

LEGISLATIVE COMMITTEE *on*
Public Health Futures



Public Health
Prevent. Promote. Protect.



October 31, 2012



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Foreword

October 31, 2012

Dear Governor Kasich, President Niehaus, Speaker Batchelder, Leader Kearney and Leader Budish:

On behalf of the Legislative Committee on Public Health Futures ("Committee"), we are pleased to submit for your consideration, eleven (11) recommendations to improve the public health system in Ohio.

Am. Sub. H.B. 487 charged the Committee to review the June 2012 report of the Futures Committee of the Association of Ohio Health Commissioners (AOHC) and develop recommendations for legislative and fiscal policies that can be considered for inclusion in the SFY 2014-2015 biennial operating budget bill. The Committee was well represented from associations and agencies, including: state and local government, members of the General Assembly, university and public health disciplines.

The recommendations submitted were thoughtfully, critically and passionately debated with a shared intent to remove barriers and improve opportunities to create a more efficient and effective local public health system.

We would like to personally thank the Committee members for giving of their time to participate in this important discussion. We look forward to working with the executive and legislative offices, public health partners and other stakeholders to explore how these recommendations may expeditiously move forward.

Sincerely,



David Burke
State Senator- 26th District
Chair



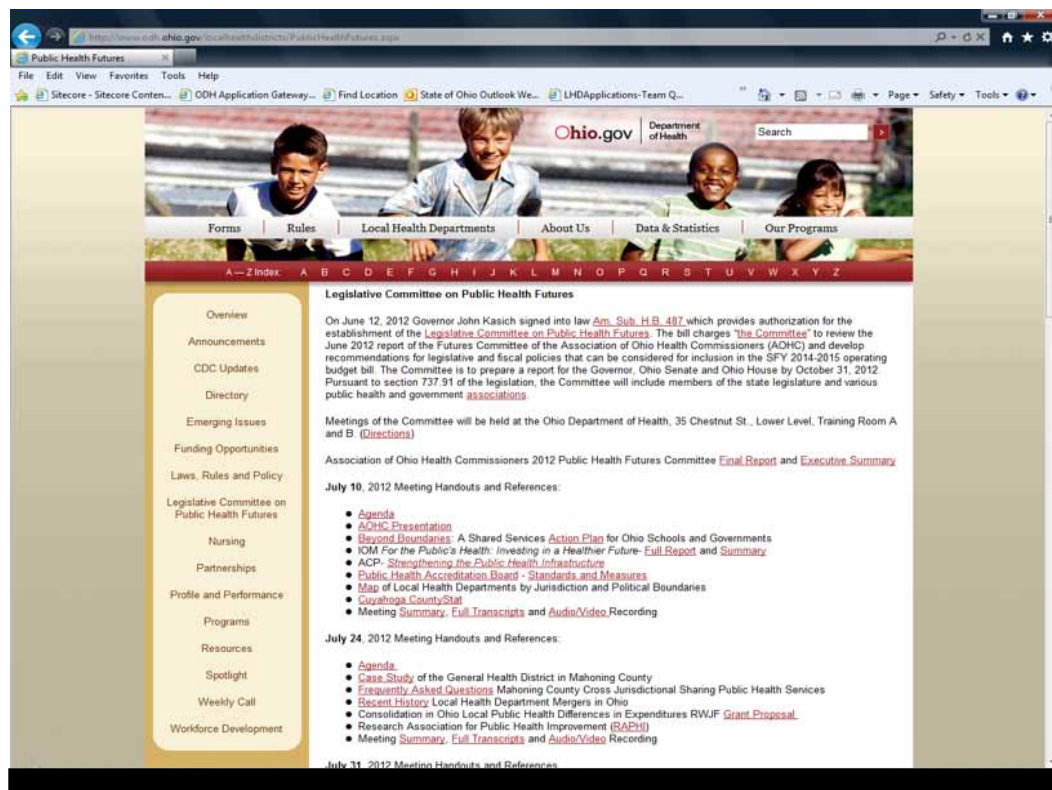
Christopher Press, FACHE
President, Blanchard Valley Hospital
Vice-Chair

Committee Process and Considerations

On June 12, 2012 Governor John Kasich signed into law Am. Sub. H.B. 487 (Appendix 1) which provides authorization for the establishment of the Committee. The bill charged the Committee to review the June 2012 report of the Futures Committee of the Association of Ohio Health Commissioners (AOHC) and develop recommendations for legislative and fiscal policies that would improve local public health services in Ohio. The Committee was to prepare a report for the Governor, Ohio Senate and Ohio House by October 31, 2012. Pursuant to section 737.91 of the legislation, the Committee included members of the state legislature and various public health and government associations (Appendix 2).

