King County

King County Public Health Operational Master Plan

Final Report and Recommendations

August 2007

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

THANK YOUS AND REPORT CONTRIBUTORS

The Public Health Operational Master Plan (PHOMP) is a collaborative effort among the King County Council, the King County Executive Office, the King County Board of Health, the Department of Public Health, the City of Seattle, suburban city representatives, and public health professionals and partners.

In particular, we wish to thank:

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EXECUTIVE SUMMARY

Public Health – Seattle & King County[1] provides a wide variety of regional services that protect and promote the health of all 1.8 million King County residents, as well as the hundreds of thousands of workers and tourists who enter the County each day. Services provided by Public Health – Seattle & King County include restaurant and drinking water inspections, hazardous waste disposal, communicable disease control, immunizations, chronic disease and injury prevention programs, health education and promotion, emergency preparedness, pandemic flu and disaster planning, family planning, maternal and child health programs, and clinical health services for low-income and uninsured residents.

Over the last decade, the provision of public health services in King County has been continually challenged due to emerging health risks, the necessity for increased disease control, and federal, state, and local mandates. At the same time, available funding has been limited or is decreasing, and the cost of providing the same level of services increases each year. Due to the increases in cost and need for public health services, coupled with funding challenges, King County engaged in a collaborative process to develop a Public Health Operational Master Plan (PHOMP). The PHOMP creates a set of operational and funding recommendations for the delivery of public health services in King County.

In May 2005, the King County Board of Health and King County Council approved a two-phase PHOMP work plan. Phase I of the PHOMP work plan established framework policies to help guide public health decisions in King County; Phase II created the operational and funding goals and strategies. The process, driven by the PHOMP Steering Committee, involved a series of background papers, partner and stakeholder input processes, and the convening of an Expert Panel on increasing access for the uninsured and underinsure in King County, which informed the issues surrounding public health in King County.

PHOMP Steering Committee Recommendation

Through a careful and in-depth review of public health, the PHOMP Steering Committee presents its findings and results in two sets of recommendations, which together set the direction for Public Health – Seattle & King County for the future:

- ***Phase I: A Policy Framework for the Health of the Public – July 2007, (pages 27 - 34),*** establishes broad policies to prioritize and guide decision making regarding the provision of public health services in King County; and

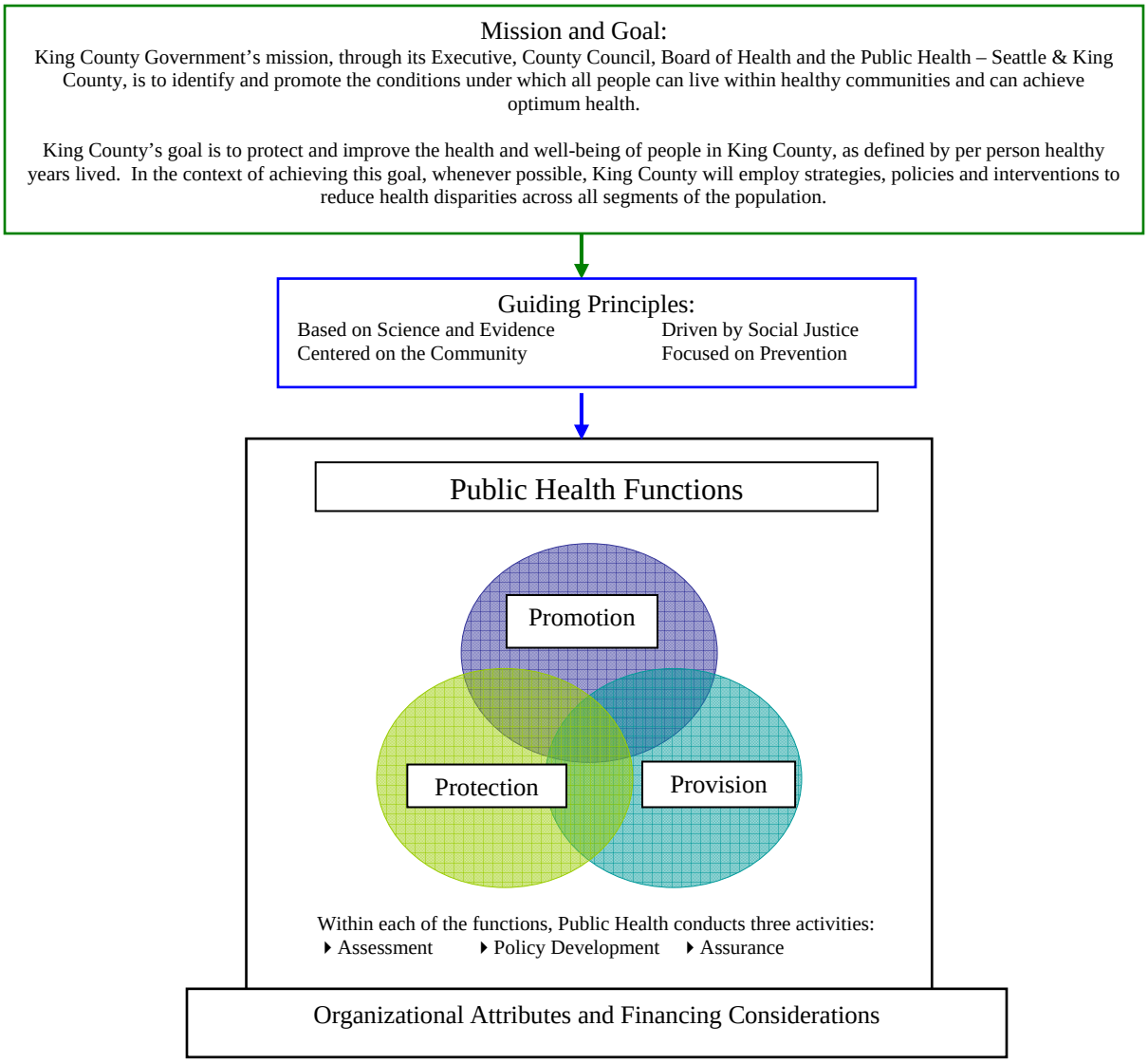
- ***Phase II: Operational and Financing Recommendations, (pages 35 - 47)***, establishes long- and short-term goals and strategies to achieve the policy direction established in the Framework.

[1] Public Health – Seattle & King County is the commonly used name for the Department of Public Health as established in King County Code.

Summary of Products

The first product from the OMP, Phase I: ***A Policy Framework for the Health of the Public – July 2007*** ("the Framework") establishes a broad set of policies, including mission and goals, to guide decision-making for public health services in King County. The Framework is summarized in Figure 1.

Figure 1: Summary of A Policy Framework for the Health of the Public



As indicated in Figure 1, the Framework affirms that the mission is for all people to "achieve optimum health", and which will be measured and defined by "per person healthy years lived".

In addition, the Framework sets forth four guiding principles that are the foundation for future decisions regarding health:

- Based on Science and Evidence
- Driven by Social Justice
- Focused on Prevention, and
- Centered on the Community

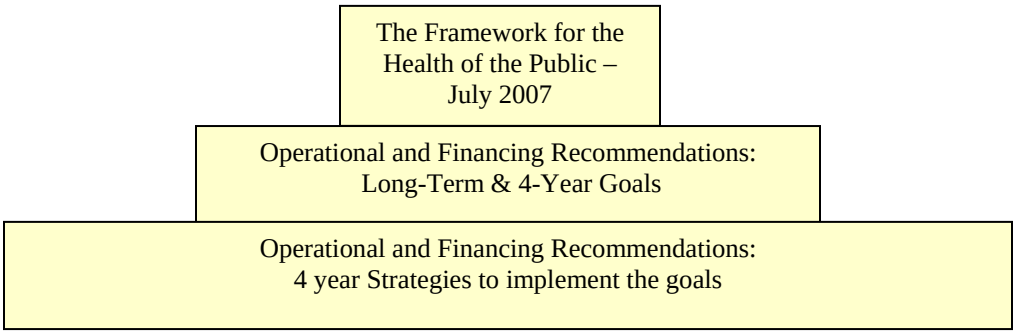
The three functions of public health – Protection, Promotion, and Provision – are unique but interrelated. For example, if King County aimed to reduce deaths and disabilities related to bicycle accidents, Public Health could support this aim through activities within each of these functions. In this example, the three-pronged strategy might include:

- Protection: Regulations mandating the use of bicycle helmets
- Promotion: Education regarding the importance of wearing bike helmets in preventing injury and death
- Provision: Treating injuries in public health centers and distributing bicycle helmets

The mission and goal for public health and the delivery of the three public health functions require both adequate, sustainable funding of strong organizational attributes such as pursuing excellence and innovation in public health practice, recruiting and retaining a talented, dedicated, well-trained and prepared workforce, and communicating clearly and accurately with our partners and the public. For more detail, please refer to the Framework itself, appearing on pages 27 - 34 of this report.

Building on the mission, guiding principles, and functions of public health developed in Phase I, the Pha se II ***Operational and Financing Recommendations*** provide long- and short-term goals and strategies for optimum health in King County. Figure 2 summarizes the Phase II recommendations and the link with the Phase I Framework.

Figure 2: PHOMP Recommendations Structure



Phase II goals and the strategies were developed after a national review of innovative practices and an internal review of Public Health – Seattle & King County. The long-term and short-term goals appear in Figure 3.

Figure 3: Overview of the Operational and Funding Recommendations Goal

	Long Term Goal (15-20 years)	**Short Term Goals (4-year)**
PROTECTION	Increase the number of healthy years lived by people in King County and eliminate health disparities through rapid identification and effective response to current and emerging diseases, environmental threats, and terrorism and other acts of intentional harm with public health consequences.	Improve the health and safety of the people of King County from the most likely and/or important threats by targeted improvements to lessen current system threat identification and response vulnerabilities.
PROMOTION	Increase the number of healthy years lived by people in King County and eliminate health disparities through developing and providing information, tools, and strategies to enable individuals and communities to identify and make healthy choices.	Develop the key elements of an effective, modern health promotion program to combat the most important underlying actual causes of preventable illness and death in King County.
PROVISION	Increase the number of healthy years lived by people in King County and eliminate health disparities through access to affordable, appropriate, and quality health care services.	Increase access to affordable, quality health care through convening and leading the development and implementation of improved community strategies to provide services.
ORGANIZATIONAL ATTRIBUTES	Increase the number of healthy years lived by people in King County and eliminate health disparities through excellence in the organizational attributes necessary to conduct the public health functions of health protection, promotion, and provision.	Raise capability to match modern public health practice needs in the organizational attribute domains of workforce quality, information for decision making, basic systems and infrastructure, and public health leadership
FINANCING	Increase the number of healthy years lived by people in King County and eliminate health disparities through sufficient, sustainable financing for the public health functions of health protection, promotion and provision.	Increase funding sufficiency and sustainability by taking key steps to increase accountability for performance, and diversification and stability of public health financing.

As noted earlier, the Guiding Principles, adopted in Phase I, are the foundational underpinnings of the work of Public Health – Seattle & King County. As such, though not explicitly stated in each goal and strategy, the four Guiding Principles of the Framework form the basis for these recommendations and the future work of public health. For more detail, please refer to the Phase II recommendations, appearing on pages 35 - 47 of this report.

INTRODUCTION

King County is establishing broad public health policy through the Public Health Operational Master Plan (PHOMP). The PHOMP was initiated to address funding challenges and increased public health needs and mandates which have and will continue to face the County for the foreseeable future. The funding challenges arise from a combination of limited or declining revenues, increasing costs of existing public health services, and increasing public health needs and mandates. In order to respond to the challenges, Public Health – Seattle & King County (PHSKC) engaged in a collaborative process with the King County Council, King County Board of Health and the King County Executive to develop the PHOMP. The PHOMP provides an effective policy framework and operational and funding strategies to protect and improve the health and well-being of all people in King County.

Background and Overview of Public Health

Public health protects and improves the health of communities. Public health accomplishes this through three functions: health protection through statutorily defined responsibilities and powers to protect the public's health; health promotion through leading efforts to promote health and prevent injuries; and provision of personal health care services for the un- and under-insured. Public health assesses health status and problems within the population, develops policy and interventions to address health problems, and assures effective interventions are delivered and evaluated. Public health interventions address the multiple determinants of our population's health – biological, behavioral, environmental, cultural, social, family and community networks, living and working conditions - in order to improve health and enhance quality of life.

There are some areas of public health that only governments can provide or have the incentive to finance. In many cases, these are areas that serve to protect the entire population and lead to significant health gains over long periods of time. Examples include:

- Coordinating preparedness for public health emergencies
- Tracking communicable diseases and responding to/containing outbreaks
- Assessing/measuring the health of the population and making these available to others
- Eliminating disparities in health among populations
- Protecting water, food, and air
- Identifying and promoting healthy behaviors or other interventions that prevent chronic disease or injury

Over the past century, these critical public health functions have led to remarkable gains in health that have dramatically increased longevity and improved quality of life. Since 1900, the average life expectancy for Americans has increased by about 30 years. Over 25 of the 30 years can be accredited to public health initiatives, while medical advances account for about five years. Some examples of public health accomplishments in the United States include:

- Safer workplaces and protections for workers have reduced the rate of fatal occupational injuries by 40% since 1980
- Smoking cessation, blood pressure control, and early detection and treatment have resulted in a 51% decrease in deaths from coronary heart disease and stroke since 1972
- Safe food and water have dramatically reduced illness and deaths and identification of essential nutrients and food fortification have almost eliminated nutritional deficiency diseases
- The fluoridation of water has reduced tooth decay and tooth loss in children and adults.
- Population-wide vaccination programs have eradicated smallpox worldwide and polio in the United States and have controlled measles, tetanus, rubella, and other diseases
- Since 1900, infant mortality has decreased 90%, and maternal mortality has decreased 99% due to better hygiene and nutrition, antibiotics, access to health care, and advances in maternal and neonatal medicine

These historical examples are provided to illustrate the tremendous benefits that accrue from a well-functioning public health system. These benefits accumulate over long periods of time and as such, it can be difficult to measure the impact of public health expenditures over shorter time horizons. Additionally, the value of public health interventions tends to be lost amid the nationwide dialogue focused on personal health care. Moreover, the delivery of public health services tends to be invisible to the public and, in many cases, taken for granted. It is not until a crisis erupts from lack of these services that the public recognizes their value.

Public Health – Seattle & King County provides a wide variety of regional public health services that protect and promote the health of all 1.8 million residents of King County, as well as the hundreds of thousands of workers and visitors who enter the County each day. In addition to providing many services directly, Public Health – Seattle & King County works collaboratively with many other entities to address health needs of people living, working and visiting in King County.

NEEDS AND MANDATES HAVE INCREASED

Over the last decade, the provision of public health services in King County has been continually challenged due to emerging health risks, the necessity for increased disease control, and other mandates. Public health needs continue to expand and diversify because of changing conditions among King County's populations, which are influenced by global, national, state, and local forces including: the epidemic of obesity which gives rise to chronic conditions like diabetes, and heart disease; emerging infectious diseases; bioterrorism; and an increasing number of people who lack health insurance.

The following are examples of the increased need for public health services:

Globalization and Demographic Changes
Because of globalization, local public health officials must be aware of health risks from all parts of the world. King County's location and economy make it a hub for international activity, bringing people and goods into the County every day. This increases the risk for transmission of

public health hazards. Additionally, the increasing diversity of the population requires that the public health and medical care systems address health issues in a growing number of cultural contexts.

Infectious Diseases, Epidemics and Pandemics
Certain conditions that were thought to have been controlled, such as tuberculosis, are reemerging. Additionally, the risk of pandemic influenza and other emerging infections is increasing, while HIV mortality has dropped precipitously and therefore more people than ever are living with HIV.

Increasing Prevalence of Chronic Diseases
Chronic diseases such as cancer, heart disease, stroke, chronic lung diseases (including asthma, emphysema and chronic bronchitis) and diabetes are the largest contributors to ill health in King County. Risk factors for chronic diseases are common and affect a growing proportion of the population.

Complex and Persistent Health Insurance Disparities
The absence of universal access to basic medical care stresses King County, its residents, and the safety net providers serving the uninsured. Within King County, wide disparities in insurance coverage exist by level of education, income, age and race.

Emergency Preparedness
Recent disasters, both local and global, have highlighted the need for emergency preparedness efforts. Emergency preparedness planning utilizes the public health system, including its ability to identify diseases; coordinate the responses of health care personnel and facilities; and distribute medicines and medical equipment.

The increasing number of federal, state and local mandates for public health services and programs pose additional challenges. At the national level, Congress and administrative bodies determine policy and mandate provision of public health services which often direct how services will be provided. These directives can impose mandates that are usually under funded or unfunded and increase the cost of provision.

In addition to federal directives, the state of Washington mandates administrative activities and provision of certain services. The legal basis for public health authority is extensive and the department operates under more than 100 references in the Revised Code of Washington (RCW) and over twenty references in the Washington Administrative Code (WAC). Public Health – Seattle & King County receives funding from the state Department of Health and other state agencies which also can impose mandates on Public Health – Seattle & King County.

At the local level, the King County Board of Health is mandated to oversee “all matters pertaining to the preservation of the life and health” of King County residents. The Board of Health has policy influence over Public Health – Seattle & King County and includes representatives from the King County Council, the Seattle City Council, suburban cites and professional members from the County. Other local mandates are given to the department by the

executive and legislative branches of the County. The City of Seattle and other local entities provide funding to the department and direct how funding will be expended.

FUNDING HAS BEEN LIMITED OR DECREASED

The 2007 Public Health Fund appropriation for Public Health – Seattle & King County (PHSKC) totals $185 million dollars. Public Health Fund expenditures are supported by significant contributions from the County's and the City of Seattle's general funds, State funds, a variety of federal sources , private foundation grants, fees and patient generated revenues. Over the past decade, Public Health – Seattle & King County has faced reductions or limitations from several of these funding sources and other revenues have remained flat resulting in expenditure cuts to cover inflationary challenges. Existing revenue sources are projected to remain limited in coming years.

Prior to 1994, cities and counties shared financial responsibility for provision of public health services. In King County, PHSKC was organized jointly between the County and the City of Seattle and received financial contributions from the suburban cities in the County. In 1993, the State legislature eliminated the cities' responsibility for funding public health. The City of Seattle continued to contribute to PHSKC financing, but the suburban cities ended their financial contributions at that time. The State legislature subsequently authorized a motor vehicle excise tax (MVET), with part of the revenue dedicated to public health services. This revenue source raised about $11 million annually for PHSKC, but replaced less than what had been contributed by the suburban cities. The County and City were unable to fulfill the remaining difference in funding loss, but did realign funding to ensure that critical services continued to be provided.

In 1999, the voters of the State passed Initiative 695, which eliminated the MVET. In the year 2000, the State legislature replaced 90% of MVET funding with State General funds. This 10% reduction resulted in loss in revenue to local health jurisdictions. This MVET "backfill" funding replacement has not increased since that time despite increased public health demands and inflation costs. In preparation for the 2007-09 biennium, the state legislature appropriated an additional $20 million dollars statewide to address specific public health needs such as prevention of communicable disease and chronic disease.

