pediatric primary care services to Medicaid HMOs. PCHD still provides maternity services in one clinical center that sees mostly undocumented, uninsured Hispanic patients and a few patients who are either non-compliant or otherwise unacceptable to the private sector. PCHD continues to provide family planning services at all five locations and limited primary care services in its smallest, most remote clinic due to a shortage of providers in the jurisdiction, and STD/TB/HIV counseling and testing, dental services for children, as well as a full range of epidemiology and communicable disease services.

Changes in the economics of the private healthcare sector, improved Medicaid reimbursement rates for prenatal and delivery services, and the advent of Medicaid managed care led to the decision to transition some clinical services. In 1988, PCHD provided prenatal care to more than 3,000 maternity patients. As the 1990s progressed and Medicaid reimbursement increased, these patients became increasingly acceptable and attractive to the private sector. Private practitioners began to compete to attract patients, and, with sufficient numbers of private providers in the county, PCHD decided that it was not appropriate to enter into this competition. As a government entity, PCHD could not compete under the same rules as the private sector, which could provide direct clinical services for patients at less cost.

Around the same time, Florida's Healthy Start program began, and staff who had been involved in direct service provision were transitioned to the new home-visiting program or into providing expanded family planning services. The Healthy Start program complements clients' clinical care, providing a level of service and intervention not usually available from private providers.

The transition was also driven by a change in philosophy: to outsource where possible and to turn PCHD's focus to the restoration of core public health services. In the 1980s, so much time and energy were devoted to primary-care initiatives that core functions were neglected. As a result, the state legislature and the general population saw county health departments as functioning solely to serve indigents. In 1996, CHOICES, a community collaborative, contracted with the University of South Florida College of Public Health to perform a countywide community health assessment. PCHD has attempted to focus community attention on the problems identified in this assessment.

Transitioning Process

PCHD partnered with several community-based organizations throughout the decision-making and transitioning processes. These included the Juvenile Welfare Board of Pinellas County, Family Service Centers, YWCA, the school district, and three hospital/health systems. PCHD's experience with partnerships has been quite positive; the agency generally tries to use existing community resources rather than developing new ones.

PCHD provided fliers and information to its centers to facilitate the continuity of care. The transition to the new private-sector clinic went smoothly, although some patients were initially unhappy with the changes.

Challenges Involved in Transitioning

- Working with the state's Medicaid program — Although initially intended to provide patients with a choice of primary care providers, the Medicaid program ultimately assigned clients to providers by zip code, without regard to previously established client/provider relationships. There was a lot of confusion.
- Obtaining the support of long-term employees — Since the transition occurred gradually, no jobs were lost as a result of privatization, and many long-term employees were pleased to return to their "roots."

Impact

PCHD does not directly monitor the process of clinical client care in the private sector, but outcomes are monitored. Findings suggest that privatization is serving the county well. PCHD initially made arrangements with a number of private practitioners to ensure that they would accept Medicaid patients referred by the health department.

The impact of the transition has been positive in general. The Healthy Start/Healthy Families programs have allowed PCHD to get into the community and obtain data. It was emotionally difficult for PCHD to give up direct prenatal services, but now it can monitor the 9,000-10,000 deliveries in the county, rather than only the 3,000 PCHD deliveries. More people can be helped, and PCHD has learned that infant mortality and low birth weight are not only problems of the low-income population.

To measure the effectiveness of the transition, PCHD is tracking high-risk infants. All services are recorded on encounter forms, and the data are entered into a statewide computer system. All case management files of home visiting clients are automated and easily retrievable.

Lessons Learned/Words of Wisdom

- Maintain neutrality. Do not align with any specific HMO or sector of the community. Do not contract with one HMO at the expense of another.

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Tacoma-Pierce County Health Department, Washington

Date: April 2000

Community/LPHA Profile

Jurisdiction Size:	710,000
LPHA Annual Budget:	$22 million
Metro, Urban, Rural:	Metro (28%), Urban (36%), Rural (36%)
Ethnic/Racial Makeup:	African-American (7.9%), Native American/Alaska Native (1.5%), Asian-American (7.1%), Latino (4.3%), Caucasian (83.5%)
Percentage of Uninsured Residents:	12%
Percentage of Medicaid Beneficiaries:	5%

Decision to Transition

In Washington, LPHAs are independent of the state. The state has an advisory role to the county. A local Board of Health made up of elected city and county officials sets policy.