The Committee convened July 10, 2012 at the Ohio Department of Health (ODH). Much of the first meeting outlined the workflow and communication process of the Committee. The Committee selected its chair, vice-chair and secretary pursuant to the enabling legislation. It was determined the Committee would meet every two weeks at ODH communicating by email and a website on the ODH webpage. The website was designed to organize meeting handouts and references by meeting date (Figure 1). All meetings were made available to committee members and interested parties via conference call and webinar, as well as, recorded. Meeting notes were transcribed by a stenographer with a meeting summary created by ODH for the Committee's approval.

Figure 1



{ <http://www.odh.ohio.gov/localhealthdistricts/PublicHealthFutures.aspx> }



Committee Process and Considerations

In addition to the AOHC Futures committee report, the Committee was presented with similar reports created through legislative directives in 1960 and 1993- summaries of those reports are included on the website. Also, presentations were made throughout the series of meetings from local health departments and stakeholders reviewing issues, such as: accreditation, shared services, consolidations, and governance. As presentations were made and other reports and resources were brought to the Committee's attention, those considerations were posted to the Committee's website.

The Committee spent significant time at each meeting reviewing the recommendations within the AOHC Futures Report. AOHC recommendations were structured around four areas: services and capacity, jurisdictional structure, financing and implementation strategy. After nine (9) meetings, the Committee has unanimously agreed to eleven (11) separate, but related recommendations.

The intent and purpose of the recommendations are to reduce barriers and provide opportunities for public health to demonstrate outcomes, improve quality, streamline reporting, and create efficiencies. In addition, the recommendations demonstrate the connectivity between ODH and local health districts and challenge the state to provide continued leadership in the areas of data, programs, and administration. If implemented, these recommendations will give public health more tools to collaborate, integrate programs and services, and improve the assurance of services for all Ohioans.



Legislative Committee on Public Health Futures

Approved Recommendations and Concepts

Performance Standards and Accreditation

All local health districts shall meet PHAB eligibility within five years. Such documentation shall be independently verified.

Outcomes and Data

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

Boards of Health

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

Multiple Agency Program Administration

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

Multi-District Public Health Levy

Revise Ohio Revised Code 3709.29 to allow for permissive multi-county levy authority for public health services.

Shared Services Resources

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

Contract/Consolidate/Merger of Contiguous and Non-Contiguous Cities or Counties

Revise Ohio Revised Code sections 3709.051 and 3709.10 to allow contiguous and non-contiguous city and county health districts to contract/consolidate/merge together within a "reasonable" geographic distance (consider AOHC regions).

Reimbursable Services

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

Chronic Disease Block Grant Funding

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

Sustainable Funding

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

Reconvene Committee

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





Appendix 1

129th General Assembly

Amended Substitute House Bill Number 487

Section 737.91

It is expected that the Futures Committee of the Ohio Association of Health Commissioners will release a report in June 2012 on the future of local public health in Ohio. The Legislative Committee on Public Health Futures shall review the Future Committee's report, and, on the basis of its review, recommend legislative and fiscal policies that would improve local public health services in Ohio. The Legislative Committee, not later than October 31, 2012, shall prepare a report that describes its review of the Future Committee's report, and that states, and provides explanations of, its policy recommendations. The Legislative Committee shall transmit a copy of its report to the Governor, the President and Minority Leader of the Senate, and the Speaker and Minority Leader of the House of Representatives for consideration as part of the operating budget for fiscal years 2014 and 2015. Upon transmitting its report, the Legislative Committee ceases to exist.

There is the Legislative Committee on Public Health Futures. Each of the following associations shall appoint one individual to the Legislative Committee: the County Commissioners Association of Ohio, the Ohio Township Association, the Department of Health, the Ohio Public Health Association, the Ohio Environmental Health Association, the Ohio Association of Boards of Health, the Ohio Municipal League, and the Ohio Hospital Association. The Association of Ohio Health Commissioners shall appoint two individuals to the Legislative Committee. The President and Minority Leader of the Senate each shall appoint two members to the Legislative Committee. The Speaker and Minority Leader of the House of Representatives each shall appoint two members to the Legislative Committee. Of the two appointments made by each legislative leader, one shall be a member of the General Assembly from the appointing member's chamber. Appointments shall be made as soon as possible but not later than thirty days after the effective date of this section. Vacancies on the Legislative Committee shall be filled in the same manner as the original appointment.