In 2000, the Seattle City Council undertook a review of public health funding and determined that the City's contributions to PHSKC were subsidizing services across the County for which the City had no mandated financial responsibility. As a result, the City gradually reduced its financial support of PHSKC from nearly $15 million in 2001 to $9.5 million in 2005. In 2007, the City has increased funding to $13 million dollars for enhanced public health services that directly benefit its residents and neighborhoods. The County, likewise suffering from its own budget problems, decreased the general fund contribution from $15.4 million in 2000 to about $12.4 million in 2004. In order to offset funding challenges, the County has increased its general fund contribution to Public Health in 2007 to over $27 million.

PHSKC also relies heavily on federal sources of revenue. Over time, federal dollars to meet new local public health needs have decreased. For example, Medicaid reimbursement rates have

remained largely flat and some funding for AIDS care and prevention has been reduced.

Factors that significantly contributed to the financial challenges faced by PHSKC and the County government include: an increased number of uninsured residents requiring services; changes in reimbursement regulations which resulted in decreased revenue; and decreased eligibility for Medicaid (a federal/state reimbursement for services).

In addition to declining or limited revenues, the cost of providing the same level of public health services increases every year. Such increases are due to the rising cost of retaining quality staff who deliver services, and double-digit increases in the cost of providing benefits to employees and higher medical and pharmaceutical costs. Moreover, the scope of public health needs in the region is also increasing with, for example, more mandates from the federal government with regard to bioterrorism preparedness and new communicable disease risks.

Process Overview of the PHOMP

Limited or declining revenues, increasing costs of providing services, and new service demands will continue to impact PHSKC well into the future. In order to respond to the challenges, King County engaged in a collaborative process with the King County Council, King County Board of Health and the King County Executive, the Public Health – Seattle & King County, the City of Seattle, suburban cities representatives and public health professionals and partners to develop the Public Health Operational Master Plan (PHOMP). The purpose of the plan is to define policies and create an operational and financing model for the provision of essential public health services in King County.

The PHOMP, conducted over a two year period, was divided into two phases. Phase I established a policy framework to guide future public health direction in King County. Phase II operationalizes this policy framework and provides long- and short-term goals and strategies to achieve the policy direction established in the Framework including funding recommendations.

From its inception, a Steering Committee, whose charter appears on page 55, provided oversight for the PHOMP process. The Steering Committee was co-chaired by the Chair of the Board of Health and the Director of the County's Office of Management and Budget. Other members serving on the Steering Committee were the Assistant County Executive, a King County Councilmember, and the Director and Health Officer of the Department of Public Health. Board of Health members representing the City of Seattle, suburban cities, and health professionals actively participated in Steering Committee meetings. The committee operated on a consensus-based model for decision making that ensured the products are reflective of the input of all participants involved in the process. King County contracted with Milne & Associates, a public health consulting firm, to provide independent expertise in preparation of the PHOMP.

The perspectives, input, and support of public health system partners and stakeholders were critical to the success of the PHOMP. Input was obtained at three specific points in the process: (1) early in the project to understand the perceptions of stakeholders; (2) towards the end of Phase I in order to gain feedback on a draft of the policy framework, and (3) near the end of

Phase II, again to gain feedback on a draft of the recommendations. Opportunities were created to obtain input throughout the process through a project website and regular briefings before the King County Board of Health and the King County Council's Law, Justice and Human Services Committee. The Office of the Director of PHSKC also sought input directly from public health partners.

FINDINGS

Phase I: Policy Framework for the Health of the Public – Findings

The first phase of the Public Health Operational Master Plan (PHOMP) established a strategic vision, or "policy framework," for the future of public health in King County. Phase I was grounded in objective research and expertise from other major metropolitan heath departments, as well as from Public Health – Seattle & King County (PHSKC), and input from partners and stakeholders. In Phase I, Milne & Associates researched and produced four papers summarizing different aspects of the public health environment in order to create a common understanding of the challenges and opportunities facing public health. The papers are attached in Appendices IX, X, XI, and XII and are:

- Role Definition: Describing the role of a public health authority in a major metropolitan region and how public health departments determine their roles.

- Health Environment: Describing the health environment in which the Public Health – Seattle & King County operates and how it is changing.

- Policy Environment: Describing the policy environment under which Public Health – Seattle & King County operates and how that environment affects what services are provided.

- Funding: Describing how Public Health – Seattle & King County and other health departments are funded and what funding streams may be at risk.

All of the papers include information that compares PHSKC to other major metropolitan health departments (MMHDs). Five MMHDs were selected for in-depth review and comparison: Alameda, CA; Columbus City; OH, Miami-Dade, FL; Nassau, NY; and Nashville-Davidson, TN. These comparable Metropolitan Health Departments (CMHD) were selected for their comparability to King County, based on a variety of criteria.

The papers were all reviewed and accepted by the PHOMP Steering Committee. The King County Board of Health and the King County Council's Law Justice & Human Services Committees also held briefings on each of the papers and provided feedback and commentary on the findings.

Several key findings informed the development of the Phase I policy framework. These findings are summarized below.

ROLE OF PUBLIC HEALTH

The focus of this paper was to describe the role of a public health authority in a major metropolitan region and how public health departments determine their roles. The paper compared the role of PHSKC against the CMHDs. Key observations and conclusions included:

> *…… there are no major gaps in functions or services provided by PHSKC when compared to the profession's definition and expectations as well as to other MMHDs. Indeed, PHSKC is perhaps one of the most comprehensive metro-size health departments in the country. This comprehensiveness appears to derive from a confluence of factors including a strong tradition of governmental public health in the PHSKC region, a dedicated and highly competent public staff, seemingly extensive mandates, along with support and expectations from stakeholders in the authorizing environment. (Role Definition Report, Appendix X, page 184)*
>
> *This situation, however, may pose challenges to PHSKC in setting strategic direction. While PHSKC, like other [major metropolitan health departments] engages in strategic planning, a traditional strategic planning process alone may not be sufficient to overcome some of the external drivers for direction setting such that PHSKC can make strategic choices and set priorities. One consequence may be a service array that outstrips available resources (Role Definition Report, Appendix X, page 184)*

HEALTH ENVIRONMENT

The focus of this paper was to describe the health environment in which PHSKC operates and how it is changing. The paper examines not only current status of the health environment but also anticipates trends relevant to the development of policy. Key observations and findings included:

- *The current health environment is tremendously precarious. There is a remarkable concurrence of health related forces globally, nationally and locally. Four aspects of the local health environment contribute to a sense of crisis: persistent health inequities, growth of chronic diseases, re-emergence of old and new infectious disease threats and an extremely fragile safety net of care for vulnerable populations. (Health Environment Report, Appendix IX, Page 143)*

- *Global, national, state and local forces are playing out within King County's health environment, including:*
    - *globalization*
    - *accelerating technological advances*
    - *huge demographic changes*
    - *widening gaps between haves and have-nots*
    - *re-emergence of the importance of infectious diseases, epidemics and pandemics*
    - *increasing prevalence of chronic diseases*
    - *complex and persistent health disparities*
    - *profound impact of social, built, and physical environment (Health Environment Report, Appendix IX, Page 143)*

- *A factor unique to the United States among modern industrialized counties is the absence of universal access to basic medical care. This fact stresses King County, its residents and the safety net providers serving the uninsured. (Health Environment Report, Appendix IX, Page 143)*

- *The OMP is an opportunity for King County and PHSKC to build on past success and face new challenges as national leaders in major metropolitan public health. (Health Environment Report, Appendix IX, Page 144)*

POLICY ENVIRONMENT

Mandates, policies, governance structure and competing interests all impact how the department operates and what services are delivered. The purpose of this paper was to describe the policy environment under which PHSKC operates and how that environment affects what services are provided. Key observations and findings included:

In comparison to the CMHD included in this analysis, PHSKC is more complex in its mandates, the mix of services provided, and its governance structure. (Policy Environment Report, Appendix XI, Page 233)

In general, PHSKC exists within a policy environment that mandates services from the Federal government (via state directives), state statutes (RCW) and regulations (WAC), and local ordinances via King County Government, the City of Seattle, the King County suburban cities, and the King County Board of Health. (Policy Environment Report, Appendix XI, Page 233)

Mandates provide considerable structure and direction for what programs and services are provided. Yet PHSKC retains a certain amount of flexibility within which they have created structures for setting programming and funding priorities. For example, the department has responded to mandates and requirements by:

- *organizing and delivering services along the framework of the ten essential public health services;*
- *using a quality management framework;*
- *focusing leadership in specific areas through strategic planning;*
- *providing measurable targets within a performance management framework. (Policy Environment Report, Appendix XI, Page 233)*

FUNDING ENVIRONMENT

The focus of this last paper describes how the PHSKC and other health departments are funded and what funding streams may be at risk. Key findings included:

- *Funding approaches for PHSKC are fairly typical of CMHD. While PHSKC has significantly higher per capita funding overall than CMHD, the department is funded in a similar fashion with many of the same sources of funding as the CMHD interviewed. (Funding Environment Report, Appendix XII, Page 295-296)*

- *Local funding for PHSKC is low. Local general fund support is higher among four of the five CMHD, both as a percent of budget and on a per capita basis. The level of local funding for PHSKC is significantly lower than that for comparable health departments. This lack limits flexibility in making decisions about what services to conduct, and limits the health department's ability to develop capacities for core responsibilities. (Funding Environment Report, Appendix XII, Page 295-296)*

- *State support of local public health is low: Total funding from the state to PHSKC in 2005 provided $16.33 per capita. When one considers all sources of funding for public health (more broadly defined and inclusive of all federal, state and local funding), a yearly survey by the United Health Foundation shows Washington State to be 44th in the nation with total per capita support of $81. ((Funding Environment Report, Appendix XII, Page 295-296)*

- *Adequate discretionary funding is essential. Most of the funding streams, and particularly federal categorical programs, available to local health departments offer limited opportunity to build capacities for services that are core to the mission of public health. Flexible funding sources are of critical importance to assuring capacities to conduct community assessments, perform communicable disease control work, and conduct population-level work designed to improve overall health status. (Funding Environment Report, Appendix XII, Page 295-296)*

- *Core capacities have been assembled creatively with categorical funding. In the absence of adequate levels of discretionary funding, virtually all health departments assemble capacities for assessment, community participation, and other core activities from creative use of categorical program funds. Those capacities are continually at risk of funding shifts among the categorical programs. (Funding Environment Report, Appendix XII, Page 295-296)*

- *Public Health Funding is not predictable. All MMHDs in the country are facing the same challenges with regard to funding. It is not possible to predict with certainty the likelihood for expansion or contraction of existing public health funding streams in the current political environment. (Funding Environment Report, Appendix XII, Page 295-296)*

- *Funding opportunities don't have equal merit. Adding more categorical programs may not really strengthen health department core capacity and may be a distraction in some instances. It can also lead to a dilution of managerial resources needed to support the department's mission. (Funding Environment Report, Appendix XII, Page 295-296)*

- *PHSKC has managed well through lean budget times. However, it is very important to understand that the nearly flat budget over the past 5 or 6 years is taking its toll. Costs increase by perhaps 5% per year while revenues at the macro level have increased less than 3% per year. It will not be possible to maintain services at current levels without new resources. (Funding Environment Report, Appendix XII, Page 295-296)*

INPUT FROM PUBLIC HEALTH PARTNERS AND STAKEHOLDERS

In addition to the research conducted by Milne & Associates, the County received input from a wide range of community health, funding, and service partners. Input from stakeholders was sought at two points during development of the Phase I policy framework: (1) early in the project to understand the perceptions of stakeholders and partners regarding PHSKC; and (2) near the end of Phase I in order to gain feedback on a draft of the Phase I policy framework.

Early in the project, Milne & Associates gathered stakeholder input during 34 meetings with over 200 participants. The input was summarized by Milne & Associates in a Stakeholder Report appearing in Appendix VIII, page 115. In general, early stakeholder perceptions in the project indicated a commitment to work together with the department to address challenges facing the community, as well as a spirit of support for improving the condition of the County's public health system.

In the fall of 2006, the second round of stakeholder input was conducted via email and the internet. The draft framework appeared on the PHOMP website for four weeks. A notice of the draft framework and request for comments was emailed out to approximately 750 public health stakeholders as well as all PHSKC employees. Recipients were invited to forward it to others who they felt might be interested. The draft framework was also made available through a link from the King County Council website, the PHSKC website, and the PHOMP website and was reviewed at the September 2006 Board of Health meeting. The survey on the PHOMP website received 581 responses. PHOMP staff carefully reviewed every response and comment. A summary of the responses can be found in Appendix V beginning on page 62. The Steering Committee integrated many of the concepts suggested by stakeholders into the restructured final policy framework that was subsequently adopted by the King County Board of Health and the King County Council. Post adoption, the King County Board of Health, the King County Council, and the Steering Committee amended the framework to expand the guiding principles to "improve cultural competency and remain flexible to changing cultural dynamics".

Phase II: Operational and Financing Recommendations – Findings

The Phase II operational and financing recommendations was informed by national research by an internal review by PHSKC, as well as research by Milne & Associates on national examples of innovative public health ideas and programs. Following is a brief overview of those findings:

INTERNAL REVIEW OF THE DEPARTMENT OF PUBLIC HEALTH

PHSKC also used the policy framework to undertake an internal review of the activities of assessment, policy development, and assurance within the three public health functions of protection, promotion, and provision. This review established the near term activities needed within the department to fulfill the policy direction adopted in the Framework. These findings are presented in summary in Figure 4 below and informed the final Phase II operational and

financing recommendations.

Figure 4: Summary Findings from Internal Review of Public Health – Seattle & King County

	PROTECTION	**PROMOTION**	**PROVISION**
Assessment	Public Health should develop/use/maintain up-to-date systems and tools which allow for timely surveillance and assessment of the factors/systems which can threaten the public's health.	Public Health should develop and use a portfolio of assessment tools, data sets and analytic methods which encompass the ability to analyze the economic, physical, behavioral, cultural, health care, and environmental factors which influences healthy choices. Routinely and accurately assess and monitor over time the health of King County.	Public Health should identify, collect, and analyze over time the information needed to assess health care access and quality of care provided for the people of King County.
Policy Development	Public Health should create and maintain the capacity for science based policy development, dissemination and implementation in the area of health care protection.	Public Health should create and maintain the capacity for science based health promotion policy development, dissemination and implementation.	Public Health should create and monitor the capacity to develop, disseminate, evaluate and/or implement evidence based policies that support accessible, high quality health care delivery.
Assurance	Public Health should create and maintain the capability to reliably assure the protection of the public from health threats using appropriate analytic, educational, regulatory, and community engagement methods.	Public Health should develop and maintain the ability to assure the successful implementation of high priority health promotions policies and/or strategies.	Public Health should develop and maintain capability to assure that all King County residents have access to appropriate, timely quality services.

NATIONAL RESEARCH

The Phase II operational and financing recommendations were based on a review by Milne & Associates of 13 major metropolitan health departments across the country. Milne & Associates based its review on the Phase I policy framework's themes of protection, promotion, and provision, organizational attributes and financing. Milne & Associates found that all departments reviewed had common challenges that are not easily resolved. Many departments face critical funding challenges, grapple to eliminate health disparities, and struggle with building strong organizational attributes. Some of the interesting and innovative ideas used to address these challenges include:

- Conducting "place based" neighborhood assessments, and the mapping of health outcomes by communities to inform policies to combat health inequities
- Establishing public health's role in community health leadership by convening and supporting formal and on-going cross-jurisdictional strategic planning
- Creating a culture of performance excellence and employee engagement through leadership training, and
- Creative uses of taxing authorities, leveraging of resources, fees, and legislative contributions in some communities have supported public health

Milne & Associates research is compiled in a report appearing in Appendix XIII, beginning on page 341.

EXPERT PANEL ON INCREASING ACCESS FOR THE UNINSURED AND UNDERINSURED IN KING COUNTY

Based on direction established in a proviso adopted in the 2007 Adopted King County Budget, the PHOMP Steering Committee appointed an expert panel to develop recommendations on how PHSKC could work collaboratively with the community to strengthen the health care safety net and improve access to heath care. The proviso, as amended in July 2007, appears on page 61 (Appendix IV) of this report.

The PHOMP Steering Committee selected 14 members for the Expert Panel who collectively brought a working knowledge of the community health care system including hospitals, specialty care, primary care, finance, system integration, knowledge of the populations being and needing to be served, public health, and private providers. The Expert Panel met four times over the course of four months to accomplish their work. The Expert Panel reviewed information and data available to analyze the un- and under-insured in King County, to identify barriers to access for care, and to develop strategies for improving access to health care for several cross-sections of the population.

The Expert Panel developed three findings and corresponding recommendations, which are summarized below:

Recommendations:

1. Establish an Ongoing Health Care Access and Capacity Assessment *(Expert Panel Report, Appendix VII, page 101)*

Expert Panel Finding: *Information on current access and health care system capacity is limited, particularly for subpopulations and sub-regions within the County. Public Health – Seattle & King County needs more complete and detailed information on the current situation and a careful analysis of projected future trends in order to make good decisions about how to more effectively improve access for uninsured and underinsured populations. Given the rapid rate of change in the health care field, this assessment process should be followed up with periodic surveys to assess the state of the health care system's "vital signs."*

Expert Panel Recommendation: *Public Health – Seattle & King County should establish an ongoing Health Care Access and Capacity Assessment process to collect critical information that will guide planning efforts to improve access to quality care for the uninsured and underinsured. During implementation of this recommendation, Public Health – Seattle & King County should collaborate with safety net partners and other providers, including community health clinics, mental health centers, drug and alcohol facilities, pharmacies, hospitals, private providers, payors, and community organizations.*

2. Develop an Access and Capacity Improvement Strategy *(Expert Panel Report, Appendix VII, page 103)*

Expert Panel Finding: *Public Health – Seattle & King County will most effectively work toward its goal of improving access and capacity by designing strategies in partnership with other community organizations that have expertise, interest, and capacity in health and human services.*

Expert Panel Recommendation: *Public Health – Seattle & King County should convene a group to work collaboratively to develop a vision for a high quality, cost effective system. The groups should establish priorities and develop strategies to improve both the capacity of the health care system and the ability of uninsured and underinsured children and adults to access that care. The group should include safety net partners and providers, including community health clinics, mental health agencies, substance abuse providers, hospitals, private providers, payer providers, and community organizations.*

3. Pursue All Promising Avenues to Increase Health Care Coverage for King County Residents *(Expert Panel Report, Appendix VII, page 104)*

Expert Panel Finding: *The Governor's Blue Ribbon Commission has put forth a set of recommendations that will, when implemented, significantly increase access to health care in King County. King County should work collaboratively with the Governor's Office and local health care organizations to achieve passage of these recommendations. However, implementation of these recommendations is at least five years away; local efforts to increase coverage should continue during the interim.*

Expert Panel Recommendation: *Public Health – Seattle & King County should join forces with local, state, and national coalitions to bring about immediate improvements in health care coverage for local children and adults.*

> In addition, Recommendation 3 noted several current and ongoing efforts that the Expert Panel chose to highlight with specific advocacy notation.