Tacoma-Pierce County Health Department (TPCHD) has transitioned direct services and currently provides no clinical services (e.g., family planning, TB, HIV, immunizations, STD, well-child, indigent care). Essentially, TCHD provides only population-based services. About 4 years ago, the Health Director approached Pierce County with a plan to transition all direct services to the private sector. His experience showed that, when a local public health agency (LPHA) tries to provide both direct and population-based services, neither is done well; preventive activities get shortchanged because persons in need always take priority. The Director proposed that TPCHD should develop capacity in the private sector and then hand off services. This meant enticing community agencies to set up shop in the county; the only existing community health center (CHC) was bankrupt.

The Board of Health believed in providing services and helping the poor and had questions about the role of LPHAs. The Health Director assured the Board that no one would fall through the cracks during the transition and that capacity would be expanded. During a series of public meetings, residents were asked what services they wanted from TPCHD. Although it was not verbalized in this way exactly, management felt that the community's needs would be best met with privatization.

Transitioning Process

Restructuring TPCHD to focus on prevention was expensive. Staff needed to be hired or retrained. The Board of Health allowed the Health Director to invest savings from an administrative re-structure and from the infrastructure of clinics that would no longer provide services. A CHC also received incentives to move to Pierce County.

TPCHD got the bankrupt CHC on its feet and persuaded more physicians to participate by aggressively marketing public health messages to the providers and their staffs through monthly office visits. The support of the local medical society was critical. The CHCs acted as a buffer so that physicians' offices would not be overrun with indigent clients. Physicians were more amenable to the role of backup support. It took about three years until TPCHD could close its doors. Since the private community was not pounding on its doors, however, TPCHD had to create providers in the community.

Partners were helpful throughout the transitioning process. They included the medical society, the three largest healthcare systems, and the CHCs.

Challenges Involved in Transitioning

- Opposition to change — LPHA staff did not want to give away patients.
- Opposition from unions — Picketing generated considerable stress.
- Need to keep politicians on track — They could have sidestepped the plan.
- Need to retain funding levels — This needs to be worked out ahead of time with the city and county.

Impact

Initially, there was some paranoia in the county, which the press exacerbated. A few months down the road, however, health officials noticed that no one was complaining. TPCHD held public hearings after the transition to discuss concerns and problems. Random interviews documented improved access to care. The agency distributed and tracked the use of vouchers that entitled residents to care across the county. Findings showed a high percentage of use. The new system enabled persons from all areas of the county to obtain treatment. The Board of Health witnessed this improved access and was reassured. Capacity had more than doubled.

It was difficult to change the image of TPCHD, which was previously invisible except in its role as clinical provider. Staff spent considerable time engaging the community. Teams went into the community to use population-based approaches to prevention. TPCHD is now much more visible because it serves the entire community. It also has large environmental and disease control programs that emphasize surveillance.

In addition to being more visible, TPCHD is more in demand for involvement in community issues. Staff members work with the criminal justice system, councils, and medical community. Internally, morale has improved considerably. The agency has hired many new staff members who believe in public health's core functions.

Although TPCHD has some process data related to the transition, it is too soon for impact data. The Office of Assessment is collecting data using a structured evaluation tool.

Lessons Learned/Words of Wisdom

- Do not make excuses. If you believe in population-based prevention activities, figure out a way to get involved. Find resources in the system, and make the painful but necessary changes.
- Be resolute in addressing staff concerns. Focus on the importance of public health as opposed to sickness care. Staff will become convinced after seeing data that the system is working.

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West Central Health District, Georgia

Date: April 2000

Community/LPHA Profile

Jurisdiction Size:	344,898
LPHA Annual Budget:	$18 million
Metro, Urban, Rural:	Metro (15%), Urban (35%), Rural (50%)
Ethnic/Racial Makeup:	African-American (45%), Caucasian (53%), Other (2%)
Percentage of Uninsured Residents:	30%
Percentage of Medicaid Beneficiarie:	26.5%

Decision Not to Transition

West Central Health District (WCHD) serves 16 counties, each of which has a local Board of Health. WCHD has a health director (a physician by law), chief of staff (usually an RN), and several other coordinators. The local public health agency (LPHA) is an umbrella agency of the Department of Human Services, Division of Public Health. The health director is officially a state employee who must implement mandates from the state but is also responsible to the Board of Health.