As soon as all members have been appointed to the Legislative Committee, the President of the Senate shall fix a time and place for the Committee to hold its first meeting. At that meeting, the Committee shall elect from among its membership a chairperson, a vice-chairperson, and a secretary. The Director of Health shall provide the Legislative Committee with meeting and office space, equipment, and professional, technical, and clerical staff as are necessary to enable the Legislative Committee successfully to complete its work.

Appendix 2

Legislative Committee on Public Health Futures

Appointing Associations and Legislators	Appointee
County Commissioners Association of Ohio	Kim Edwards, Ashland County Commissioner
Ohio Township Association	Heidi Fought, Legislative Director, <i>OTA</i>
Ohio Department of Health	Martin Tremmel, Deputy Director, <i>Secretary</i>
Ohio Public Health Association	Nancy Shapiro, R.N., Delaware County General Health District
Ohio Environmental Health Association	Jennifer Wentzel, OEHA, President
Ohio Association of Boards of Health	Walter Threlfall, DVM, Delaware County General Health District
Ohio Municipal League	Anita Scott Jones, City of Middletown
Ohio Hospital Association	Christopher E. Press, FACHE President, Blanchard Valley Hospital, <i>Vice-Chair</i>
Association of Ohio Health Commissioners	D.J. McFadden, M.D., Health Commissioner, Holmes County General Health District
Association of Ohio Health Commissioners	Gene Nixon, Health Commissioner, Summit County Public Health
President Niehaus	Senator David Burke, <i>Chair</i>
President Niehaus	Tim Ingram, Health Commissioner, Hamilton County Public Health
Senator Kearney	Michael Thomas, M.D., University of Cincinnati
Senator Kearney	Senator Capri Cafaro
Speaker Batchelder	Representative Barbara Sears
Speaker Batchelder	Representative Lynn Wachtmann
Representative Budish	Representative Nickie Antonio
Representative Budish	Jennifer Scofield, Special Assistant to Edward FitzGerald, Cuyahoga County Executive

Appendix 3

Organization and Financing of General Health Districts

Staff Research Report No. 41 – Ohio Legislative Service Commission

December, 1960

Ohio citizens assume that their water is safe to drink, that their food and milk are pure, that sanitation facilities are satisfactory, and that local restaurants have been inspected periodically by competent public health officials. Most people also expect the local health department to take steps to curb the incidence and spread of contagious and infectious diseases, and to offer nursing services in the home, in clinics and in schools. Ohio's people, furthermore, usually assume that they can enter any community in the state and be assured of reasonable health protection.

For most people, these are largely unconscious assumptions, since a local public health program is seldom directly visible. Failures of a public health program, however, may become dramatically evident in an outbreak of disease, absence of services needed in an emergency, and in the discovery that a child has for years been suffering from a dental, sight, hearing, or other defect long undetected because screening and case finding in the schools has been inadequate.

Providing adequate public health services entails a paradox. In one sense it is everybody's business because every individual citizen can suffer in a community with low public health standards; in another sense, public health is nobody's business because individuals are likely to think of public health as applying to their neighbors but not to themselves. Yet a good public health record in a health district tends to make the job of the public health administrator more difficult because the need for public health services is not apparent.

Some cities and counties in Ohio do not afford citizens with the public health services they have a right to expect. Each city and county in Ohio by law must have a health department, but some of these districts fail to protect the health of the people within the district. Some districts employ part-time, and in some instances, poorly trained personnel. The result is the absence of the essential public health services which the average person assumes are available to prevent the spread of disease, to locate and help the child with a defect, to provide clinics for maternal and infant care, to provide home nursing services for the aged, the convalescent, and the handicapped, and to educate the people as to the means of improving and maintaining their health.

{ The causes of inadequate public health services in some communities are threefold: (1) many small city and county health districts are unable to finance, employ and effectively use needed qualified personnel; (2) the financial resources of many health districts are inadequate, unstable, diverse in character, and suffer from additional shortcomings in collection procedures; and (3) local boards of health in some districts appear to lack interest in developing a satisfactory public health program, or competence to do so, if interested. }

Adequate public health services in all communities can be developed through a combination of local efforts and legislation designed to help local health districts to help themselves.