The work of the Expert Panel will be a basis for and inform the implementation of the Phase II: Operational and Financing Recommendations (pages 35 to 47). The Expert Panel's report appears in Appendix VII. A response to their report from PHSKC appears in Appendix VI, page 95.

INPUT FROM PUBLIC HEALTH PARTNERS AND STAKEHOLDERS

A four-pronged approach was conducted to obtain feedback from public health partners and stakeholders on draft Phase II recommendations. Three focus groups were comprised of national experts, the Washington State Department of Health, and Washington State Local Public Health Officials, respectively. The draft Phase II recommendations were also sent to 172 local King County public health partners for review and comment. The comments received resulted in an increased emphasis in the operational recommendations on the elimination of health disparities and the value of community partnerships.

PHOMP STEERING COMMITTEE RECOMMENDATION

Based on the findings presented, the PHOMP Steering Committee presents its findings and recommendations in two sets of recommendations, which together set the direction for Public Health – Seattle & King County for the future:

Phase I: The Framework for the Health of the Public – as amended in July 2007, **(pages 27 - 34),** establishes broad policies to prioritize and guide decision making regarding the provision of public health services in King County. The amendment from the January 2007 version reflects the vision of the Steering Committee to expand the guiding principles to "improve cultural competency and remain flexible to changing cultural dynamics"; and

Phase II: Operational and Financing Recommendations, **(pages 35 - 47),** establishes long- and short- term goals and strategies to achieve the policy direction established in the Framework.

PUBLIC HEALTH OPERATIONAL MASTER PLAN: A POLICY FRAMEWORK FOR THE HEALTH OF THE PUBLIC – AMENDED JULY 2007

I. King County's Mission & Goal for the Health of the Public

King County Government's mission, through its Executive, County Council, Board of Health and the Department of Public Health, is to identify and promote the conditions under which all people can live within healthy communities and can achieve optimum health.

King County's goal is to protect and improve the health and well-being of all people in King County, as defined by per person healthy years lived. In the context of achieving this goal, whenever possible, King County will employ strategies, policies and interventions to reduce health disparities across all segments of the population.

II. Definitions

1. Health: King County regards health as a state of physical, mental and social well-being and not merely the absence of disease or infirmity.

2. Factors Affecting Health: King County recognizes that many factors affect health. For example, health is affected by age, race, income, ethnicity, immigrant/refugee status, gender, sexual orientation, gender identity, neighborhood, level of education, health behaviors, environment, housing, accessibility of quality health care, genetics and the provision of public health services.

3. Public Health: Public health is defined as the organized efforts to (a) protect the population from natural and human-made health threats, (b) promote health by providing reliable information and an environment in which people and communities can make informed decisions that impact their health, and (c) assure the provision of quality preventative and curative health services. Public health is carried out by the public health system, which includes the governing bodies of County government, the department of public health, and the many public health partners. Public Health – Seattle & King County is the regional entity that leads, mobilizes and coordinates the broader public health system to accomplish the work of public health. Public health partners are those governmental entities, private organizations, communities, and individuals who are working with the department of public health, either formally or informally, to advance the health of the community.

4. Healthy Community: King County considers a healthy community to be a place where social infrastructure and policies support health and where essential public health services, including quality health care, are available. In a healthy community: community members and groups actively communicate and collaborate with one another to achieve healthy conditions; the contributions of ethnically, socially and economically diverse community members are valued; the broad array of determinants of health is addressed; and individuals are able to make informed, positive choices in an environment that protects and supports health.

III. Guiding Principles

King County's Public Health strategies, policies and programs shall be:

1. Based on Science and Evidence: King County's public health strategies are based whenever possible on science and evidence.

2. Focused on Prevention: King County recognizes that the best investments are those that prevent disease and promote good health. Prevention and promotion strategies achieve optimal health impact in the most cost-effective manner.

3. Centered on the Community: King County's public health solutions require collaboration of the entire community. In order to arrive at solutions which best meet the needs of all, King County's public health system must include partnerships with a wide variety of communities, government agencies and private organizations[2], improve cultural competency and remain flexible to changing cultural dynamics.

4. Driven by Social Justice: King County will proactively pursue the elimination of preventable differences in health among different population groups. Public health will be a voice for the needs of the weak, the poor, minorities and the disenfranchised.[3] Solutions will be measured by improved health outcomes for the population.

[2] King County values the partnerships with cities and unincorporated areas in order to improve the health of the entire region. King County values the role that the City of Seattle has in the delivery of public health services in Seattle and the significant financial contributions that the City of Seattle dedicates for public and community health services in Seattle. As many of the services provided by King County government can affect health, the County will engage its departments in considering the health impacts of County services and opportunities to improve health through the development of County policies, such as those embodied in the County Comprehensive Plan.

[3] Compelling evidence shows differential rates of health problems among populations based on race, income, ethnicity, immigrant/refugee status, gender, sexual orientation, gender identity, health insurance status, cognitive and physical impairments, neighborhood, and level of education. These health disparities are persistent and increasing in King County. These disparities demand priority attention and a long-term commitment to identifying and eradicating their causes.

IV. Public Health Functions

King County acknowledges that public health includes promotion of physical, behavioral, environmental, social, and economic conditions that improve health and well-being; preventing illness, disease, injury, and premature death; and creating health equity.

King County's governmental public health functions include:

1. Health Protection: King County has fundamental and statutorily defined responsibilities and powers to protect the public's health. These responsibilities include functions such as: tracking disease and other threats to the public's health; preventing and treating communicable diseases; regulating dangerous environmental and workplace exposures; and ensuring the safety of water, air, and food. Regulatory action should be taken when it is warranted and will result in significant improvements to the public's health and safety. King County must also prepare for and respond to natural and human-made disasters and plays a leadership role in engaging the community in emergency preparedness.

2. Health Promotion: King County is responsible for leading efforts to promote health and prevent injuries such as those from traffic accidents and unsafe handling of firearms, and chronic conditions such as heart disease, diabetes, and obesity. These complex health challenges often are best addressed through voluntary actions by individuals and organizations in combination with governmental policies that make the right health choice the easy health choice. Through a collaborative and educational approach, Public Health – Seattle & King County encourages voluntary actions with science-based evidence and effective interventions that maximize people's ability to make healthy choices.

3. Providing Preventative and Curative Quality Health Care Services: King County's role in personal health care services is to help assure access to high quality health care for all populations and to fulfill critical public health responsibilities such as preventing the spread of communicable diseases. Helping to assure access to quality health care includes convening and leading system-wide efforts to improve access and quality, advocating for access to quality health care for all, forming partnerships with services providers, and/or directly providing individual health services when there are important public health reasons to do so.

To fulfill its responsibilities in each of three functions listed above, the department undertakes the following types of activities:

A. Assessment: Public Health – Seattle & King County must regularly track health status, identify emerging health problems and disease outbreaks, analyze health outcomes and interventions, and report on these to the public. Through this activity, the department supports the development of effective responses by all components of the public health system.

B. Policy Development: Public Health – Seattle & King County must work in collaboration with community and government leaders to formulate evidence-based public policies designed to solve health problems.

C. Assurance: Public Health – Seattle & King County must engage policy-makers and the public in determining those services that will be guaranteed to every member of the community and ensure that these services are available through encouraging action by public and private entities, implementing regulatory requirements, ensuring communities and the public health staff are prepared to respond to public health emergencies or directly providing services.

V. Organizational Attributes of Public Health – Seattle & King County

King County intends that its department of public health shall:

- Pursue excellence and innovation in public health practice, including prudent risk-taking and applied research
- Recruit and retain a talented, dedicated, well-trained and prepared workforce
- Provide recognized leadership, both adaptive and directive
- Communicate clearly and accurately with our partners and the public
- Emphasize collaboration when so indicated
- Develop and maintain state of the art tools and systems to protect the public's health, promote healthy communities and provide reliable, high quality public health services
- Lead system-wide strategic planning and performance evaluation in order to continually improve effectiveness and to help assure that resources of the public health system are being effectively deployed to achieve priority health outcomes
- Adhere to sound operational practices and systems including assuring the transparency, cost effectiveness, and accountability of its activities, services and outcomes

VI. Prioritizing Public Health Strategies

King County will use the following criteria to guide prioritization of public health strategies, while recognizing that prioritization also requires value-based judgments across public health functions that are not directly comparable. Strategies that most fully address the set of criteria should have highest priority.

Values/Principles
- The strategy is consistent with this policy framework
- The strategy assists in achieving health equity

Evidence & Measurement
- The strategy is predicted to create a larger increase in the number of healthy years lived than other current or potential activities
- The strategy either addresses a demonstrated, measurable public health need or is a defensible precautionary effort to protect health when the risk is uncertain
- The strategy has been successful elsewhere and/or affords an opportunity to innovate with a reasonable likelihood of being successful
- The strategy maintains public health programs and interventions that are working
- The strategy has objective measures to evaluate progress

System
- The strategy utilizes and enhances the strength of the public health system, including public health partners and the community
- The strategy avoids unnecessary duplication of the work of other organizations
- The public health system has the necessary infrastructure and adequate funding has been identified to support the strategy or actions are being taken to develop the necessary resources
- The strategy uses and enhances existing systems or develops new systems where needed in order to prepare and respond to public health emergencies

Funding
- Local, flexible funding is necessary for the support of critical public health functions and key infrastructure (including planning, research, and analysis) and should also be used to leverage other funds
- Licensure programs should be supported by fees
- A funding opportunity exists to support the strategy

VII. Essential Responsibilities of the Public Health – Seattle & King County:

The essential responsibilities of the Public Health – Seattle & King County are defined by the National Association of County and City Health Departments, Operational Definition of a Functional Local Health Department.[4] The definition is a shared understanding of what people in any community, regardless of size, can expect from a department of public health.

- Understands the specific health issues confronting the community, and how physical, behavioral, environmental, social, and economic conditions affect them
- Investigates health problems and health threats
- Serves as an essential resource for local governing bodies and policymakers on up-to-date public health laws and policies
- Engages the community to address public health issues
- Coordinates the public health system's efforts in an intentional, non-competitive, and non-duplicative manner
- Ensures compliance with public health laws and ordinances, using enforcement authority when appropriate
- Addresses health disparities
- Prevents, minimizes, and contains adverse health effects from communicable diseases, disease outbreaks from unsafe food and water, chronic diseases, environmental hazards, injuries, and risky health behaviors
- Leads planning and response activities for public health emergencies
- Collaborates with other local responders and with state and federal agencies to intervene in other emergencies with public health significance (e.g., natural disasters)
- Implements health promotion programs
- Provides science-based, timely, and culturally competent health information and health alerts to the media and to the community
- Develops partnerships with public and private healthcare providers and institutions, community based organizations, and other government agencies (e.g., housing authority, criminal justice, education) engaged in services that affect health to collectively identify, alleviate, and act on the sources of public health problems
- Strategically plans its services and activities, evaluates performance and outcomes, and makes adjustments as needed to continually improve its effectiveness, enhance the community's health status, and meet the community's expectations
- Provides its expertise to others who treat or address issues of public health significance
- Employs well-trained staff members who have the necessary resources to implement best practices and evidence-based programs and interventions
- Facilitates research efforts that benefit the community
- Conducts research that contributes to the evidence base of public health

[4] National Association of County and City Health Departments, November, 2005

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PUBLIC HEALTH OPERATIONAL MASTER PLAN: OPERATIONAL AND FINANCING RECOMMENDATIONS

PROLOGUE

A focus on Health Disparities and Community Partnerships are key guiding principles as stated in "A Policy Framework for the Health of the Public – July 2007" (Policy Framework). These principles are ingrained and are the foundational underpinnings of all work of the Department of Public Health. The Policy Framework Mission and Guiding Principles guide these recommendations and are re-iterated here to serve as a reminder and a touchstone for these critical philosophies.

"King County's Mission & Goal for the Health of the Public

King County Government's mission, through its Executive, County Council, Board of Health and the Department of Public Health, is to identify and promote the conditions under which all people can live within healthy communities and can achieve optimum health.

King County's goal is to protect and improve the health and well-being of all people in King County, as defined by per person healthy years lived. In the context of achieving this goal, whenever possible, King County will employ strategies, policies and interventions to reduce health disparities across all segments of the population.

Guiding Principles

King County's Public Health strategies, policies and programs shall be:

1. Based on Science and Evidence: King County's public health strategies are based whenever possible on science and evidence.

2. Focused on Prevention: King County recognizes that the best investments are those that prevent disease and promote good health. Prevention and promotion strategies achieve optimal health impact in the most cost-effective manner.

3. Centered on the Community: King County's public health solutions require collaboration of the entire community. In order to arrive at solutions which best meet the needs of all, King County's public health system must include partnerships with a wide variety of communities, government agencies and private organizations[5], improve cultural competency, and remain flexible to changing cultural dynamics.

4. Driven by Social Justice: King County will proactively pursue the elimination of preventable differences in health among different population groups. Public health will be a voice for the needs of the weak, the poor, minorities and the disenfranchised.[6] Solutions will be measured by improved health outcomes for the population."

[5] King County values the partnerships with cities and unincorporated areas in order to improve the health of the entire region. King County values the role that the City of Seattle has in the delivery of public health services in Seattle and the significant financial contributions that the City of Seattle dedicates for public and community health services in Seattle. As many of the services provided by King County government can affect health, the County will engage its departments in considering the health impacts of County services and opportunities to improve health through the development of County policies, such as those embodied in the County Comprehensive Plan.

[6] Compelling evidence shows differential rates of health problems among populations based on race, income, ethnicity, immigrant/refugee status, gender, sexual orientation, gender identity, health insurance status, cognitive and physical impairments, neighborhood, and level of education. These health disparities are persistent and

PHASE II RECOMMENDATIONS:

King County acknowledges that public health includes promotion of physical, behavioral, environmental, social, and economic conditions that improve health and well-being; preventing illness, disease, injury, and premature death; and creating health equity. King County's governmental public health functions include Protection, Promotion, and Provision.

- Health Protection: King County has fundamental and statutorily defined responsibilities and powers to protect the public's health. These responsibilities include functions such as: tracking disease and other threats to the public's health; preventing and treating communicable diseases; regulating dangerous environmental and workplace exposures; and ensuring the safety of water, air, and food

- Health Promotion: King County is responsible for leading efforts to promote health and prevent injuries such as those from traffic accidents and unsafe handling of firearms, and chronic conditions such as heart disease, diabetes, and obesity

- Provision of Preventative and Curative Quality Health Care Services: King County's role in personal health care services is to help assure access to high quality health care for all populations and to fulfill critical public health responsibilities such as preventing the spread of communicable diseases

increasing in King County. These disparities demand priority attention and a long-term commitment to identifying and eradicating their causes.

PHOMP Phase II: Long-Term and Four-Year Goals

PROTECTION	PROMOTION	PROVISION	ORGANIZATIONAL ATTRIBUTES	FINANCING
Long-term Goal: Increase the number of healthy years lived by people in King County and eliminate health disparities through rapid identification and effective response to current and emerging diseases, environmental threats, and terrorism and other acts of intentional harm with public health consequences.	**Long-term Goal:** Increase the number of healthy years lived by people in King County and eliminate health disparities through developing and providing information, tools, and strategies to enable individuals and communities to identify and make healthy choices.	**Long-term Goal:** Increase the number of healthy years lived by people in King County and eliminate health disparities through access to affordable, appropriate, and quality health care services.	**Long-term Goal:** Increase the number of healthy years lived by people in King County and eliminate health disparities through excellence in the organizational attributes necessary to conduct the public health functions of health protection, promotion, and provision.	**Long-term Goal:** Increase the number of healthy years lived by people in King County and eliminate health disparities through sufficient, sustainable financing for the public health functions of health protection, promotion and provision.
4-year Goal: Improve the health and safety of the people of King County from the most likely and/or important threats by targeted improvements to lessen current system threat identification and response vulnerabilities.	**4-year Goal:** Develop the key elements of an effective, modern health promotion program to combat the most important underlying actual causes of preventable illness and death in King County.	**4-year Goal:** Increase access to affordable, quality health care through convening and leading the development and implementation of improved community strategies to provide services.	**4-year Goal:** Raise capability to match modern public health practice needs in the organizational attribute domains of workforce quality, information for decision making, basic systems and infrastructure, and public health leadership.	**4-year Goal:** Increase funding sufficiency and sustainability by taking key steps to increase accountability for performance, and diversification and stability of public health financing.

HEALTH Protection: Goals & Strategies

King County has fundamental, statutorily defined responsibilities and powers to protect the public's health. Examples of these responsibilities include tracking disease and other health threats; preventing and treating communicable diseases; regulating dangerous environmental and workplace exposures; ensuring the safety of water, air, and food; and preparing for and responding to natural and human-made threats and disasters. Health protection action, including regulatory activities, must be balanced against limiting personal freedoms, but should be undertaken when the results will yield significant improvements to the health and safety of individuals and the community.

Long-term Health Protection Goal: Increase the number of healthy years lived by people in King County and eliminate health disparities through rapid identification and effective response to current and emerging diseases, environmental and other threats, and terrorism and acts of intentional harm with public health consequences.

Four-year Health Protection Goal: Improve the health and safety of the people of King County from the most likely and/or important threats by targeted improvements to lessen current system threat identification and response vulnerabilities.

Four-year Health Protection Assessment Strategy:

Rapidly and accurately assess key infectious and environmental health threats and response efforts through selected enhancements in:

1. Collection and analysis of electronically transmitted data
2. Methods for measuring the health of vulnerable populations
3. Capability to monitor the health care delivery system

Four-year Health Protection Policy Development Strategy:

Identify and enact appropriate science-based health protection policies important to the health of King County residents through improved:

1. Identification of best legislative and regulatory policy options effective against important threats and acceptable to the residents of King County
2. External relations with policy makers and advocacy with external stakeholders
3. Advance identification and development of key policies necessary to mitigate health threats
4. Cross jurisdictional coordination and linkages with adjacent local, state, and federal public health policy makers

Four-year Health Protection Assurance Strategy:

Better protect the public from key infectious and environmental health threats through improved coordination of the health response system and the targeted strengthening of weak health protection system elements, including:

1. Rapid investigation and response to potential infectious and environmental health dangers, including those reported by providers or the public
2. Methods for timely and complete dissemination of information about health threats and response measures

3. Culturally competent outreach to targeted at-risk populations
4. Health care system response capacity, including reserve and surge capacity

HEALTH PROMOTION: Goals & Strategies

King County is responsible for leading efforts to promote health and prevent disability arising, for example, from injuries from traffic accidents or unsafe handling of firearms, or from chronic conditions such as heart disease, diabetes, and obesity. These complex health challenges often are best addressed through voluntary actions by individuals and communities. Through a collaborative and educational approach, Public Health – Seattle & King County encourages adoption of science-based, effective interventions that help make the right health choice the easy choice to make.

Long-term Health Promotion Goal: Increase the number of healthy years lived by people in King County and eliminate health disparities through developing and providing information, tools, and strategies to enable individuals and communities to identify and make healthy choices.

Four-year Health Promotion Goal: Develop the key elements of an effective, modern health promotion program to combat the most important underlying actual causes of preventable illness and death in King County.