WCHD has not transitioned any services, and transitioning of primary care services has not been discussed because of the lack of service delivery alternatives. In some counties, the health department is the only service provider. Some counties have no local hospitals and thus are obligated to provide services directly. WCHD continues to perform traditional public health functions.

More than half of the population in the jurisdiction is African American and therefore at high risk for cardiovascular problems. Although national policy is focused on eliminating health disparities, the state has reduced county funding. Health officials would like to stop providing direct services, but it is not feasible at this time. WCHD has not been able to conduct a community assessment because of reduced state funding. It would be very difficult to undergo a formal assessment, as staff are hard-pressed to fulfill even legal requirements, such as checking on immunizations at day-care facilities.

WCHD, heavily involved in providing primary care services, has several arrangements with Columbus Regional Medical Center and benefits from the hospital's indigent care trust fund. WCHD is also the beneficiary of a private hospital and receives money for women's health care. It has set up screening programs for hormone replacement therapy and mammography. WCHD has a mobile van to work with pregnant teens and the homeless and to provide HIV, Hepatitis B, and TB testing. In addition, the WCHD operates a diabetes clinic from which the state recently cut funds and collaborates successfully with the private sector for nutrition services, counseling, and foot screening.

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Appendix D: Survey Responses

Note: All of these interviews were conducted in May 2000. The situation presented is what was occuring during this time, and the circumstances might have changed since the interview was conducted. Feel free to contact the local health department directly using the contact information provided to seek additional information.

Health Departments That Have Transitioned Services

Dutchess County Department of Health, New York

The health department has incrementally moved away from providing some direct clinical services. Each program is evaluated individually based on: community need, current enrollment, community/provider capacity, strengths and weaknesses of various options, cost analysis, political impact, and fit with public health core functions. The health department discontinued its child health clinics because of an increase in provider capacity. The termination of the clinics occurred over a several month period during which the health department ensured that each child received primary care. The health department transitioned the WIC program one year ago from county administration to a not-for-profit community health center. This process was extremely complex because it involved thousands of clients, ten staff members, and less-than-optimal administrative communication. The WIC transition was also complicated by a transfer of state oversight from Albany to the New York City region. At the same time, the health department embarked on several substantive partnerships. With a change in culture, public-private partnerships became the standard for addressing most public health issues. Many of these collaborations either planned for services in which the county was a provider or stakeholder (e.g., influenza, pneumococcal) or influenced community activities related to a public health problem.

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Leon County Health Department, Florida

The health department provides direct clinical services only when suitable community providers are not available. The health department continuously evaluates what services need to be provided. Over the last several years, the health department transitioned most of its clinical maternity program to provide maximum capacity in preparation for welfare reform. The health department also transitioned its primary care program to keep a voluntary health clinic in the community viable after an expansion grant was not renewed. The health department has been involved in a community initiative to make universal access to primary health care a reality in the community. Health department representatives meet regularly with staff from the local not-for-profit hospital, medical society, and both community clinics that provide primary health care to low-income populations. It took several years of contracting with private providers to create the desired level of experience in maternity care. In primary care, the goal was quality of care, community-based care, and a focus on population-based rather than clinical care. The health department contracted with two primary care centers. The transition was effective three months after arrangements were in place and current patients were notified.

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Lewis County Public Health and Social Services Department, Washington

Lewis County transitioned STD and immunization services due to lack of revenue and (in the case of STD services) loss of trained staff. The transfer of immunization services has been a gradual process while the local public health agencies (LPHA) trains physician office staff in immunization practice and delivery. Health department staff who previously provided immunization services now conduct quality assurance activities in private offices. The health department's mission changed from ensuring that children who come to the clinic are fully immunized to ensuring that all children in the county are fully immunized. The decision to transition services was made and implemented in collaboration with a community advisory committee but with limited discussion with potential community partners.