Responsibility for financing and administration of local public health services in Ohio has been traditionally located in local health districts. A state responsibility for the broader aspects of public health, however, has for many years been accepted by the General Assembly, the Ohio Public Health Council, and the Ohio Department of Health. The Hughes-Griswold Act of 1919, for example, was acclaimed nationally at the time as a major accomplishment in public health. This law: required 2,158 city, village, and township health units to combine into 88 general (county) health districts and 92 city health districts; required both general and city health districts to employ a health commissioner, public health nurse, and clerk; and provided that each district would receive up to \$2,000 annually to pay for up to one-half of the salaries of these health officials.



Within the past decade the legislature has demonstrated its interest in improving local public health services. The General Assembly has authorized general (county) health districts to vote public health levies of up to .5 mill, subject to renewal every five years; amended the statute governing procedures for combining general and city health districts in order to facilitate such unions; considered but rejected a proposal that health districts be reduced in number to the 88 counties plus the eight cities over 100,000 in population; and requested that this study of the organization and financing of general health districts and of the selection of boards of health in these districts be undertaken.

The Ohio Department of Health, furthermore, has constantly promoted local public health programs through its direct services and special projects; supervisory and consultant activities; laboratory services; encouragement of voluntary combination of districts; in-service training programs and conferences for local health personnel; and distribution of federal grants-in-aid to local health districts.

This report presents an analysis of the desirability and feasibility of improving the organization and financing of general health districts. Three basic issues are presented: To what extent, if any, does the General Assembly wish to provide for the reorganization of health districts? To what extent, if any would changes be desirable in the statutes governing local and state financing of public health services? To what extent, if any, can the present method of selecting boards of health in general health districts be improved?

This report undertakes to analyze the existing laws pertaining to the organization and financing of the 88 general health districts and to the selection of boards of health, to describe the problems arising therefrom, and to indicate the possible alternative solutions to these problems. It is not the purpose of this report to study the specific problems of individual health districts. Attention is given in this report to city health districts as well as to the general health districts, because district consolidation involves the union of city and general health districts, because city districts provide useful comparisons with general health districts, and because some city health districts provide certain services in the surrounding general health district.

Some knowledge of local public health services is essential to understand the organizational and financial problems in general health districts. The following discussion indicates the nature of a local public health program, the varying factors affecting district health needs, and the duties of public health personnel.



Appendix 4

Healthy People, Healthy Communities

An Agenda for Public Health Reform

Report of the Ohio Public Health Services Study Committee

October 13, 1993

EXECUTIVE SUMMARY

The Ohio Public Health Services Study Committee was created with the enactment of Substitute House Bill 179 by the 119th Ohio General Assembly. The Committee concludes the significant restructuring of Ohio's public health system will be required to achieve the vision of "Healthy People in healthy communities." Under current law, dating back to the Hughes-Griswold Act of 1919, variations in the organization of local health districts result in differences in governance and authority between city and county health districts. Additionally, the Committee determined that local health departments are not funded in a consistent manner and rely on sources of revenue that are inadequate and unstable. Furthermore, recent data confirm that many local health departments are unable to offer a comprehensive range of public health services, including many direct services aimed at reducing the spread of communicable diseases.

The Committee's new vision for public health in Ohio recognizes that all levels of government have an increasing responsibility for the health of the public. As a guide to its recommendations, the Committee endorses the concept that **Assessment**, **Policy Development**, and **Assurance** constitute the core functions of the public health system. **Assessment** means the regular collection, analysis, and sharing of information about the health status of populations, risk factors for disease, and health systems resources. **Policy Development** results in a course of action that integrates problem identification, technical knowledge of possible solutions, and societal values. **Assurance** means confirming that necessary services are provided and/or that necessary resources are available to reach agreed upon goals, either by encouraging private sector action, by requiring it, or by providing services directly.

Against the backdrop of a vision of public health based on core public health functions and the practices implied by those functions, the Ohio Public Health Services Study Committee developed a set of recommendations, which are summarized below.