Four-year Health Promotion Assessment Strategy:

Develop and maintain a small number of cross-cutting, core data sets needed to measure and understand barriers to making healthy choices and to assess and improve the effectiveness of key health promotion interventions.

Four-year Health Promotion Policy Development Strategy:

Better identify and disseminate the most important evidence-based health promotion policy and programs through:

1. Up-to-date knowledge of proven and possible effective health promotion programs and policies, including knowledge generated by local innovation and original research
2. Effective individual and community advocacy for behavior changes required for successful voluntary policy adoption
3. Linkage with appropriate policy leaders, institutions, and thought leaders in key "non-public health" health promotion policy settings (businesses, civic and religious organizations, schools, other governmental agencies)

Four-year Health Promotion Assurance Strategy:

Begin to systematically increase the likelihood that people and communities in King County will make healthy choices through targeted development of health promotion activities that:

1. Attack the most important risk factors influencing healthy years lived in King County, including tobacco, obesity, injury
2. Capitalize on 21st century techniques and modalities for education and promotion including effective communication, community empowerment and social marketing
3. Target vulnerable populations, as appropriate, with specific strategies designed to improve health equity by correcting the "market failure" of historic health promotion activities
4. Effectively engage with community leaders and institutions including schools, businesses and civic and religious organizations

HEALTH PROVISION: Goals & Strategies

King County's role in personal health care provision is to help assure access to high quality health care for all populations. Helping to assure this access includes convening and leading system-wide efforts to improve access and quality, advocating for access to quality health care for all, forming partnerships with services providers, and directly providing individual health services when there are important public health reasons to do so.

Long-term Health Provision Goal: Increase the number of healthy years lived by people in King County and eliminate health disparities through access to affordable, appropriate, and quality health care services.

Four-year Health Provision Goal: Increase access to affordable, quality health care through convening and leading the development and implementation of improved community strategies to provide services.

Four-year Health Provision Assessment Strategy:

Develop the core data sets to obtain and disseminate accurate and credible basic information regarding access to, and quality of, health care in King County.

Four-year Health Provision Policy Development Strategy:

Develop community-based policies to improve access to quality health care through:

1. Convening of the local health care payor, provider, and consumer community to create a vision and identify local strategies for more cost-effective use of health care resources and improved health care access
2. Actively engaging with core safety net providers, including community health centers, to increase collaboration and identify methods to improve planning, efficiency and integration
3. Determining, in concert with strategies 1 and 2 above, the appropriate role of PHSKC in the direct provision of health care services
4. Building the Puget Sound Health Alliance as a force for regional innovation in health care
5. Advocating across purchaser, health care provider, health plan, and governmental sectors for health care system reform

Four-year Health Provision Assurance Strategy:

Improve the quality of health care delivered by health care providers in King County through the implementation of:

1. Prioritized activities to increase the proportion of King County residents who receive recommended clinical preventive services
2. Actions derived from Policy Development above to reduce the number of King County residents with inadequate access to health care
3. Puget Sound Health Alliance and King County programs and policies to improve the quality and cost-effectiveness of employer-purchased health care

Improve the quality and cost-effectiveness of key health services delivered directly by PHSKC, including:

1. Emergency medical services
2. Medical care for inmates at the King County jails
3. Health services provided at PHSKC Health Centers and at other direct service locations (such as the tuberculosis and HIV/STD clinics), as determined by the processes described in Policy Development above

ORGANIZATIONAL ATTRIBUTES: Goals & Strategies

The regional public health system, as described in the policy framework, must contain key elements of organizational excellence to successfully execute strategies to improve the health of the public.

> ***Excerpt from the Adopted Policy Framework for the Health of the Public- January 2007:***
>
> **"V. Organizational Attributes of Public Health – Seattle & King County**
> King County intends that its department of public health shall:
>
> - *Pursue excellence and innovation in public health practice, including prudent risk-taking and applied research*
> - *Recruit and retain a talented, dedicated, well-trained and prepared workforce*
> - *Provide recognized leadership, both adaptive and directive*
> - *Communicate clearly and accurately with our partners and the public*
> - *Emphasize collaboration when so indicated*
> - *Develop and maintain state of the art tools and systems to protect the public's health, promote healthy communities and provide reliable, high quality public health services*
> - *Lead system-wide strategic planning and performance evaluation in order to continually improve effectiveness and to help assure that resources of the public health system are being effectively deployed to achieve priority health outcomes*
> - *Adhere to sound operational practices and systems including assuring the transparency, cost effectiveness, and accountability of its activities, services and outcomes."*

Long term organizational attributes goal: Increase the number of healthy years lived by people in King County and eliminate health disparities through excellence in the organizational attributes necessary to conduct the public health functions of health protection, promotion, and provision.

Four-year organizational attributes goal: Raise capability to match modern public health practice needs in the organizational attribute domains of workforce quality, information for decision making, basic systems and infrastructure, and public health leadership.

Four-year strategy to improve Workforce Quality:

Improve workforce capability and skills to competently perform the public health activities of assessment, policy development and assurance by developing:

1. Policies and methods to broadly recruit promising talent
2. Systems to assess staff performance, provide key training, and identify, reward, and retain high performing employees
3. Sufficient departmental capacity in policy development, advocacy and external relations and to assure scientific excellence in public health practice

Four-year strategy to improve Information for Decision-Making:

Rapidly collect, accurately analyze, and effectively use public health information by building key organizational capabilities, including:

1. Strong connections between data collection and program delivery, so that information collected is both needed and used
2. Cross-cutting capability to identify and implement efficiencies and synergies for systems to collect the key information priorities identified in this plan, including health care access, emergency response performance, infectious and environmental health threats, and the effectiveness of key health promotion strategies
3. Excellence in translating data to information that is useful to policy makers and the public, and skills to clearly and proactively communicate this information so that it is used

Four-year strategy to improve Basic Systems and Infrastructure:

Improve capability of Public Health to fulfill its functions through selective enhancement of key system elements including:

1. Modernizing key business tools and administrative systems to improve business efficiency
2. Based upon assessment of public health needs, strengthen the connection with community through (a) increasing public health staff's involvement in community activities and coalitions, and (b) increasing venues for community-based public health activities, including through increased use of the Public Health Centers and other community sites
3. Building the foundation of an academic health department by strengthening the links and connections with appropriate schools of study at the University of Washington and other institutions

Four-year strategy to improve Public Health Leadership:

Develop necessary leadership and leadership competencies at all levels of the organization by:

1. Providing training, on-the-job opportunities, and mentorship for development of leadership skills in key staff
2. Creating, from the top, a culture that expects performance and accountability, fosters leadership, and rewards collaboration and creativity;
3. Empowering and encouraging front-line decision making, innovation, entrepreneurship and prudent risk-taking
4. Actively seeking opportunities to increase the presence and credibility of public health leadership in the County and city governments

FINANCING: Goals & Strategies

As a state, Washington ranks 44th in per capita funding for public health.[7] In 2007, local funding from the County general fund comprised 15%[8] (or $14.88 per capita[9]) of Public Health – Seattle & King County's public health fund appropriation. The remaining funding was provided through federal, state, city, and grants, much of which is restricted in use for specific programs. Flexible funding sources are of critical importance to assuring capabilities to conduct community assessments, perform communicable disease control work, and conduct population-level work designed to improve overall health status.[10] Our regional public health system, as described in the policy framework, requires sustainable, predictable, flexible, and adequate funding.

Long-term Financing Goal: Increase the number of healthy years lived by people in King County and eliminate health disparities through sufficient, sustainable financing for the public health functions of health protection, promotion and provision.

Four-year Financing Goal: Increase funding sufficiency and sustainability by taking key steps to increase accountability for performance, and diversification and stability of public health financing.

Four-year strategy to increase Accountability for Performance:

Increase the confidence of policy makers and taxpayers in the return on investments in public health by:

1. Routinely developing and articulating program logic models and business plans with timelines and deliverables
2. Adhering to the prioritization principles listed in Phase 1 of this OMP, including projected impact and cost-effectiveness of activities
3. Developing and reporting on key performance measures and accountabilities
4. Improving operational efficiencies and effectiveness through streamlining, standardization, and continuous quality improvement of business and program functioning

Four-year strategy to increase Financing Diversification:

Assure overall public health functioning by expanding and diversifying the sources of funding through:

1. Improving our capabilities in competitive grant development and grant execution for programs that are consistent with the mission, goals, and principles adopted in the Policy Framework
2. Advocating for increased categorical federal public health funding for local jurisdictions

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[7] Data from Milne & Associates Funding Issue Paper; June 7, 2006. page 3

[8] General Fund contribution to the Public Health Fund as a percent of the Total Public Health Fund – does NOT include Jail Health or EMS; Total 2007 budget GF contribution to Public Health: $27,323,026 Total Public Health Fund: $184,750,710; Total GF for King County as a whole: $649,681,224;

[9] see Foot note 4 for general fund contribution; Total population assumption: 1,835,300.

[10] Milne & Associates, Funding and Budget Policy Findings, Page 1.

3. Advocating for increased state public health funding, both categorical and flexible, for local jurisdictions
4. Working with city governments within King County to identify appropriate city investments and efforts to improve the health of their residents and communities
5. Developing selected public-private partnerships to leverage private sector resources
6. Strategically using County resources to build capacity to compete for and leverage other resources

Four-year strategy to increase Financing Stability: Protect core public health functioning by minimizing reliance on volatile funding sources, increasing non-categorical funding sources, and creating long-term, stable and predictable funding alternatives including:

1. Developing options for a dedicated source of local financing for public health, (such as a levy lid lift, dedicated, utility tax, dedicated sales tax for public health or other financing authority)
2. Assessing the feasibility of public/private financing mechanisms such as a 501(c)3 public health foundation or a public development authority
3. Advocating for the stable and predictable local resources needed for public health to meet its responsibilities
4. Advocating for local, state and national health care financing reforms

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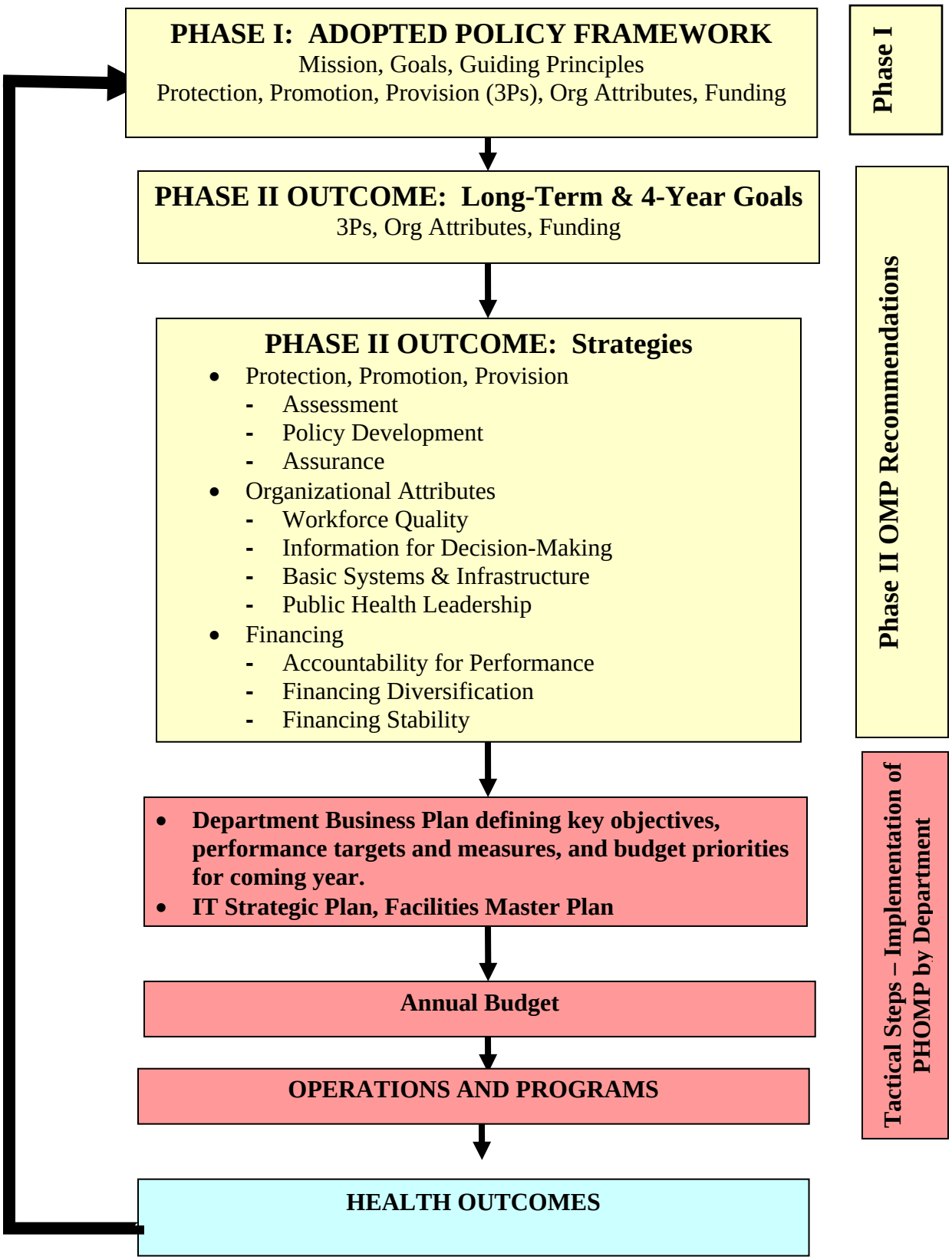
CONCLUSION AND NEXT STEPS

With the completion of the Public Health Operational Master Plan (PHOMP), Public Health – Seattle & King County (PHSKC) has a solid vision and foundation for the future of public health in King County. The PHOMP provides a mission for the health of King County, four guiding principles on which to base future policies and strategies, a set of long term and four year goals, as well as a set of four year strategies to accomplish those goals.

The PHOMP is not a static document with a fixed number of strategies that, once implemented, lead to the highest level of efficiency and effectiveness. As circumstances change and new ideas are raised this plan should continually evolve. PHSKC will evaluate and update the four year goals and strategies and continue progress toward accomplishing the mission to identify and promote the conditions under which all people can live within health communities and can achieve optimum health in King County.

Figure 5 on page 46, illustrates how the PHOMP will be implemented by Public Health – Seattle & King County. The Framework established the vision for public health. Phase II established long- and short-term goals and strategies that will move King County toward achieving optimum health for all residents. The department will implement those strategies through the existing County processes including the annual department business plan and budgets. This will ensure that the strategies are integrated into the daily operations and programs in the health department.

Figure 5: PHOMP Recommendations and Next Steps



APPENDICIES

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I. PHOMP Initiating Proviso: Excerpt from King County Ordinance 15083

Sections 14 (Office of Management and Budget) and 79 (Public Health):

By March 31, 2005, the office of management and budget, in collaboration with Public Health – Seattle & King County and staff of the council and the board of health, shall submit to the board of health and the council for their review and approval, a detailed work plan for an operational master plan for public health. The operational master plan shall have two phases. Phase I of the operational master plan shall provide a policy framework for meeting the county's public health responsibilities. It shall include a review of public health mandates, needs, policies and goals and recommend the adoption of comprehensive public health policies to guide future budgetary and operational strategies developed in phase II of the operational master plan. Phase II shall: (1) review the department of public health's functions and operations; (2) evaluate service delivery alternatives for meeting the public health needs of the community as effectively and efficiently as possible; and (3) develop recommended implementation and funding strategies. Phase I of the operational master plan shall be reviewed and approved by the board of health by resolution and the county council by motion. Phase II of the operational master plan shall be reviewed and approved by the council by motion with input from the board of health. The work plan for the public health operational master plan shall include a scope of work, tasks, schedule, milestones and the budget and selection criteria for expert consultant assistance. In addition, the work plan shall also include proposals for: (1) an oversight group to guide development of the plan that shall include executive, council and board of health representation; (2) a coordinated staff group to support plan development; and (3) methods for involving funding and service provision partners and other experts in public health in the development of the operational master plan. The work plan for the public health operational master plan must be filed in the form of 16 copies with the clerk of the council, who will retain the original and will forward copies to each council member, to the chair of the board of health and to the lead staff of the law, justice and human services committee or its successor.

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II: PHOMP Steering Committee Membership and Charter

(Based on KCC Motion 12122)

Members:
Co-Chair: Honorable Julia Patterson, Chair of the King County Board of Health (effective January 2007) replaced the Honorable Carolyn Edmonds, Chair of the King County Board of Health (from 2005 to 2007)
Co-Chair: Bob Cowan, Director of Management and Budget, Executive Office
Honorable Jane Hague, Council Member, King County Council
Sheryl Whitney, Assistant County Executive, Executive Office
Dr. David Fleming, Director and Health Officer, Public Health – Seattle & King County (February 2007) replaced Dorothy Teeter, Interim Director, Public Health – Seattle & King County (from 2005 to January 2007)

Active and Valued Contributors:
Honorable Sally Clark, Councilmember, City of Seattle
Honorable Dave Hutchinson, Mayor, City of Lake Forest Park
Dr. George Counts, Professional Medical Member, King County Board of Health

Primary Staff:
Toni Rezab, Project Manager, Office of Management and Budget
Kathy Uhlorn, Public Health – Seattle & King County and King County Board of Health Staff
Carrie S. Cihak, King County Council Central Staff
Jerry DeGrieck, City of Seattle

Steering Committee Purpose:
- Provide guidance to the consultant and the staff team and hold them accountable for completion of the OMP
- Communicate and disseminate information from the process to stakeholders and others, as appropriate
- Make recommendations, as appropriate, to other entities (e.g. government bodies or agencies)

Steering Committee Process:
- Utilize the expertise of an independent consultant
- Receive input and expertise from stakeholders
- Identify data and information needed for analysis by the consultant and others
- Provide a forum for the open discussion and review of analysis

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III. Scope of Work as adopted by King County Motion 12122

PUBLIC HEALTH OPERATION MASTER PLANNING – APRIL 2005
ORDINANCE 15083 – PROVISO RESPONSE

In response to Ordinance 15083 Provisos 14-P3 and 79-P1, this submittal presents the workplan for a public health operational master plan.

Proviso Directive

In Ordinance 15083 adopting the 2005 Annual Budget for King County, the King County Council adopted two companion provisos -- one for the Office of Management and Budget and one for the Seattle-King County Department of Public Health ("the Department") -- that require the submittal of a workplan for a public health operational master plan. The provisos require that the workplan be developed in collaboration with the Department, the Office of Management and Budget, the Board of Health, and the King County Council by March 31, 2005. The workplan is to include a scope of work, timeline, budget, criteria for selection of expert consultants, and proposals for oversight, staffing and involvement of our community partners. The text of the proviso is included as Attachment 1.

On March 30, the Executive requested by letter to the Council an extension of the March 31 submittal date to April 15, 2005.