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Livingston County Public Health Department, Michigan

The public health department has transitioned direct services to a limited extent. In general, the policy is to provide direct personal health services to the community when capacity does not exist elsewhere and services are not accessible, affordable, or equitably available to vulnerable populations. The state Medicaid agency moved the Medicaid population into a managed care model for comprehensive health services delivery in 1996. The public health department transitioned out of providing EPSDT (well-child visits) services as these became the responsibility of qualified health plans. The public health department retained the ability to provide immunization, STD, and family planning services to the Medicaid population but was required to bill the health plans for the services to preclude the creation of barriers to access. The public health department also continued to provide maternal and infant support services to pregnant women enrolled in Medicaid in either qualified health plans or under fee-for-service. The public health department is the only Title X agency (provider of family planning services) in the community and the only certified provider of maternal and infant support services. Its continued service provider role may be reevaluated if private-sector competition moves into the community. Local support from hospitals, healthcare providers, and community-based organizations ensure the continued presence of key public health programs.

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Los Angeles County Department of Health Services, California

In 1995, the Department of Health Services was split into two Divisions: the Division of Personal Health Services and the Division of Public Health. The health department transitioned all clinical services except TB and STD treatment and childhood immunizations. The health department had a large clinical services delivery system, consisting of six hospitals, six comprehensive health centers, and 27 primary care centers. As part of the transitioning decision, well-child supervision became part of general pediatric care, prenatal care fell under obstetrical practice, and family planning became part of gynecologic care. Childhood immunization was

transitioned into pediatric care. The health department still conducts immunization-only clinics to avoid missed opportunities for immunizing children but tries to connect each child to a permanent source of pediatric care. Clinical public health services (TB, STDs, immunization) are carried out in 13 public health centers. The health department negotiated 69 contracts with private partners covering 134 clinic locations in which uninsured patients can receive reimbursable primary care. The health department found the private sector willing to provide services with reimbursement.

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Orange County Health Care Agency, California

In 1995, the agency decided to transition the provision of some direct services. The county's bankruptcy provided the opportunity to examine non-traditional approaches and the county's core business focus. The decision to transition prenatal care services derived from the adequate number of private medical providers to meet the needs of the county's Medicaid-eligible population and the active interest of these providers in Medicaid patients. The county worked closely with the local medical association, hospitals with obstetrical services, an association of community clinics, and a community-based organization (Maternal Outreach Management Systems-MOMS) to plan and implement the transition process.

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Phelps County Health Department, Missouri

In November 1998, the health department transitioned home health services, which were sold to a local hospital. Other services were expanded because the county was designated a healthcare provider shortage area (HPSA) surrounded by six other HPSA counties with even fewer services. Home health services were sold because of poor reimbursement and increasing regulatory requirements. The local hospital had more resources for the services and expected to at least break even.

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Public Health-Seattle and King County, Washington

The health department applies a data-driven decision process to determine service and program directions. The overall context for this process is the Washington State Public Health Improvement Plan (PHIP), which was promulgated in 1994 as the framework for implementing the core functions of public health — coming on the heels of Medicaid managed care. Historically, the health department has delivered a variety of population-based and clinical services out of 15 major sites and numerous and changing satellites and community partner sites. On a community-by-community basis, each clinical service is assessed on: public health impact, level of unmet need, capacity of other community-based providers to serve that need, economic efficiency of the delivery model, agency with maximum capacity to leverage resources to serve this need, and community/political support for the service.

As a result of this assessment process, the health department transitioned pediatric services at three sites and family health at one site in the county outside Seattle in 1998. The health department continues to provide primary care services in one county and three Seattle sites, and WIC, family planning, immunizations, dental, and other categorical direct services at more than 12 sites. Since the majority of pediatric patients were Medicaid-insured, the community health center (CHC) was able to expand capacity with patient-generated revenue. Collaborative efforts increased information, referrals, and resource sharing between the two agencies, especially related to translation, outreach, Medicaid enrollment, and communicable disease services. This work of system development and resource coordination continues, as the partnership between the CHC delivering primary care and the health department delivering "wrap-around" services expands. The health department also collaborated with the hospital to open a primary care family clinic. The work is ongoing, and staff members at all levels are involved in system development, care coordination, and problem solving.