- Local Public health departments should be restructured into new jurisdictions with the authority and responsibility to provide the core public health functions.
- The geopolitical boundaries of the restructured jurisdictions should be coincident with county boundaries.
- These jurisdictions should be governed by a Board of Health appointed by a District Public Health Council consisting of the jurisdiction's elected leadership.
- The public health system will be strong when it has appropriate personnel, authority, and resources, and will be well-funded when its revenue base is adequate, certain, flexible, and stable.
- The state should assume a major responsibility to fund the cost of providing core public health functions and practices. State funding for these efforts should come from a public health trust fund. Local funding should come from the inside millage, fees, and health levies.

- 
- Accountability and accreditation of the public health jurisdictions should be based on documented abilities to provide core public health functions and practices.
 - The public health jurisdictions should employ staff that demonstrates administrative and medical leadership, as well as competence in the public health disciplines of nursing, environmental health, health education, nutrition, and community assessment.
 - Public health jurisdictions should assure the provision of direct preventive and personal health services. These include primary care and clinical preventive services, as well as services for the management of communicable and chronic diseases and newly emerging public health problems. Priorities should emphasize population-based services.
 - Public health jurisdictions must have increased capacity to prevent and control communicable diseases through epidemiologic investigations, direct services, and timely and appropriate administrative responses.
 - Environmental health risks should be assessed within the public health jurisdiction. The jurisdiction should assure that adequate environmental health resources and services are available.
 - The public health jurisdiction should have a central role in the development of community health policy and in the allocation of resources in the community.
 - Any proposal to reform the health care delivery system must provide for a strong and well-funded public health system.
 - Public health jurisdictions should be encouraged to strengthen relationships with state agencies and with other local providers of health and human services.

To achieve a new vision of public health, the Committee has offered a set of recommendations specifically directed at improving the health status of the populations served. These recommendations address deficiencies in Ohio's current system and offer a model based on core public health functions and practices that will assist public health officials in efforts to reform and enhance the public health system.



Appendix 5

Association of Ohio Health Commissioners

Public Health Futures

Considerations for a New Framework for Local Public Health In Ohio

June 15, 2012

EXECUTIVE SUMMARY

Recognizing the need to critically assess the feasibility of sustaining 125 local health departments (LHDs) and to develop proactively new approaches to improving effectiveness and efficiency, the Association of Ohio Health Commissioners (AOHC) established the Public Health Futures Project in 2011 to explore new ways to structure and fund local public health. The project has guided AOHC members through a critical look at the current status of local public health and a careful examination of crossjurisdictional shared services and consolidation as potential strategies for improving efficiency and quality.

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

OBJECTIVES

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

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

RECOMMENDATIONS

Local public health capacity, services, and quality

1. All Ohioans, regardless of where they live, should have access to the Core Public Health Services described in the Ohio Minimum Package of Local Public Health Services. (see Minimum Package diagram)
2. All local health departments (LHDs) should have access to the skills and resources that make up the Foundational Capabilities in order to effectively support the core services.
3. The Ohio Minimum Package of Local Public Health Services should be used to guide any future changes in funding, governance, capacity building, and quality improvement.
4. All LHDs should become eligible for accreditation through the Public Health Accreditation Board (PHAB).
5. LHDs that meet Minimum Public Health Package standards should be prioritized for grant funding in their jurisdiction.
6. The biennial LHD Health Improvement Standards reported to the Ohio Department of Health via the Ohio Profile Performance Database should serve as the platform for assessing LHD provision of the Minimum Package. The Profile Performance Database may need to be updated periodically to capture the Core Public Health Services and Foundational Capabilities.
7. The Association of Ohio Health Commissioners (AOHC) supports a review of current laws and regulations to determine where mandates may need to be revised or eliminated and should advocate for elimination of mandates that do not align with the Minimum Package of Public Health Services.

Jurisdictional structure

8. Decisions about the jurisdictional structure of local public health in Ohio should be based upon LHD ability to efficiently and effectively provide the Minimum Package of Public Health Services. Additional factors that should be considered are:
 - a. Number of jurisdictions within a county,
 - b. Population size served by the LHD, and
 - c. Local geographic, political, and financial conditions. (see Structure Analysis diagram)
9. All LHDs should assess:
 - a. Their ability to provide the Minimum Package of Public Health Services,
 - b. The potential impact of cross-jurisdictional sharing or consolidation on their ability to provide those services, and,
 - c. The feasibility of and local conditions for cross-jurisdictional sharing or consolidation.
10. Most LHDs, regardless of size, may benefit from cross-jurisdictional sharing. However, LHDs serving populations of <100,000 in particular may benefit from pursuing cross-jurisdictional sharing or consolidation to ensure adequate capacity to provide the Minimum Package.