Motivation for a Public Health Operational Master Plan

The objective of the public health operational master plan is to develop a sustainable operational and financing model for the provision of public health services to the citizens of King County. Over the last decade, the provision of public health services in King County has been continually challenged due to increasing disease control and other mandates; while at the same time available funding has been limited or is decreasing. Increased need and limits on funding are expected to continue in the future. The significant reduction in funding at the state, local and federal levels for public health interventions has eroded the department's resources required to address ongoing problems such as HIV/AIDS, chronic diseases, and immunizations. In recent years, federal and state mandates have focused on the emerging issues of bioterrorism, emergency preparedness post 9-11, and communicable diseases (SARS, pandemic influenza, and West Nile Virus) providing insufficient funding for new problems and reductions in support for ongoing disease control, prevention, assessment, and evaluation. Adding to the problems created by changing needs and limited and variable revenues, the cost of providing the same level of services increases each year.

Without further examination and change in funding and operations, the current trend will force decreased levels of public health protection for King County. An operational master plan will assist the Department in addressing past and future challenges strategically and rationally.

Scope of Work for a Public Health Operational Master Plan (PHOMP)

The PHOMP will be a two-year planning effort conducted in two phases. Phase I will establish broad policies on the provision of public health services in King County. Phase II will result in recommendations regarding operational implementation and funding.

The outcomes of Phase I and Phase II shall reflect the flexibility needed to accommodate dynamic and changing community health conditions and emerging health issues. Moreover, the work product shall be presented in language and concepts that can readily be understood by those not in the public health field in order to provide uniform understanding. Work on the PHOMP will use as a starting point existing work and products developed by the Department. Review of this existing work will help to educate non-Department staff working on the PHOMP and will form a basis for developing outcomes in Phase I and Phase II.

The scope of work for the PHOMP will not include operations of Jail Health, which has undergone a review through the Jail Health Services Strategic Business Plan process from which recommendations are currently being implemented, and Emergency Medical Services, which annually updates its EMS Strategic Plan in partnership with the participating cities and fire districts in King County.

Phase I

The outcome of Phase I will be the establishment of a broad policy framework to prioritize and guide decision making regarding the provision of public health services in King County. The framework will include:

(1) The mission and goals for the County's provision of public health services
(2) The roles and responsibilities of the Department, including a set of needed and evidence-based public health services and functions
(3) Policy guidelines addressing practices such as performance measurement, evaluation, budget and financial accountability
(4) Policy guidelines regarding funding

The framework will be developed through:

(1) Reviewing the current vision, mission, goals, priorities, and existing policies and work of the Department such as the *2003 Proviso Report Public Health – Seattle & King County Public Health Priorities and Funding Policies*
(2) Reviewing national and state standards, mandates and frameworks for evaluating public health services
(3) Understanding the role of a major metropolitan health department in a regional government, including functions, mandates, environment, and funding
(4) Establishing a comparison, among major metropolitan health departments serving regions of similar size and complexity to King County, of public health functions and services, best practices, and methods to analyze and report on the health status of the community
(5) Conducting a baseline assessment of health in the County against which progress can be measured and forecasting the region's future public health needs
(6) Understanding the Department's current services, programs, budgets, expenditures, and revenues;
(7) Forecasting major revenue sources and understanding what services are most at risk of reduced funding
(8) Soliciting input from stakeholders and monitoring changes in their systems that have prospective potential impacts on the Department

The framework resulting from Phase I is to be adopted by the both the Board of Health and the King County Council. The framework will provide a basis for the work in Phase II. Phase I is anticipated to be ready for presentation to the Board of Health and the King County Council by March 2006.

Phase II

The outcome of Phase II will be recommendations regarding operational implementation and funding that are consistent with the Phase I framework. These recommendations will include:

(1) Options regarding service level and delivery of regional public health services

(2) Options for improving the efficiency and effectiveness of the delivery of regional public health services and functions such as performance measurement and evaluation, organizational structure, contracting and budgetary and financial accountability
(3) Options for stable funding for public health services

These recommendations will build on the work in Phase I and be developed through:
(1) Identifying gaps in services or duplication of effort
(2) Evaluating and comparing operations of major metropolitan health departments, including public health services provided, organizational structure, and functions such as performance measurement and evaluation, contracting and budgetary and financial accountability
(3) Identifying linkages with other service providers or County functions and evaluating possibilities for collaboration and alternative means of providing services
(4) Identifying services that support the effectiveness of other County functions
(5) Evaluating and comparing the funding of major metropolitan health departments
(6) Soliciting input from stakeholders and monitoring changes in their systems that have prospective potential impact on the Department
(7) Analyzing the impacts of and estimating the revenues generated by alternative funding mechanisms

Phase II will follow and build on Phase I, with completion in March 2007. The King County Council will approve the recommendations resulting from Phase II, with input from the Board of Health.

Budget, Staffing and Oversight

The King County Council adopted in Ordinance 15083, $320,000 to support the work of the PHOMP. Of this amount, $250,000 will be used to hire a consultant to assist in completing the scope of work and the remainder supports a Senior Policy Analyst position in the Office of Management and Budget who will act as the project manager. The King County Council has dedicated at least a half-time position to staffing this effort, the King County Board of Health has dedicated a staff person, and the Department has dedicated a project manager. The Office of the Director of Public Health and the Public Health Leadership Group also actively support the project.

A steering committee will guide the project and will be comprised of five members: the Chair of the Board of Health, a member from the King County Council, Director of the Office of Management and Budget, a representative from the King County Office of the Executive, and the Director of the Department. The Director of the Office of Management and Budget and the Chair of the Board of Health will co-chair the steering committee.

The Office of Management and Budget will provide project management and contract authority, working closely and collaboratively with staff from the Department and the King County Council.

In addition to the oversight committee, a coordinated staff group will be established to complete the project. It will include, at a minimum, the project manager from the Office of Management and Budget, the project manager from the Department, representatives from the Department's leadership group, King County Council central staff, and King County Board of Health staff. As the project moves forward, additional staff will participate as needed including, for example, department programmatic staff, state board of heath staff, representatives of service providers and other service partners, and staff with financial expertise.

Selection Criteria For Consultant

The PHOMP will utilize the independent expertise of a national consultant(s). It is feasible that more than one consultant will be employed depending on the expertise needed and available. The consultant(s) chosen for this project must, at a minimum, have:

- Experience related to major metropolitan health department leadership, including national exposure to more than one system, in order to draw on that experience when issues and questions of operational practices, funding strategies, and comparisons to other major metropolitan health departments arise
- Experience translating the purpose, paradigms, work, issues and opportunities of major metropolitan health departments from public health based terminology into language and concepts readily understood by non-public health professionals in order to provide uniform understanding of the role and responsibilities of the Department
- Experience defining the role and responsibilities of public health in metropolitan areas and developing a consensus framework to prioritize and provide a method for decision making for elected officials and other policy makers in light of the flexibility needed to accommodate dynamic and changing community health conditions and emerging health issues
- Experience developing innovative recommendations for funding and operational strategies in order to assist the Department to continue to face future challenges

The PHOMP steering committee will approve a selection process for choosing a consultant. The Chair of the Board of Health, the Director of the Department, and the Director of the Office of Management and Budget shall approve the final selection of the consultant(s).

Methods For Involving Funding And Service Partners

In accordance with the proviso directive, the public health operational master plan will include input from a wide range of community health, funding, and service partners. The consultant will be asked to propose specific methods for soliciting stakeholder input, including:

- A structured process for engaging the expertise of entities such as:
    - The Centers for Disease Control and Prevention
    - The Centers for Medicare and Medicaid Services
    - The Washington State Department of Public Health
    - The Washington State Department of Ecology
    - The City of Seattle
    - The University of Washington School of Public Health
    - Others as identified

- A structured process for involvement of stakeholders such as:
    - Cities within King County
    - Clients
    - Federal agencies such as the Health Resources and Services Administration, the Environmental Protection Agency, National Institutes of Health, and other relevant regulatory agencies
    - Relevant state and local elected officials
    - King County Community Based Organizations (CBOs)/Community Clinics
    - King County Hospitals/Health Care Organizations
    - Private Funders
    - Area schools of medicine, public health, nursing, pharmacy, social work, public policy and urban planning

IV: Provision Proviso: Excerpt from King County Ordinance 15652, as amended by King County Ordinance 15873 on July 23, 2008

Sections 3 (Office of Management and Budget) and 30 (Public Health):

Provided that:

(1) By September 1, 2007, the executive will submit to the council for review and approval by ordinance and to the board of health for review operational and financing recommendations developed through Phase II of the Public Health Operational Master Plan ("PHOMP"), as required by Motion 12122. The recommendations shall include a process for working collaboratively with the community on strengthening the community health safety net. The council finds that the current model for delivery of clinical services provided by Public Health – Seattle & King County is not financially sustainable and that there are opportunities to achieve better health outcomes by coordinating with the community health care safety net to produce a more effective system of care for the increasing number of uninsured and underinsured individuals in King County.

(2) The collaborative process will result in recommendations to strengthen the community health care safety net, including recommendations regarding: (a) a vision for provision of health care to the un-and under-insured in King County; (b) improvements in access to health care for the uninsured and underinsured, the working poor, the mentally ill, and others facing barriers in receiving care; (c) the role of the department in the direct provision of health care services, and (d) options for timely and smooth transition for any changes in service delivery in order to ensure that those currently being served can continue to receive care.

(3) The PHOMP recommendations for this collaborative process will include: (a) the scope of work identified in subsection (2) (a) through (d) of this proviso, including factors that contribute to barriers to access to care; (b) the role of Public Health – Seattle & King County as a convener; (c) the community sectors and partners who should be involved and a timeline for transmittal of appointment motions to the council; and (d) an estimated timeline for completion.

(4) These recommendations for this collaborative process shall be developed as part of Phase II of the PHOMP under the guidance of the PHOMP steering committee. The PHOMP steering committee shall develop the recommendations for the collaborative process in consultation with an expert panel familiar with King County's community health care safety net. The members of the panel shall be selected by the PHOMP steering committee. The panel shall work in conjunction with the PHOMP consultants and staff team in developing options for review by the PHOMP steering committee.

(5) Any report, plan and proposed ordinance required to be submitted by this proviso must be filed in the form of 12 copies with the clerk of the council, who will retain the original and will forward copies to each councilmember and to the lead staff of the board of health and the law, justice and human services committee, or their successors.

V: Web-Survey Stakeholder Summary – Phase I Early Draft Framework

The second round of stakeholder input was conducted via email and the internet. The draft framework appeared on the PHOMP website for four weeks. A notice of the draft framework and request for comments was emailed out to approximately 750 public health stakeholders as well as all Department employees. Recipients were invited to forward it to others who they felt might be interested. The draft framework was also made available through a link from the King County Council website, the PHSKC website, and the PHOMP website and was reviewed at the September BOH meeting. The survey on the PHOMP website received 581 responses.

Eight Questions were asked:

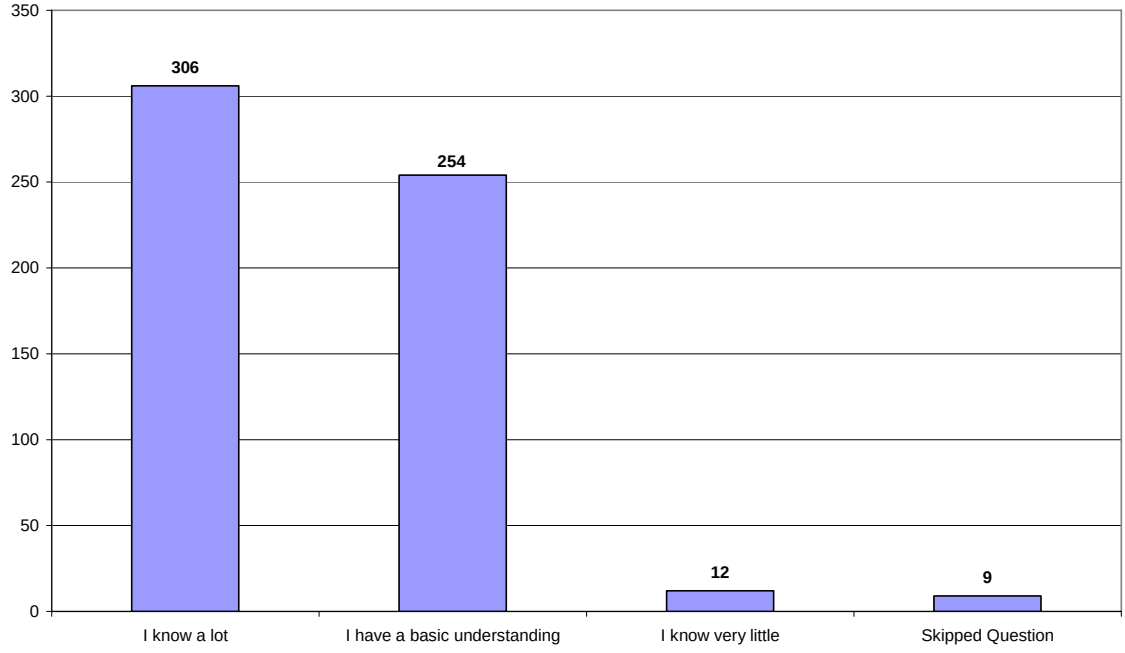
1. How would you characterize your knowledge of public health and public health issues?
2. What are the top five issues facing public health? (Drop down box provided)
3. If question #2 did include one or more of your top five issues facing public health, please write those that were missing here; otherwise move to question #4. Thank you.
4. The draft polices contain guiding principles for King County government. Please indicate if you agree, disagree, are neutral or have no opinion.
5. Please provide us with any additional comments/thoughts regarding the guiding principles. At a minimum, for those guiding principles that are checked with "disagree", please indicate why you disagree and suggest changes that would make the statement acceptable.
6. The draft polices contain factors for prioritizing public health investments for King County government. Please indicate if you agree, disagree, are neutral or have no opinion.
7. Please provide us with any additional comments/thoughts regarding the factors to prioritize. At a minimum, for those guiding principles that are checked with "disagree", please indicate why you disagree and suggest changes that would make the statement acceptable.
8. Consider the framework as a whole, is there anything you would like to add or change?

This survey was not statistically valid as it was targeted to a specific public health population (750+ partners) and all public health employees.

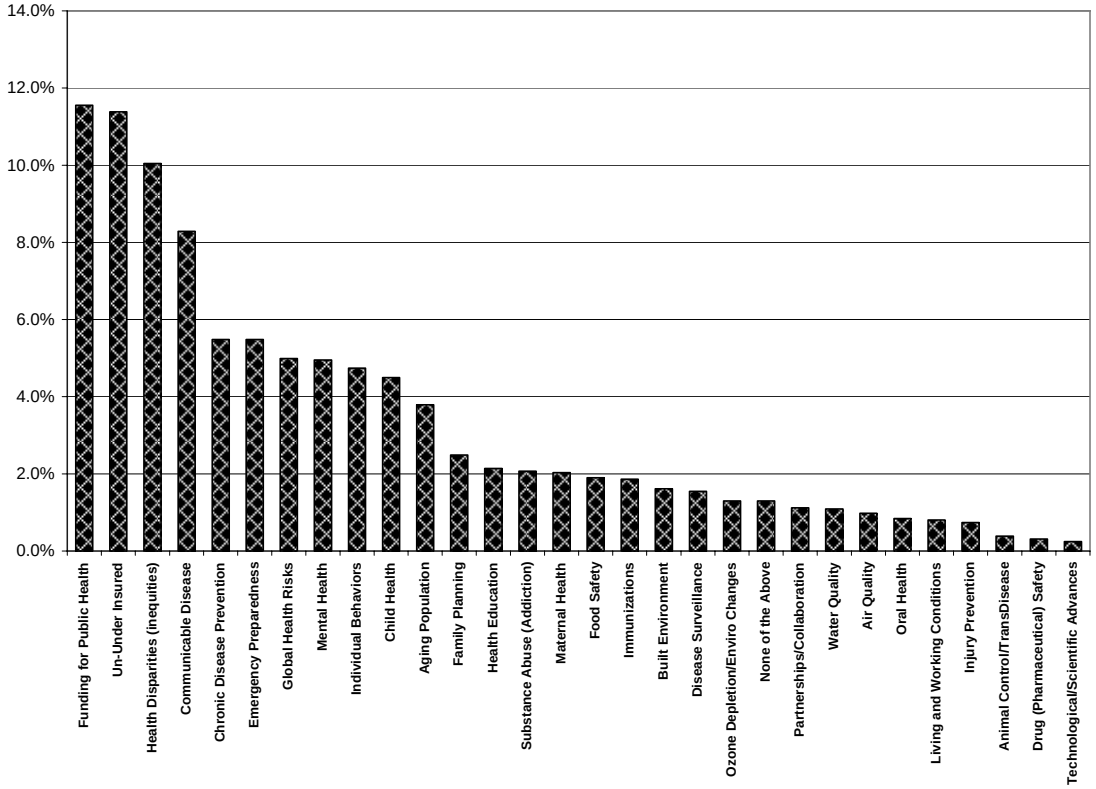
As a note, since the vast majority of respondents supported the guiding principles, the comments reflected in this document, are to point out the differing or disagreeing viewpoints. Comments are as written with the exception for correction for spelling.

A summary of the responses are found in this appendix. The Steering Committee integrated many of the concepts suggested by stakeholders into the restructured final policy framework that was subsequently adopted by the King County Board of Health and the King County Council.

Q1: How would you characterize your knowledge of public health and public health issues?
Respondents = 581



Q2: What are the top five issues facing public health? Respondents = 579; (Skipped = 2)



Q3: If question #2 did not include one or more of your top five issues facing public health, please write those that were missing here; otherwise move to question #4. Thank You.

Total Respondents: 147
Skipped the Question: 434
Total Survey Responses: 581

The 147 respondents generated a total of 287 priority issues that are either duplicative of issues noted in the drop down menu in question #2 or are issues not noted in question #2.

Examples of issues noted that were not available in the drop down menu were (this list is not inclusive or exhaustive; it is merely here to provide a sampling of issues for early information):

- Building healthy communities -social capital, norm building, institutional support
- Climate Change
- Addressing POVERTY as separate issue from RACE/gender etc.
- Aging without economic resources
- better framing of public health issues to broaden support for PH
- Global Warming
- Growing Hispanic Population needs
- Importance of early nurturing in infant brain and social/emotional development
- Poor public transportation
- Poverty and the ability to be working and poor
- science education - make better decisions

Question 5: Please provide us any additional comments/thoughts regarding the guiding principles. At a minimum, for those guiding principles that are checked with "disagree"; please indicate why you disagree and suggest changes that would make the statement acceptable.

166 respondents provided feedback on one or more of the guiding principles.
415 respondents skipped this question.
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581 Total respondents to the survey

Many comments received on this question did not specifically address a guiding principle, but were generic in structure or provided overall comments.

There were:

- *3 comments on the guiding principles.*
  - *Redundancy within the guiding principles*

> "I disagree with the statements on excellence, preparedness, and measurement. While I agree that these principles are important, I don't believe that they should guide the future of public health. When there are people who are dying of treatable diseases because they lack access to a health care system, it doesn't matter how excellent the public health system is or how prepared we are for a disaster that may or may not happen or how these people will figure into our statistics. I think that

when public health is truly guided by the issue of equity and sustainability, these other principles will follow."