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San Angelo-Tom Green County Health Department, Texas

The health department transitioned adult primary care and sick- and well-baby services because of the existence of infrastructure to provide these services elsewhere and budget cuts by the local city council. A community health center (CHC) took over the clinic as a satellite operation. The Texas Department of Health participated in the decision because state primary health care funds were involved. The CHC now has the state Primary Health Care Contract. The health department continues to provide immunization, STD, and TB services.

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Southington Health Department, Connecticut

The health department provides the following direct services: environmental health protection, limited health promotion/health education, epidemiology and infectious disease follow-up, statistics, and planning. The health department is transitioning into covering for or arranging for the 10 essential services. Current or planned partner organizations include: YMCA, Visiting Nurses and Homecare, Senior Citizens Department, Youth Services Department, Parks and Recreation Department, local specialty hospital, long-term care and elder-care facilities, Social Services/Welfare Department and the local Board of Education.

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Southwest Washington Health District

Public health leaders in Washington State endorsed the recommendations of the Institute of Medicine's report, *The Future of Public Health*. The report urged public health across the country to recommit to serving populations through the core functions of "assessment, policy development and assurance." In keeping with that policy direction, Washington passed the Public Health District, in turn, adopted the policy of transitioning toward services that served whole populations.

The services that have been transitioned to private health care providers are:

- Home Health — to the Southwest Washington Medical Center (1985 approx)
- Prenatal Care Program — to the First Steps Maternity Clinic (1988)
- Well Child and Sick Care Clinic — First Steps Women's and Children's Clinic and other private medical providers (1993)
- Travel Clinic (immunizations and counseling) — local private providers (1997?)
- Immigration Screening and Physicals — to private providers in other communities
- Immunizations through State Supplied Vaccine Distribution Program. The Health District continues to provide immunizations due to limited access to private providers.
- SWIFT Dental Clinic — to Sea Mar Community Health Center (1999)
- HIV/AIDS Case Management — to Clark County Department of Community Services (2000)
- Public Health Laboratory — due to budget cuts in 2000. Private labs now provide water testing and reference lab services.

Decision to transition services was based on fit with Public Health Improvement Plan, availability of other providers in the community, services at least the same quality as provided by the Health District, and prioritization of funds for population based services (such as assessment, health promotion and access to health care).

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Springfield/Greene County Department of Public Health and Welfare, Missouri

The health department transitioned one direct service (prenatal care) and modified another (sick-child care). The transition of prenatal services from the public to the private sector was completed in 1996. The sick-child clinic began transition from a single freestanding clinic to six school-based clinics in 1998. Approximately 40 physicians are currently under contract with the health department to provide prenatal and delivery services. The health department provides free pregnancy testing and counseling and immediate physician referral for prenatal care for those testing positive. The health department refocused its services from one freestanding clinic and opened six school-based clinics to address additional need. However, management now believes that closing the freestanding clinic was a mistake because of growing physician reluctance to take on new Medicaid children. The health department also runs a family practice clinic and a dental clinic and offers STD, HIV/AIDS, TB, and immunization services. There are no plans to privatize these services because of lack of private-sector interest and their inclusion as core community health prevention activities. The only services that are considered for transition are primary care not linked to population-based intervention, such as prenatal care and Medicaid child health services. Transition efforts involved two large tertiary hospitals, a medical society, the state department of health, and a community collaborative, Advocates For A Healthy Community (AFAHC).

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Tompkins County Health Department, New York (ok)

The health department stopped providing well-child clinics because local physicians felt that the clinics were causing fragmentation of care (even though they were unwilling to see Medicaid families) and the health department was unable to recruit and retain a family nurse practitioner. The health department still provides immunization, communicable disease control, TB, and HIV counseling and testing services. It contracts out STD services. The decision was made entirely by the health department. Management notified the partner agencies, and all worked collaboratively to help families find medical homes. With reductions in funding, such as non-funded state mandates, health departments are forced to prioritize services. Unfortunately, however, the public sector is often not ready to take on this challenge.