RECOMMENDATIONS

Local public health capacity, services, and quality

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

Financing

13. All LHDs should have adequate funding to maintain the Minimum Package of Public Health Services. AOHC should continue the work of the Public Health Futures Financing Workgroup to identify cost estimates for the Minimum Package (Core Services and Foundational Capabilities) by November 2012.
14. The Ohio Department of Health and LHDs should work together to shift the focus from managing fragmented program silos and funding streams toward improving and coordinating state and local organizational capacity to effectively deliver the Minimum Package.
15. AOHC should advocate for block grants or direct contracts when possible so that communities can implement programs based on Community Health Assessment and Improvement Plan priorities.
16. AOHC should work to assure that local health departments are able to obtain fair reimbursement from public and private payers for eligible services (including efforts to streamline insurance credentialing).
17. AOHC should explore new mechanisms for improving the stability and sustainability of federal, state, and local funding, such as:
 - a. Dedicated percentage of inside millage in lieu of local levies,
 - b. Standardized cost methodology to establish fees for programs where no explicit fee-setting authority currently exists,
 - c. Increasing Local Health Department Support (“state subsidy”) to LHDs to support Foundational Capabilities,
 - d. Excise taxes (e.g., tobacco, sugar-sweetened beverages, medical transactions), and
 - e. Integrated health care delivery reimbursement.

Implementation Strategy

18. AOHC should seek funds to support feasibility assessments, transition planning, and incentives necessary for LHDs to implement the new framework (such as submitting a proposal to the RWJF Center for Sharing Public Health Services grant program).
19. AOHC should convene a meeting with state health policy leaders to formally present and discuss the recommendations of the Public Health Futures final report and to collaboratively plan strategies and action steps to advance forward progress toward the vision for the future.

CORE PUBLIC HEALTH SERVICES

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

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

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

OTHER PUBLIC HEALTH SERVICES

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

Clinical preventive and primary care services

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

Specific maternal and child health programs, such as

- WIC (Women Infants and Children) nutrition program
- Help Me Grow home visiting program (HMG)
- Bureau for Children with Medical Handicaps program (BCMHC)

Non-mandated environmental health services, such as

- Lead screening, radon testing, residential plumbing inspections, etc.

Other-optional depending on community need and other available providers

- Home health, hospice care, home visiting programs (other than HMG)
- School nurses; Drug and alcohol use prevention; Behavioral health
- Municipal ordinance enforcement

FOUNDATIONAL CAPABILITIES

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

Quality assurance

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

Information management and analysis

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

Policy development

- Policy analysis and planning
- Expertise for policy, systems, and environmental change strateHMG)

Resource development

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

Legal support

- Specialized consultation and analysis on public health law

Laboratory capacity

- Environmental health lab
- Clinical lab services (as appropriatediseases. Not all are listed here.

Support and expertise for LHD community engagement strategies

- Community and governing entity engagement, convening and planning
- Public information, marketing, and communications
- Community health assessment and improvement planning
- Partnerships to address socio-economic factors and health equity



Does the Local Health Department (LHD) have the capacity to efficiently provide the Ohio Minimum Package of Public Health Services?

- Adequate funding to support FTEs necessary for Core Services, and
- Adequate funding to support FTEs necessary for Foundational Capabilities, and
- Able to complete PHAB accreditation pre-requisites and apply for accreditation

Yes

No

Number of Jurisdictions in County
AND
Population Size Served by LHD

County has
more than one
LHD
OR
LHD population
size is <100,000

County has one
LHD
OR
LHD population
size is 100,000+

A

Maintain continuous
quality improvement,
maximize efficiency, and
seek accreditation

B

Assess feasibility and
local conditions for LHD
consolidation

Local choice based on
feasibility assessment

- Relationships and leadership
- Local geographic, political, and financial context
- Potential impact on efficiency, capacity, and quality

Is consolidation feasible
and beneficial?

If yes, pursue
consolidation

No

C

Obtain needed
capabilities from
formal cross-
jurisdictional
sharing (such
as Council of
Governments,
Service Center or
other contractual
arrangements)

LEGISLATIVE COMMITTEE ON
Public Health Futures



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Department of Health