"Some policies also appear to be reiterations of other policies. These policies might be eliminated or merged with other policies. For instance, 'Pursue Excellence and Innovation' could probably be achieved through the policy to 'Measure Community Health'. 'Engage all County Departments' is covered through 'Form Partnerships'. 'Assure Access to Health Care' is covered through 'Create Equity in Health', or visa versa. 'Assure Sustainable Infrastructure' is essentially covered through the accomplishment of the other principles. For these reasons, policies that might be deleted were marked as neutral because they are not disagreeable as much as redundant with other policies."

- *17 comments referring for a need for greater funding (examples given):*

"Seek additional sources of funding. All of these guiding principles depend on adequate funding of Public Health."

"I think you have outlined goals which cover the highest needs. I think your funding challenges undermine every goal you are trying to achieve. The work the SKCDPH has done in the past has been exemplary - I expect you will figure out how to continue - even with resource limitations."

- *39 comments provided general public health comment or comments that would be helpful in setting priorities in Phase II of the OMP*.

CREATE EQUITY IN HEALTH

Guideline as written for stakeholder input:

Create Equity in Health: It is a pre-eminent goal of King County to eliminate preventable differences in health among different population groups. Compelling evidence shows higher rates of health problems based on race, income, ethnicity, immigrant/refugee status, gender, sexual orientation, gender identity, health insurance status, neighborhood, and level of education when compared to the rest of the county. These health disparities have been persistent and have been increasing in King County.[11] The problems identified by these data demand priority attention and a long-term commitment to creating and sustaining systems that support health for all.

Staff Summary of responses providing a differing or disagree perspective:

- *4 comments reflected concern with the words "pre-eminent".*

"Creating Equity in Health - I'd agree with this principle if the word 'pre-eminent' were removed. I'm concerned that this may limit prioritization of big gain opportunities over the goal of a consistent median point."

- *1 comment suggested adding "cognitive and physical impairments".*

"In your definition of health disparities and those at risk for not receiving good healthcare, I would include persons with cognitive and physical impairments."

- *Commenters reflected the need to not reduce everyone to a lower health status, but to raise all to optimum health.*

"Creating Equity in Health -- reduce or eliminate health inequalities by raising up those groups experiencing poorer health to the same or higher health status than the groups experiencing the best health. Not that everyone would achieve some 'middle.'"

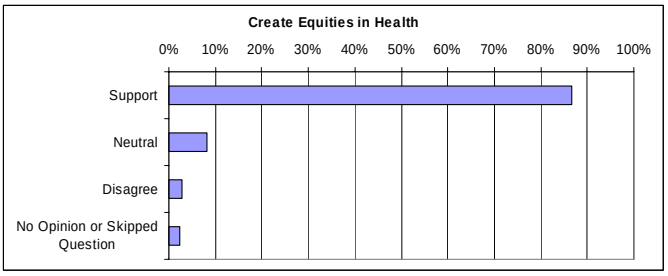
- *Commenters reflected a message that solving health inequities is overwhelming.*

"Create equity in health - Equity in health is too ambiguous. The definition will be forever expanding and never obtained while the cost will skyrocket. Equity in Basic Health, with a firm definition of what that entails would be a more obtainable goal. Assure access to health care - Same issue as Equity, a decision needs to be made, which maybe a tough decision, as to what are the Basic Health Needs that should have universal access, not total access left open to interest group manipulation over time. The dollars required will end up defeating the entire system."

"I don't believe King County or Public Health can successfully take on the responsibility for ensuring universal access or zero health disparities. It will distract too much from other work where the County can have more impact I think considering the health consequences of all services is theoretically a nice idea, but impractical."

[11] The Health of King County, 2006 (*http://www.metrokc.gov/HEALTH/hokc/ppt/index.htm*)

Survey Data from Question 4: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)



Support: 87% (503)
Neutral: 8% (48)
Disagree: 3% (16)
No Opinion or skipped: 2% (14)

Total comments given directly related: 17
Total respondents to the survey: 581

INVEST IN PREVENTION AND HEALTH PROMOTION:

Guideline as written for stakeholder input:

Invest in Prevention and Health Promotion: King County values prevention of poor health conditions as the most cost-effective avenue to achieving optimum health. King County will invest in prevention and health promotion strategies, recognizing that preventing ill health is ethically and financially preferable to treating avoidable conditions.

Staff Summary of responses providing a differing or disagree perspective:

- ✔ *Commenters reflected a value to include a broader population focus.*

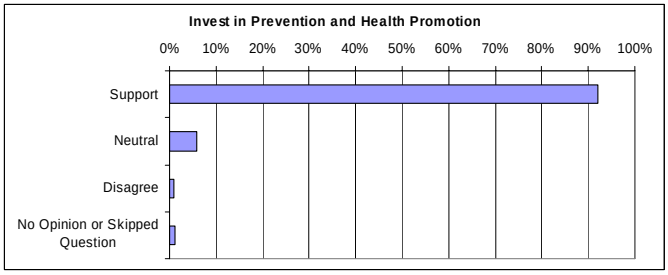
"I think the guiding principle above 'invest in prevention and health promotion' is too narrow/disease and individual health behavior focused---and needs to be widened to true health promotion---health and community focused. "

"more emphasis on prevention and child health. We must have / create an environment in which all living things (particularly children) can reach and maintain their potential."

Survey Data from Question 4: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 92% (535)
Neutral: 6% (34)
Disagree: 1% (5)
No Opinion or skipped: 1% (7)

Total comments given directly related: 9
Total respondents to the survey: 581



PURSUE EXCELLENCE AND INNOVATION

Guideline as written for stakeholder input:

Pursue Excellence and Innovation: The County intends that its health department be a recognized national leader in pursuing best practices and innovation in local public health practice. To fulfill its responsibilities for public health within its resource limitations, the County assures that its health department has the resources to support an organizational structure with strong leadership, a well trained and prepared workforce, sufficient service capacity and the modern information systems required.

Staff Summary of responses providing a differing or disagree perspective:

- *Even though the "support" percentage was less than 80%, this guideline had one of the highest "neutral" responses at 18%. (The other two which had similar neutral responses were Measure Community Health and Engage All County Departments.)*

- *7 of the 13 respondents addressed focusing on providing best possible service without the need of being a national leader.*

  "King County Public Health should strive to serve its citizens in the best way possible, without focusing on being a national leader."

  "Excellence is service delivery to our local communities and citizens do not need to be driven by a goal to be a national leader. The application of best and evidence based practice will be sufficient. At a time when our resources are declining putting effort and resources into developing and maintaining national exposure and reputation are not warranted. I suggest retaining the part of this goal that speaks to excellence and drop the emphasis on being a national leader."

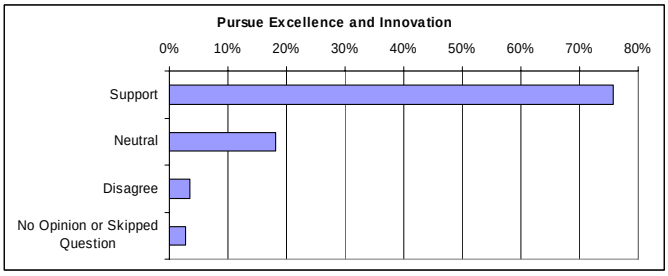
- *1 comment proposed to add research into the framework.*

  "Public Health needs to be involved in research. I suggest including the words research and pilot programs' as part of the description under the guiding principle of 'Pursue Excellence and Innovation', and to broaden the sentence mentioned above."

Survey Data from Question 4: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 76% (440)
Neutral: 18% (105)
Disagree: 3% (20)
No Opinion or skipped: 3% (16)

Total comments given directly related: 13
Total respondents to the survey: 581



BE PREPARED

Guideline as written for stakeholder input:

Be Prepared: It is a fundamental responsibility of government to rapidly and effectively respond to health threats and emergencies. The County is committed to building and maintaining the capacity to respond before emergencies occur by developing response plans and responding vigorously when emergencies occur. The public health department should maintain a highly trained workforce that can be rapidly deployed to respond to both large and small health emergencies. Collaboration with all partners, including private sector, other government organizations and key individuals, is essential.

Staff Summary of responses providing a differing or disagree perspective:

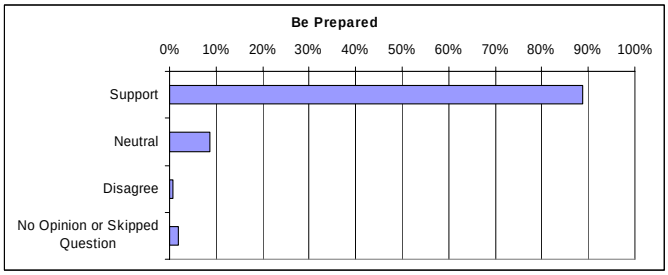
- ✔ *5 of the 8 comments reflected a need for a balanced approach to preparedness, noting that there is concern with dollars being diverted from existing programs to emergency preparedness.*

"Preparedness: although I think it is important to be prepared for emergencies I hate to see monies that could be allocated for basic health care for those in need used to prepare for something that may never happen. There needs to be some balance there."

Survey Data from Question 4: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 89% (516)
Neutral: 8% (50)
Disagree: 1% (4)
No Opinion or skipped: 2% (11)

Total comments given directly related: 8
Total respondents to the survey: 581



MEASURE COMMUNITY HEALTH

Guideline as written for stakeholder input:

Measure Community Health: Another primary responsibility of government is the regular measurement of the health of people and communities. The County's ability in tracking health status and identifying emerging health problems is essential for the response of the health department as well as of the public health and health care systems as a whole. King County is committed to the regular assessment of health needs to help inform and support appropriate responses as conditions among the population change.

Staff Summary of responses providing a differing or disagree perspective:

- *Even though the "support" percentage was less than 80%, this guideline had one of the highest "neutral" responses at 18%. (The other two which had similar neutral responses were Engage All County Departments, and Pursue Excellence and Innovation.)*

- *Overall comments that were provided supported the concept of measurement of the community but expansion to include more community and culture competency.*

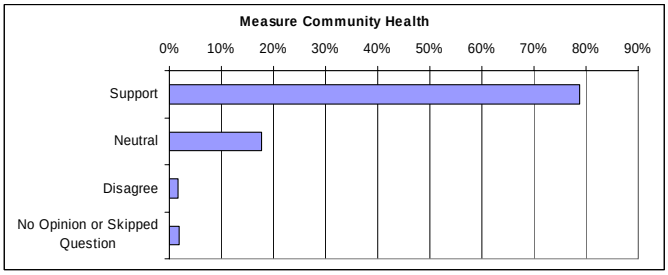
"These should include dissemination of 'health status' and other finding back to the community."

"While I support the guiding principal, it would be nice to include the community when possible. Especially when you're measuring community health. Any form of measurements or research (if done in a community of color) should include the community from the beginning of the research design or project in order for it to be culturally appropriate."

Survey Data from Question 4: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 79% (457)
Neutral: 18% (103)
Disagree: 2% (10)
No Opinion or skipped: 2% (11)

Total comments given directly related: 9
Total respondents to the survey: 581



FORM PARTNERHIPS

Guideline as written for stakeholder input:

Form Partnerships: A strong public health system must include partnerships with a wide variety of organizations because health is highly dependent on a range of factors, including the environment, economics, transportation, air quality, education, built environment, and health care, among others. Partnerships needed to address these factors must include those not traditionally thought of as having direct health-related missions.

Staff Summary of responses providing a differing or disagree perspective:

- *Most responses felt that partnerships are positive and important, those that disagreed reflected a need to be more inclusive.*

  "Partnerships should include the people we are serving. We need to meet people where they are by understanding them and their lifestyles. We need to seek stakeholder participation in trying to decide what is best for that population."

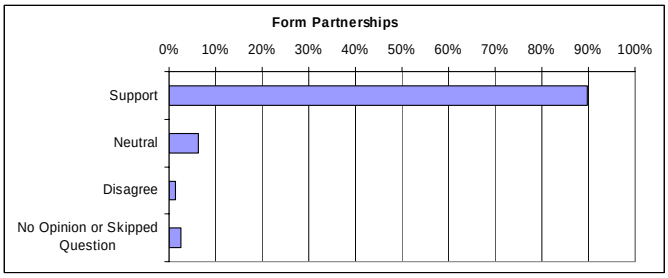
  "Public Health – Seattle & King County also needs to be a good partner in the state (and with the state) - start with Puget Sound neighbors and expand beyond that geography."

  "I agree with all those points. I also believe it's really important for Public Health to have a good working relationship with city of Seattle, federal government and the state so they all can work together on this global issue!"

Survey Data from Question 4: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 90% (521)
Neutral: 6% (37)
Disagree: 1% (8)
No Opinion or skipped: 3% (15)

Total comments given directly related: 10
Total respondents to the survey: 581



ENGAGE ALL COUNTY DEPARTMENTS

Guideline as written for stakeholder input:

Engage all County Departments: Because many of the services provided by King County government can affect health, the County must consider health consequences from all its services. In addition to public health, services such as transportation, public works, criminal justice, animal control, land use and human services must be considered in the context of this framework. The County will also consider incorporating a health focus into other County policies, such as its Comprehensive Plan.

Staff Summary of responses providing a differing or disagree perspective:

- *Even though the "support" percentage was less than 80%, this guideline had one of the highest "neutral" responses at 18%. (The other two which had similar neutral responses were Measure Community Health and Pursue Excellence and Innovation.)*

- *General comments reflected a concern over inclusion of non-County entities.*

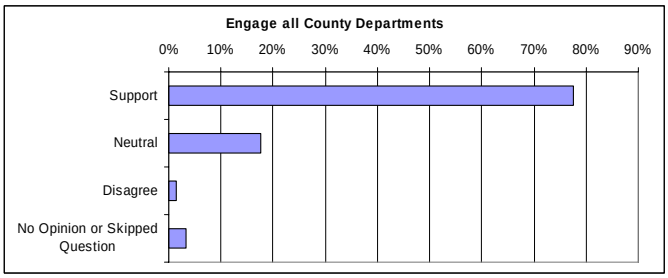
"Engage all County departments' should be expanded to include all local governments. King County can't do it alone -- we need very close partnerships across the City of Seattle, suburban cities, school districts, housing authorities, and the myriad other public entities in the region"

"View engaging all county departments as a means of carrying out and living by guiding principles, not as principle per se. More such cross-departmental work is certainly needed, but it seems quite 'internal' to call out as an overall guiding principle. Also, nothing is said about partnership with the many cities of King County - ?"

Survey Data from Question 4: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 78% (451)
Neutral: 18% (102)
Disagree: 2% (9)
No Opinion or skipped: 3% (19)

Total comments given directly related: 7
Total respondents to the survey: 581



ASSURE ACCESS TO HEALTH CARE

Guideline as written for stakeholder input:

Assure Access to Health Care: The government's role in personal health care services is to help assure access to high quality health care for all populations. Assurance can be realized by directly providing the services and/or by forming partnerships with service providers. The County will actively develop partnerships with other providers of primary medical care, specialty care, mental health, dental and hospital services to create and sustain the greatest possible access to high quality culturally competent health care. The County will also advocate for access to health care for all.

Staff Summary of responses providing a differing or disagree perspective:

- *This area received the largest comments directly to the guideline*
- *Several comments voiced viewpoints on the clinic closures*
- *14 comments reflected a negative position to the county providing primary care*

  *"A*ssure Access to Health Care - I actually agree that a guiding principle should be to Assure Access to Health Care. However, I believe PHD over emphasizes the direct provision of primary care services and the statement, as written, encourages/allows this practice to continue. Statement should be re-written to emphasize the policy/planning aspects of assurance and minimize direct service provision aspect and limit PHD provision to areas where it is able to address uniquely."

- *A set of comments focused on which level of government should be providing service, role of private entities, and need for advocacy.*

  "After reading the full text of the guiding principles, I am concerned that assuring access to health care will be sought primarily through community partnerships, rather than providing direct services ourselves. While I am not a provider or clinic staff person, my observation has been that other health care organizations don't adequately meet the need. For one example of many, Planned Parenthood (while getting federal funds to serve low-income clients) turns away clients that our department continues to serve. In sum, I think that assuring access to health care through partnerships is too weak a guideline."

  "The 'Assure Access to Health Care' is a little misleading as to which level of government is responsible. I don't think local government is primarily responsible for creating an environment of access to health care. KC should participate with the State of Washington leading that effort."

  "Personal health care is not the government's role. It is the government's fundamental role to be ready to respond to emergencies, but that does not include public health care. Health care is personal, not a core responsibility of government to ensure everyone person has it. It is a private sector issue, not the role of government to 'take care' of us."

"Within the realm of primary health care services, we are well aware of the demographic trends and financial pressures identified in the OMP's environmental scan. Among our six community health centers, we have seen a 12 percent increase in the number of uninsured medical patients over the past five years. Given that we see 115,000 medical patients per year – seven times the volume seen by the public health clinics – we feel this trend very acutely. Moreover, the draft OMP policy framework affirms that the government's role in assuring access to health care "can be realized by directly providing the services and/or by forming partnership with service providers." We note that in the most recent survey by the National Association of County and City Health Departments, 14 percent of health departments provide primary health care services directly, while 73 percent invest in such services through nongovernmental community partners. We furthermore understand that the long-term sustainability of the system must include investments by other levels of government. It is clearly important to craft a sustainable, effective mix of services and roles between the health department, its community health care partners, and other government entities. We know this is not a simple task, but the OMP process offers an excellent opportunity to tackle it thoughtfully and collaboratively."

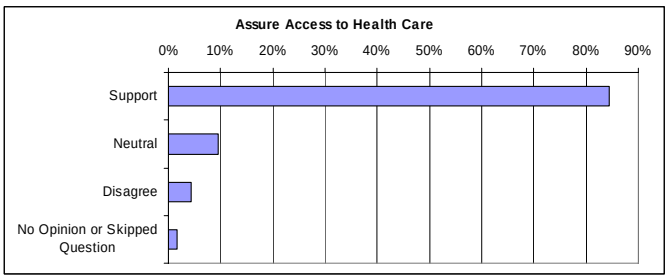
- *A few comments voice opinions on which population government should serve. (This might be more aptly addressed through Phase II discussions)*

"I do not feel it is King County's responsibility to assure access for personal health care to all. Yes, we must assure high quality health care to the public that we serve. We need to require income verification on all programs offered by King County. Not all the population is without insurance. Many do not choose to use their private insurance provided through their employer as they may have a co-pay. Thus many are using Public Health services and do not fit into the guidelines. This also includes pharmacy items that are covered with a co-pay by employer provided insurance. Also, the household income guidelines should include both working adults income regardless of whether they are married or not. It is not the responsibility of the County to take care of all populations."

Survey Data from Question 4: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 85% (491)
Neutral: 9% (55)
Disagree: 4% (25)
No Opinion or skipped: 2% (10)

Total comments given directly related: 35
Total respondents to the survey: 581



ASSURE SUSTAINABLE INFRASTRUCTURE

Guideline as written for stakeholder input:

Assure Sustainable Infrastructure: King County will assure a sustainable public health infrastructure and appropriately flexible resources to meet changing needs for essential public health services. The public health infrastructure must include a dynamic organizational structure, capacity and management practices of PHSKC. Best practices will guide the department's management practices to achieve operational efficiency, fiscal accountability, and program effectiveness.