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Waco-McLennan County Public Health District, Texas

The health district underwent a two-year process to focus on population-based services. The decision to transition clinical services was community based. Well-child and prenatal services were selected to be transitioned, as there was a willing private and not-for-profit healthcare provider. Partners throughout the decision-making and transitioning processes included: 20 incorporated cities and counties, hospitals, physicians, family practice residency training program, community organizations, agencies and associations, the Texas Department of Health, and interested citizens.

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Yakima Health District, Washington

The decision to transition direct services was a long, involved process that included members of the local Board of Health, a Public Health Council of community partners, and the state health department. Participants based their decisions on the results of local/statewide assessments of services. The transition was influenced somewhat by changes in funding structures as well as philosophical changes at the Board and management levels. The arduous process included the transition of MCH functions, the transfer of WIC programs, the sale of home health services, the transition of pediatric clinics and immunization services, and the transfer of treatment/prevention services for TB and STDs to local partner agencies. The health district retains oversight and assurance functions for the activities involved in these programs. As additional opportunities became available within the jurisdiction, the health district convened members of the local health community to determine whether other organizations had the capacity to provide the services. All determinations to outsource services were based upon the tenet that government should not compete with local organizations if these organizations can cost-effectively provide services to all citizens regardless of their ability to pay. The health district has a long history of partnerships with local agencies and organizations, including hospitals, community health centers, Indian Health Service (IHS), tribal health, education and social services, school districts, family planning agencies, local, state, and federal government agencies, and a variety of not-for-profit and proprietary agencies and organizations. A recent assessment of immunization rates showed that after transition of all immunization programs to community partners, immunization rates have risen.

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Yolo County Health Department, California

The health department transitioned direct services in 1990 and 1994, primarily due to cost overruns. Jail/juvenile detention medical services and dental services were transferred in 1990 and indigent medical services in 1994. STD clinic services and some immunization services have been transitioned in the last 5 years. Jail/juvenile detention medical services were contracted to a private organization (California Forensic Medical Group), and indigent medical services were contracted to a consortium (Yolo Health Alliance, comprised of Sutter Davis Community Hospital, a community clinic, and a medical group). The consortium was established to deliver care to the indigent population.

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Health Departments That Have Not Transitioned Services

Akron City Health Department, Ohio

The health department has not transitioned direct clinical services. The health department has never been a full-service primary care provider but continues to provide categorical primary care services, including well-child care, immunizations, prenatal care, TB and STD diagnosis and treatment, hypertension diagnosis and treatment, travel clinic, Pap smears, adult dental care, breast and cervical cancer screening, counseling and substance abuse services, and nutrition services. Medicaid managed care has reduced the number of children seeking services in the department, but consolidation of services into one site provides enough patient volume to warrant continuation. Demand for all other services has stayed level. The health department has no plans to transition direct services in any program category.

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Allen County Health Department, Ohio

The health department continues to provide perinatal, child health, family planning, STD/HIV, and immunization services. A few years ago, management thought that, with Medicaid managed care on the horizon, the agency would be moving away from direct care. However, Medicaid managed care has not been a panacea in Ohio; it has fallen apart in major cities, and there seems to be little, if any, interest on the part of local hospitals or physicians to participate. Therefore, the health department continues to be the safety net, especially in child health because of a shortage of pediatricians. There are an adequate number of perinatal care providers in the county, but they will not see low-income women.

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Boston Public Health Commission, Massachusetts

The Health Commission is not transitioning out of the provision of direct care services. The types of services provided by the Health Commission are either those that benefit from a city-wide single provider approach (e.g., emergency medical services, school-based health centers, TB services) and those services that community-based agencies are disinclined to provide because of inadequate reimbursement or the nature of the population (e.g. homeless services, population-specific substance abuse services). Most often the populations served by the Commission are the most vulnerable, the underinsured or uninsured and/or those with substance abuse and mental health needs. The Health Commission is expanding some direct provision of services where there is a need to add services at particular locations (e.g., adding mental health services at school-based clinics and hepatitis C screening at drug treatment facilities). The Health Commission works closely with many community-based organizations (including 26 independent community health centers and numerous hospitals) in determining which services should be offered.