Staff Summary of responses providing a differing or disagree perspective:

- *Commenters reflected a proposal to include system infrastructure (beyond the public health department) and noting the needs for workforce development and information technology*

  "Workforce development needs to also be part of the guiding principles to really be a national leader."

  "It's essential to assure a solid and sustainable public health infrastructure that is independent of 'disease du jour' (BT, pandemic flu etc)."

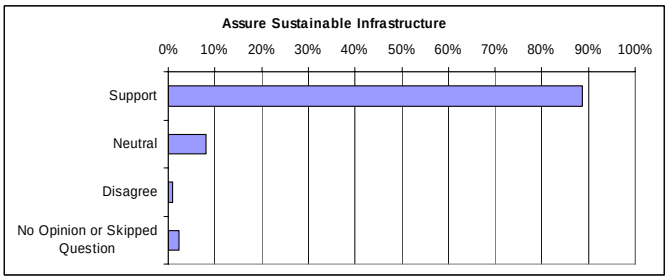
  "Second, we are pleased to see a commitment to the sustainability of the public health infrastructure, and not just the activities pursued directly by the health department……"

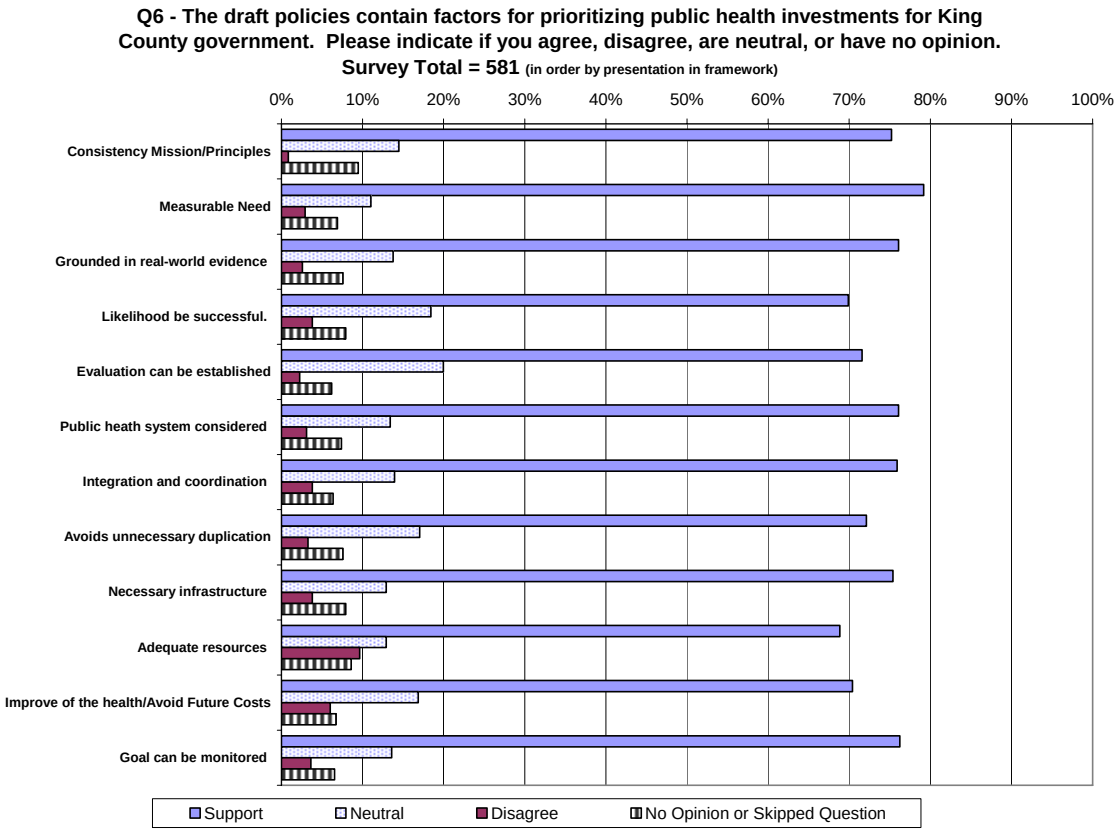
  "There should be a bigger emphasis on the IT infrastructure that is needed to support the goals above. It should also focus on how it can use IT to improve the administrative systems considerably (automate the systems and integrate database compatibility) with its eye to streamlining its systems and personnel needed to administer improved operations."

Survey Data from Question 4: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 89% (515)
Neutral: 8% (47)
Disagree: 1% (5)
No Opinion or skipped: 2% (14)

Total comments given directly related: 5
Total respondents to the survey: 581




Q6 - The draft policies contain factors for prioritizing public health investments for King County government. Please indicate if you agree, disagree, are neutral, or have no opinion.
Survey Total = 581 (in order by presentation in framework)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Consistency Mission/Principles
Measurable Need
Grounded in real-world evidence
Likelihood be successful.
Evaluation can be established
Public heath system considered
Integration and coordination
Avoids unnecessary duplication
Necessary infrastructure
Adequate resources
Improve of the health/Avoid Future Costs
Goal can be monitored
Support
Neutral
Disagree
No Opinion or Skipped Question

7. Please provide us any additional comments/thoughts regarding the factors to prioritize. At a minimum, for those that are checked with "disagree"; please indicate why you disagree and suggest changes that would make the statement acceptable.

160 respondents provided feedback on one or more of the guiding principles.
421 respondents skipped this question.
---
581 Total respondents to the survey

As a note, since the majority of respondents supported or were neutral to the factors to prioritize, the comments reflected in this document, are to point out the differing or disagreeing viewpoints.

Many comments received on this question did not specifically address a factor to prioritize, but were generic in structure or provided overall comments.

There were:

- *12 comments regarding general comments on the factors to prioritize (examples)*

  "Although this is fine in theory, there may be issues that are new or emerging and for which there is little evidence based practice or clear evaluation methodology but nevertheless need to be addressed……"

  "I don't disagree with the draft policy factors listed, but I question how reasonable they are to implement or consider."

- *12 comments regarding funding*

  "Our resources are not unlimited and that needs to be taken into consideration also."

- *40 comments provided general public health comment or comments that would be helpful in setting priorities in Phase II of the OMP*.

1. CONSISTENCY WITH KING COUNTY'S MISSION FOR THE HEALTH OF THE PUBLIC AND GUIDING PRINCIPLES

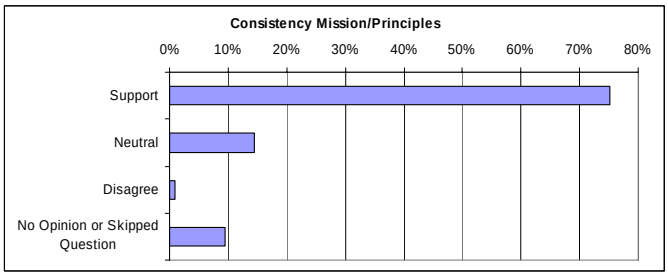
Staff Summary of responses providing a differing or disagree perspective:

No comment to summarize.

Survey Data from Question 6: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 75% (437)
Neutral: 14% (84)
Disagree: 1% (5)
No Opinion or skipped: 9% (55)

Total comments given directly related: 0
Total respondents to the survey: 581



2. THERE IS A DEMONSTRATED, MEASURABLE NEED FOR THE PROPOSED ACTION.

Staff Summary of responses providing a differing or disagree perspective:

- *Some commenters disagreed by not wanting to forgo doing work because of being unable to prove the need, or it applies to a small sample, or not including a qualitative need.*

  "Some creative, pilot projects may be based on small samples or limited experience and not on measurable needs"

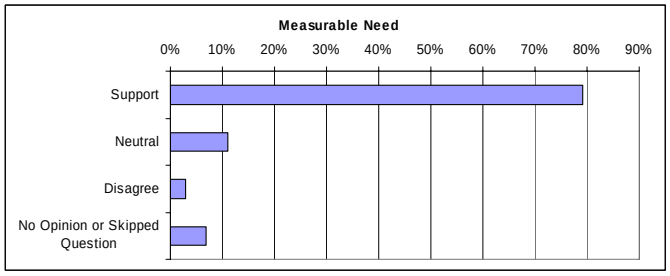
  "Requirements for measurable need with numbers often isolate communities not involved with the recruitment of this data, and numbers or measurable outcomes don't always include qualitative/descriptive information that conveys underlying issues facing community health."

  "I disagree with the 'demonstrated need' part of the draft policy. I think KC would be well served by adopting the precautionary principle. PHSKC can't really be an innovative leader and NOT be using the precautionary principle. Rather than address a reasonable likelihood the action would be successful, even if there is a CHANCE of success, thereby improving health, the action would be worth doing."

Survey Data from Question 6: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 79% (460)
Neutral: 11% (64)
Disagree: 3% (17)
No Opinion or skipped: 7 % (40)

Total comments given directly related: 5
Total respondents to the survey: 581



3. THE PROPOSED ACTION IS GROUNDED IN REAL-WORLD EVIDENCE THAT IT WORKS AND/OR AFFORDS OPPORTUNITY TO INNOVATE AND CREATE CUTTING-EDGE APPROACHES

Staff Summary of responses providing a differing or disagree perspective:

- *8 comments reflected the need for innovation*
  "While there is a need to utilize evidence-based research in public health practice, it is equally important to be innovative. To eliminate health disparities, innovation is needed. Clearly, the traditional approaches and thinking is not working."

  "…pioneering alternative methods often requires that we take the change and establish the evidence vs. relying on it before hand"

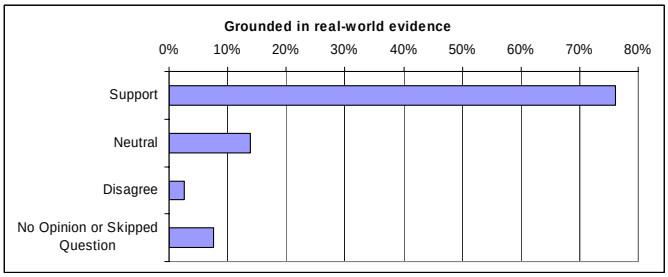
- *5 comments reflected that innovation without underlying evidence based information may be a concern*

  "A proposed action should not be considered if it only provides an opportunity to be innovative and cutting edge. I would support this if the word 'or' were removed."

Survey Data from Question 6: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 76% (442)
Neutral: 14% (80)
Disagree: 3% (15)
No Opinion or skipped: 8% (44)

Total comments given directly related: 15
Total respondents to the survey: 581



4. THERE IS A REASONABLE LIKELIHOOD THAT IMPLEMENTATION OF THE PROPOSED ACTION WOULD BE SUCCESSFUL

Staff Summary of responses providing a differing or disagree perspective:

- *Commenters are concerned that success as a determining factor is unclear or would not be able to assure it.*

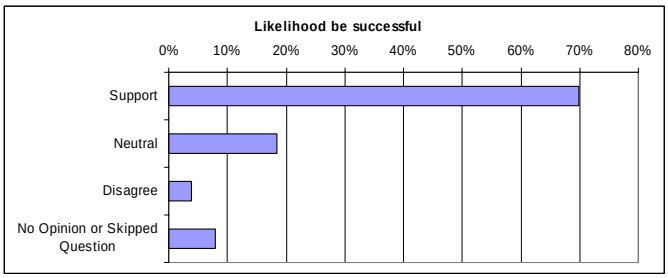
  "I disagreed with statements that I felt would support only those proposals that would be successful because there will not always be tried and proven solutions."

  "Reasonable likelihood of success - This statement is too open ended. Who is the determiner of likelihood?"

Survey Data from Question 6: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 70% (406)
Neutral: 4% (107)
Disagree: 18% (22)
No Opinion or skipped: 8% (46)

Total comments given directly related: 4
Total respondents to the survey: 581



5. OBJECTIVE, MEASURABLE EVALUATION CRITERIA CAN BE ESTABLISHED TO EVALUATE PROGRESS TOWARD MEETING THE RELATED GOAL.

Staff Summary of responses providing a differing or disagree perspective:

- *Respondents reflected the viewpoint to balance evaluation of qualitative to quantitative needs.*

  "There are health issues whose outcomes are not easily measured which could use funding, but don't get it because hard data is hard to get.."

  "We need to invest in the kind of evaluation that can withstand peer review."

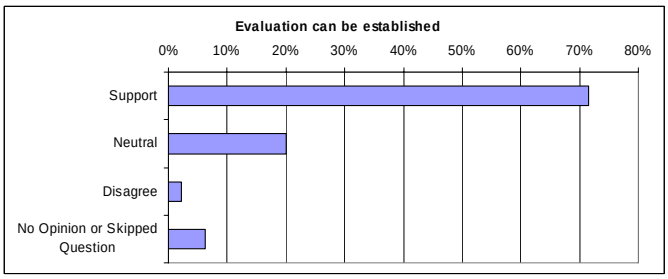
  "At times studies to measure or quantify the need waste time and resources. There needs to be a balance of quantitative and qualitative analysis so that the analysis doesn't bog down the application of a solution. At the same time, the analysis should be thorough and common sense to avoid throwing money towards a solution that is just a band aid."

  "I am neutral on the evaluation statement because it is very difficult to get sufficient funding to do decent evaluations. It's a worthy goal of course."

Survey Data from Question 6: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 72% (416)
Neutral: 20% (116)
Disagree: 2% (13)
No Opinion or skipped 6% (36)

Total comments given directly related: 19
Total respondents to the survey: 581



6. THE INTERESTS OF THE LOCAL PUBLIC HEALTH SYSTEM AS A WHOLE ARE CONSIDERED AND, WHERE POSSIBLE, ADDRESSED; OPPORTUNITIES FOR COLLABORATION AMONG SYSTEM PARTNERS ARE IDENTIFIED.

Staff Summary of responses providing a differing or disagree perspective:

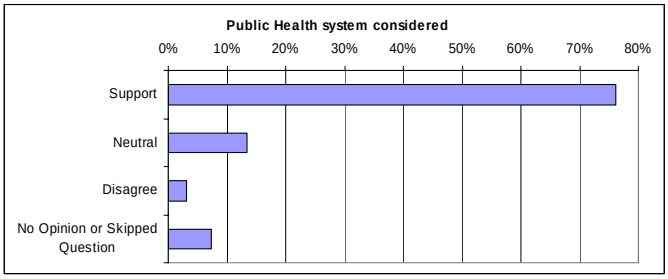
- *There were not disagreed perspectives per se, but recognition to include a broad collection of agencies including research agencies.*

"The goal should be to form specific partnerships that can directly foster desired outcomes, such as strong collaborative links with UW, Gates, and other agencies that can make a difference."

Survey Data from Question 6: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 76% (442)
Neutral: 13% (78)
Disagree: 3% (18)
No Opinion or skipped: 8% (43)

Total comments given directly related: 3
Total respondents to the survey: 581



7. A HIGH LEVEL OF INTEGRATION AND COORDINATION OF PROGRAMS AND PARTNERS CAN BE ACHIEVED, PREVENTING INEFFICIENT SEPARATION OF RELATED SERVICES.

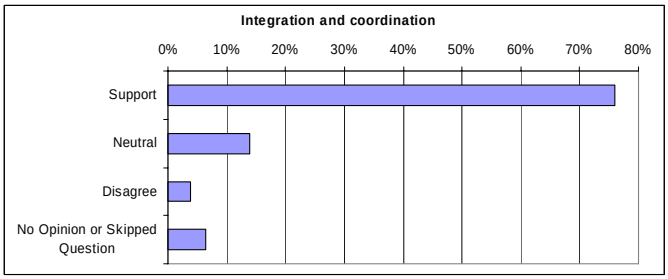
Staff Summary of responses providing a differing or disagree perspective:

No comments voicing a disagree perspective.

Survey Data from Question 6: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 76% (441)
Neutral: 14% (81)
Disagree: 4% (22)
No Opinion or skipped: 6% (37)

Total comments given directly related: 5
Total respondents to the survey: 581



8. THE PROPOSED ACTION AVOIDS UNNECESSARY DUPLICATION OF THE WORK OF OTHER ORGANIZATIONS.

Staff Summary of responses providing a differing or disagree perspective:

- *Comments reflect a concern that some level of duplication may not be a bad thing.*

  "Duplication issue: What can sometimes appear at first blush as duplication may in some cases be attempts to provide a range of culturally appropriate services (using different partners) and different styles. Cookie-cutter approaches and over-consolidation of services in a handful of organizations can risk leaving out many segments of the population, and reduce our ability to truly address health disparities."

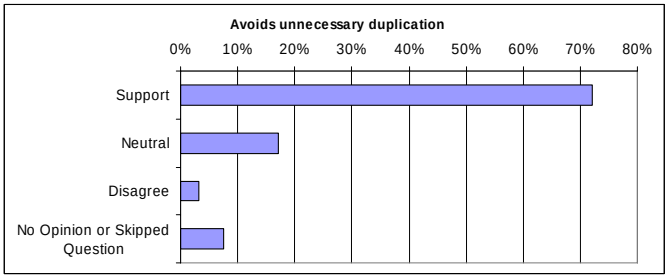
  "Avoid unnecessary duplication' There may be circumstances where duplication is appropriate to help fill gaps, provide alterate or better approaches, maintain expertise in the field, etc. I would not want this to be rigidly enforced."

- *Commenter proposes that the framework provide a method to analyze who should provide the service.*

  "One factor should include an analysis of who/what entity should implement the activity/services. The factors imply this, but this needs to be more explicit. Even if it is Public Health's responsibility, there still needs to be a determination of whether Public Health should undertake the activity/service itself or work with partners or contract it out. Also, there needs to be an additional step: assure that public health funding is aligned with addressing the greatest needs and highest priorities."

Survey Data from Question 6: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 72% (419)
Neutral: 17% (99)
Disagree: 3% (19)
No Opinion or skipped: 8% (44)



Total comments given directly related: 8
Total respondents to the survey: 581

9. THE PUBLIC HEALTH SYSTEM HAS OR WILL DEVELOP THE NECESSARY INFRASTRUCTURE TO SUPPORT THE ACTION.

Staff Summary of responses providing a differing or disagree perspective:

"Development of the necessary infrastructure should include workforce development. We can have all of the goals, policies & procedures we want but if the workforce is not equipped to carry them out, we would have done all of this for nothing."

"PH system has or will develop the necessary infrastructure... I don't think PH should develop new infrastructure each and every time a new issue arises. I think the goal should be to have a solid infrastructure that is able to flex to meet changing needs and to consider other options in extraordinary circumstances."

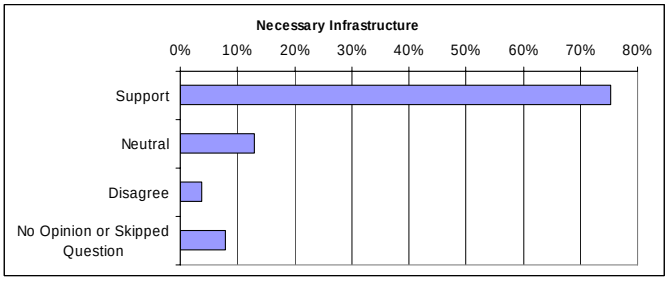
"The public health system has or will develop the necessary infrastructure to support the action - I'd change this to say the community has or will develop the infrastructure. Why limit the solutions to just the public health system if there are private or community based systems."