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Buncombe County Health Department, North Carolina

The health department is the major provider of indigent care for those without access to a physician, and the active caseload of patients is growing. The health department will continue to provide services because there are no other resources in the community to fill this gap. All major players in the healthcare market in the county were brought together and are members of a health consortium called Health Partners that helps coordinate and facilitate interactions among agencies. If services were given up, the health department would no longer be a significant player in the healthcare community. In most ways, local public health agencies (LPHAs) are better prepared to provide care to the underserved population than is the private medical community.

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Halifax County Health Department, North Carolina (ok)

Clinical services are the health department's only source of new financial resources. The health department is one of only two safety-net providers in the poor, rural county. Presently, local funds are being taken away from health departments, and no new funds are slated for health departments to support a return to core public health functions. The health department's biggest revenue opportunity is in becoming a provider for third-party insurance companies and Medicare and possibly obtaining the status of a rural health clinic. The services that may be transitioned or eliminated will be those that are 100% funded by county appropriation monies, such as HIV/AIDS, laboratory, and adult health services. The health department is currently partnering with The Rural Health Group, Inc., of Jackson, North Carolina, for provision of clinical services.

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Lake County General Health District, Ohio

The health district is not transitioning any preventive clinical services. The health district is the county's only provider of TB management/prevention, developmental well-child checks for low-income/no-pay clients, and low-cost immunizations. The health district also runs the grant-funded tri-county HIV anonymous test sites. The health district had never been a provider of acute or sick-care services. Any specialized grant-based

county projects that required medical or direct personal health care, such as prenatal clinics, have always been subcontracted out. The health district has always partnered with local agencies (e.g., Family Planning Association, hospital, human services, mental health) with primary expertise in these areas of prevention. This has eliminated duplication of efforts.

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New Britain Health Department, Connecticut

The health department has not transitioned any services but has instead formed many community partnerships. These partnerships have been beneficial in creating alliances, decreasing competition among community organizations, creating networks, and ensuring resources to medically underserved persons. The health department is constantly faced with a large population of city residents who are medically underserved. New Britain also faces a shortage of physicians for primary care and dental services. It is necessary to consider economic burdens, geographic isolation, inaccessibility to health care, and substance abuse. To overcome these obstacles, the health department often seeks partnerships or collaborations with other community organizations. These partnerships often help the health department receive funding and reduce the burden on limited staff. The partnerships have proven to be highly effective and rewarding, both to the health department and to other community organizations. They have helped to channel efforts and resources directly to the medically underserved population. These partnerships provide collaboration rather than competition among community agencies applying for the same funding. Two main partners include the community health center and Visiting Nurses Association.

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Northampton County Health Department, North Carolina

The health department has not transitioned direct services because it is located in a rural county with few providers. The health department is considering transitioning adult monitoring services and is currently adding only a limited number of patients because of the lack of Medicaid or state dollars to support the program. The health department collaborates with area hospitals and the Rural Health Group, Inc.

For more information, contact:
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Tulsa City-County Health Department, Oklahoma

The health department's approach is to maintain clinical services and enhance core public health services concurrently. Tulsa is the largest city in the United States without a public hospital. Therefore, the health department is an integral part of the safety net for the uninsured. The health department has also become the largest provider of maternity services to the Hispanic population. About 65% of the maternity caseload is Hispanic. Preventive clinical health services are very limited in the community. The health department has invested significant resources in strengthening core public health functions while maintaining clinical services. The health department is using a one-stop-shopping format for service delivery, partnering with human service organizations and employment offices. It also partners with a hospital, the state Medicaid agency, and medical schools. The health department provides significant case management and outreach activities.

For more information, contact:

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Unified Government of Wyandotte County/Kansas City Public Health Department, Kansas

Service delivery issues are currently being explored. The health department may transition prenatal clinical services because it has been receiving messages from the federal government about MCH funding and getting local public health agencies out of these types of services. Other reasons for wanting to transition services include: physician costs, the willingness of the community hospital and medical university to discuss community modeling, the exploration of core public health, and lack of revenue. The agency is currently partnering with the community hospital and medical university's obstetrics/gynecology division.

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Woodbridge Township Department of Health and Human Services, New Jersey

The health department has decided not to transition direct services because they comprise an unfilled need in the community. In continuing to provide clinical services, the health department has formed useful partnerships with the Middlesex County Health Department and JFK Medical Center, Edison, New Jersey.

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