"If you do not have the infrastructure in place before an action is taken the likelihood of smooth transition or success of action is greatly diminished. It would affect employee and public acceptance and desire of any change to succeed. Waiting until the infrastructure is in place makes any action more acceptable."

Survey Data from Question 6: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 75% (438)
Neutral: 13% (75)
Disagree: 4% (22)
No Opinion or skipped: 8% (46)

Total comments given directly related: 6
Total respondents to the survey: 581



10. ADEQUATE RESOURCES TO SUPPORT THE PROPOSED ACTIVITIES HAVE BEEN IDENTIFIED BOTH IN THE CURRENT BUDGET AND TO SUSTAIN THE ACTIVITY AS NEEDED INTO THE FUTURE, OR A PLAN EXISTS FOR SUSTAINING PROGRESS TOWARD THE GOAL SHOULD FUNDING NOT BE AVAILABLE.

Staff Summary of responses providing a differing or disagree perspective:

- *This factor generated the greatest amount of disagree checkmarks at just about 10%.*
- *The majority of disagreement related to not addressing an issue due to not having a resource plan.*

"I'd hate to eliminate an opportunity that can benefit people even if it's a short term return just because I can't guarantee that it can be sustained. Helping people now is better than not trying."

"Sometimes, being 'cutting edge' means you test things out without a clear plan for how it will be funded in the future--the results can be used to make a case for future funding. It would be a shame to lose flexibility if we really had to say EXACTLY how everything will be funded in the future....could stifle and hurt progress toward goals."

"I would hate to see PH not addressing an important issue (i.e. a TB outbreak in the community) because there wasn't a clearly identified funding pool in place. In my mind, acting quickly and decisively AND balancing funding resources is the *art of Public Health*"

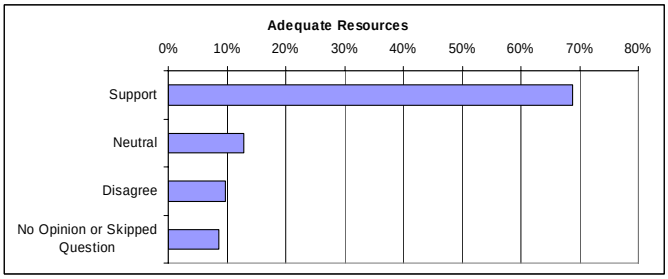
"How about 'Current and ongoing resources have been identified, or there is a reasonable plan for progress in the event funding is not available'"

"I don't think the financial factor should play as great a role in determining public health investments as need and potential impact. I would rather see a concerted, activist effort to adequately fund public health so we could do the work that we need to do."

Survey Data from Question 6: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 69% (400)
Neutral: 13% (75)
Disagree: 10% (56)
No Opinion or skipped: 8% (50)

Total comments given directly related: 19
Total respondents to the survey: 581



11. THE PROPOSED ACTION NOT ONLY CONTRIBUTES TO THE IMPROVEMENT OF THE HEALTH OF THE POPULATION BUT THE INVESTMENT ALSO AVOIDS FUTURE COSTS.

Staff Summary of responses providing a differing or disagree perspective:

- *Most offered support for improving health.*

- *All 23 offered to disagree with the "avoids future costs"*
  "A proposal should improve health. Setting the standard that it must also save money sets a standard that will stop some very valuable interventions that improve health and may break even or cost an acceptable amount."

  "For the second to last factor I would change the wording slightly to indicate not all future costs can be avoided or thought of prior to the proposed action."

  "I especially take issue with the statement 'avoids future costs'. Many needed actions are long-term, to be measured in decades rather than years. And cost savings (in terms of health care costs etc) are not always measurable and certainly not always evident for years/decades."

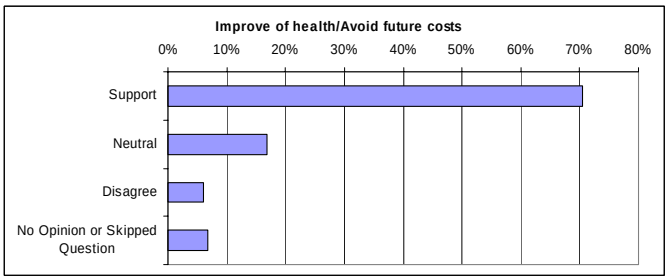
  I would rephrase from 'avoids future costs' -- not all public health actions may be proven to avoid future costs, nor is this the main reason to engage in public health action. The costs saved may be beyond financial costs. I would be concerned about how this will be measured.

  "While it is true that Public Health must maintain some sort of budget soundness, health care should not be, especially in THIS arena, measured by monetary issues alone. We MUST put public interest and welfare first and find a way to afford them."

Survey Data from Question 6: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)

Support: 70% (409)
Neutral: 17% (98)
Disagree: 6% (35)
No Opinion or skipped: 7% (39)

Total comments given directly related: 23
Total respondents to the survey: 581

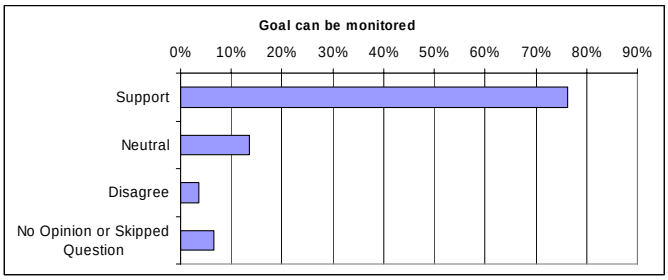


12. PROGRESS TOWARD THE GOAL CAN BE MONITORED OVER TIME WITH PRACTICAL TOOLS OF ACCOUNTABILITY FOR PERFORMANCE, FOR MEETING PUBLIC HEALTH STANDARDS, AND FOR BUDGET COMPLIANCE.

Staff Summary of responses providing a differing or disagree perspective:

No comments that disagreed with monitoring over time.

Survey Data from Question 6: (Not statistically valid, rounded to the nearest percent, actual count in parentheses)



Support: 76% (443)
Neutral: 14% (79)
Disagree: 4% (21)
No Opinion or skipped: 6% (38)

Total comments given directly related: 1
Total respondents to the survey: 581

8. Consider the framework as whole, is there anything you would you like to ADD or CHANGE?

115 respondents provided feedback to this question.
466 respondents skipped this question.
---
581 Total respondents to the survey

Overview:

1. Of the 115 comments provided, the vast majority of the comments provided general public health comment or comments that would be helpful in setting priorities in Phase II of the OMP.

2. There were a set of comments that were suggestions or specifically related to the framework. Those that have themes that are not already addressed either in the comments received on the guiding principles or factors to prioritize are summarized and attached here.

"Be Outcome Based":

"I suggest adding a guiding principle: 'Be outcome based' of something to that effect. Set clear goals, big, ambitious goals that will necessarily involve many entities beyond the local public health department. Then develop strategies in collaboration with many partners. Public Health's role should be the convener, the catalyst, for these regional health goals. Maybe much of the work and the cost is borne by others. Just a thought."

"How disappointing that every one of the 9 'guiding principles' is a process rather than an outcome! Of course government should 'assure access'--but why? In order to reduce morbidity due to selected health outcomes."

"The policy framework could better clarify core responsibilities and essential services by addressing community results the policies ought to accomplish. For instance, the policy regarding prevention and health promotion might read: 'King County values prevention of poor health conditions as the most cost effective avenue to achieve optimum health and reduce avoidable hospitalizations.' 'Optimum health' is not a measurable goal. Adding a community result, such as 'reduce avoidable hospitalizations', provides a performance indicator to measure the effectiveness of public health investments (i.e., reduction in number of people hospitalized for illnesses that would not normally require hospitalization). It also better focuses limited public health resources to health factors for which hospitalization would not normally be necessary (i.e., pneumonia / influenza immunizations). For these reasons, among others -- the Steering Committee might want to re-examine a shorten list of guiding principles for the purpose of identifying and adding the community results they hope to achieve."

Strategic Planning:

First, we are pleased to see a strong emphasis on the health department's role in system-wide planning and coordination. The health department has a unique and critical role in the local health care system as an impartial convener of that system. Collection, analysis and dissemination of

epidemiological and other data are all necessary for all community partners to understand trends, meet community needs, and adapt over time. Identifying and convening key players in the public health system for the purposes of planning and coordination is something only government can do. The health department has unique resources – human, financial and technological – that can be used to identify and monitor trends, educate the community, and support complex planning and coordination activities.

Role of Public Health and Uses of the Framework:

"It should also more clearly articulate the role of Public Health in building/supporting/leading the public health system. The framework should be more explicit in how it will be used to determine the services/activities for which King County government will take responsibility. I know that the level of services will always be dependent on available resources, but the County should indicate the services it will fund and seek resources for - in other words, what it will take responsibility for. The framework should be used in Phase II and beyond to assure that Public Health's funding and organizational structure are aligned with its priorities."

"Since we all know money is tight, the implication of the above is PH will continue to do many things OK rather than a few things very well. I don't see that this effort has made any tough choices."

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VI: Public Health Response to the Expert Panel Report

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.
David Fleming, MD, *Director and Health Officer*

August 21, 2007

TO: Public Health's Operations Master Plan (PHOMP) Steering Committee

FROM: David Fleming, MD, Director and Health Officer

RE: Expert Panel Finding and Recommendations

On behalf of Public Health-Seattle & King County (PHSKC), I'd like to thank the Expert Panel for their interest and commitment to address the health care needs of our community. Their expansive working knowledge and understanding of health care delivery issues contributed to rich discussions and recommendations aimed to strengthen our health care system. These recommendations are a good starting point and outline key steps that PHSKC should take to respond to the pressures and opportunities in the current health care environment.

The recommendations are broad and provide PHSKC with a foundation to build a community-based vision and plan to respond to the safety-net issues of the underinsured and uninsured. They are consistent with the goals and next steps delineated in the PHOMP's Health Provision function. In the next several months, PHSKC will more specifically delineate the Health Provision assessment, policy development, and assurance strategies to better define system gaps and to improve access to quality health care. PHSKC will develop detailed work plans and engage/convene appropriate and strategic community-based teams and technical advisors this fall.

Priorities and tactics will, of course, change over the next four years, as the health care policy environment shifts. Public Health-Seattle & King County will use the recommendations of the expert panel as guiding principles during this time of change.

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Gregory J. Nickels, *Mayor*

King County
Ron Sims, *Executive*

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VII: Expert panel Report on Increasing Access for the Uninsured and Underinsured in King County Report

Increasing Access for the Uninsured and Underinsured in King County

Findings and Recommendations
of the
EXPERT PANEL

July 2007

EXPERT PANEL MEMBERS

Rosemary Aragon, Pacific Health & Preservation & Development Authority
Kathy Cahill, Global Health Strategies, Gates Foundation
Elise Chayet, Harborview Planning & Regulatory Affairs
Charles Chu, Former Member, Board of Health
Mary Hampton, Veterans Administration, Puget Sound Health Care System
Helen Harte, Quality Community Health Plan
Maxine Hayes, Washington State Department of Health
Dan Lessler, Harborview Medical Center
Michael Lippman, Public Health – Seattle & King County
Karen Matsuda, US Public Health Service
Terri Olsen-Miller, Community Health Centers of King County
Judy Morton, Swedish Hospital
Tony Pedroza, Valley Medical Center
Roger Rosenblatt, School of Public Health, University of Washington
Linda Weedman, YWCA Housing Services

EXPERT PANEL STAFF

David Fleming, Public Health – Seattle & King County
Dorothy Teeter, Public Health – Seattle & King County
Kathleen Uhlorn, Public Health – Seattle & King County
Toni Rezab, King County Office of Management & Budget

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Increasing Access to Quality Health Care among the Uninsured and the Underinsured in King County

Background

Public Health Operational Master Plan

King County is currently in the process of completing a Public Health Operational Master Plan. This Plan describes the three primary functions of Public Health – Seattle & King County -- promotion, protection, and provision -- and sets priorities for the next four years. Public Health – Seattle & King County will pursue these priorities through assessment, policy development, and assurance activities.

In addition, the Plan provides guidance on the principles that should underlie King County's public health functions, including efforts to expand access to health care for those who are uninsured or underinsured. The guiding principles affirm that the system should be centered on the community, driven by social justice, based in science and evidence, and focused on prevention.

The Role of the Expert Panel

Public Health - Seattle & King County convened an Expert Panel in April 2007 to develop recommendations regarding how King County can work collaboratively with the community to strengthen the community health safety net and improve access to health care for children and adults who are either uninsured (have no insurance coverage at all) or underinsured (have inadequate insurance to cover health care needs and face barriers to health care).

The Expert Panel, comprising individuals with expertise in a broad array of health care and social services, held four highly productive meetings to develop the information and recommendations that appear in this report.

Expert Panel Deliberations Process

The Expert Panel met four times over the course of three months. During these sessions, the panel discussed the elements critical to addressing the problem of access to care for uninsured and underinsured children and adults in King County. The most important steps in their process included:

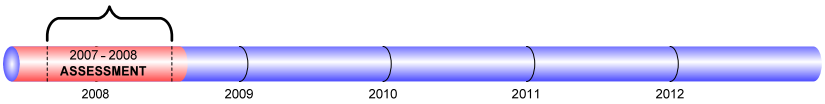
- Analysis of the profile of uninsured and underinsured children and adults in King County, including age, income, language, employment status, and other factors
- Identification of barriers to care for different types of uninsured and underinsured children and adults (summarized in the matrix that appears in Appendix I)
- Examination of the current capacity of the health care safety net, including system stressors such as high levels of uncompensated care, challenges recruiting physicians, inappropriate utilization of emergency rooms, and other related issues
- Review of innovative approaches in place in other communities, e.g., the innovations in the practice model the Southcentral Alaska Foundation and Alaska Native Medical Center have implemented
- Research into promising approaches that policymakers, research groups, and community-based processes have identified (summarized in the matrix that appears in Appendix I)
- Identification of major system changes that impact the provision and financing of health care, including the Governor's Blue Ribbon Commission, the Washington State Mental Health Division's Transformation Initiative, and other important initiatives that impact health care
- Recognition of the important relationship between the Public Health Operations Master Plan and the work of the Expert Panel
- Discussion of key findings to guide the panel members' strategy development
- Development of strategies Public Health – Seattle & King County should pursue to bring about an improvement in access to care for those who are uninsured and underinsured

By examining the fundamental factors in play with regard to access to care, the Expert Panel was able to identify a strategic direction for Public Health – Seattle & King County to follow. This direction, which incorporates the panel's findings, recommendations, and implementation approaches, will guide the department's access improvement efforts over the coming years.

Recommendations and Implementation Approaches

The Expert Panel identified the following recommendations for Public Health - Seattle & King County to pursue in order to improve access to quality health care for uninsured and underinsured children and adults in King County.

Recommendation #1



Establish an Ongoing Health Care Access and Capacity Assessment

Expert Panel Finding:

Information on current access and health care system capacity is limited, particularly for subpopulations and sub-regions within the County. Public Health - Seattle & King County needs more complete and detailed information on the current situation and a careful analysis of projected future trends in order to make good decisions about how to more effectively improve access for uninsured and underinsured populations. Given the rapid rate of change in the health care field, this assessment process should be followed up with periodic surveys to assess the state of the health care system's "vital signs."

Public Health – Seattle & King County should establish an ongoing Health Care Access and Capacity Assessment process to collect critical information that will guide planning efforts to improve access to quality care for the uninsured and underinsured.

During implementation of this recommendation, Public Health - Seattle & King County should collaborate with safety net partners and other providers, including community health clinics, mental health centers, drug and alcohol facilities, pharmacies, hospitals, private providers, payors, and community organizations.

The assessment should consider current access and capacity issues as well as project the financial and service delivery impacts of the Governor's stated commitment to expand coverage to all those who are currently uninsured and underinsured. (More information on the Governor's Blue Ribbon Commission recommendations follows on page 9.) In addition, given the differences in geographic regions within King County, the assessment process should include sub-regional geographic analysis.

The major components of the health care access and capacity assessment should include:

- Analysis of the current profile of uninsured and underinsured populations, e.g., the proportion that fall into the population groups identified by the Expert Panel (children and adults with mental illnesses who are enrolled in the mental health system and likely on Medicaid, children and adults with mental illnesses who are not enrolled in the mental health system, the working poor, undocumented individuals, all uninsured and underinsured children and adults, and children and adults who are eligible but not enrolled in insurance)

- Projections of the future profiles of the sub-regional populations -- based on the potential implementation of expanded State coverage, these projections should address issues such as the extent of coverage for newly-insured populations, the coverage status of undocumented individuals, etc.

- Assessment of the health care system's current and future capacity; this assessment should look at the ability of all segments of the health care system (primary care, including medical, dental, and behavioral health; preventive services; specialty care; and hospitals) to serve the population that is currently covered as well as to handle the additional volume of people who will be covered if the State dramatically expands coverage by 2012

- Analysis of the transportation challenges and realities which make it difficult for individuals and families to obtain health care

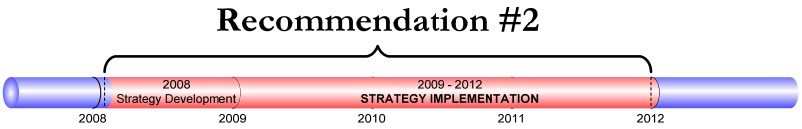
- Evaluation of the functionality of system connections, including information transfer, coordination of care, and referrals among primary care, specialty care, and hospital care -- this analysis will be essential in ensuring that the system is capable of providing coordinated quality care, both now and in the future

Implementation Approach

Technical Assistance Resources

Public Health - Seattle & King County should call on a variety of organizations and individuals to assist in the completion of the Health Care Access and Capacity Assessment. These organizations and individuals can provide data as well as potentially contribute their expertise in assessment, data collection and analysis, capacity mapping, system design, and system financing. In addition, those providing technical assistance will be helpful in increasing the level of understanding regarding the access and capacity issues facing sub-regions and populations in King County.

A list of potential organizations and the types of data they may be able to contribute to the health care access and capacity assessment process appears in Appendix II.



Develop an Access and Capacity Improvement Strategy

Expert Panel Finding: Public Health - Seattle & King County will most effectively work toward its goal of improving access and capacity by designing strategies in partnership with other community organizations that have expertise, interest, and capacity in health and human services.

Public Health - Seattle & King County should convene a group to work collaboratively to develop a vision for a high quality, cost effective system. The groups should establish priorities and develop strategies to improve both the capacity of the health care system and the ability of uninsured and underinsured children and adults to access that care.

The group should include safety net partners and providers, including community health clinics, mental health agencies, substance abuse providers, hospitals, consumers, private providers, and community organizations.

The focus of the Access and Capacity Improvement Strategy effort should include the following:

- Creation of a system vision that utilizes knowledge and leverages resources to achieve improved health care results and increased cost effectiveness
- Identification of system improvement strategies that will build connections and close identified gaps among primary care providers (medical, dental, and behavioral health), including electronic information-sharing, referral agreements, and co-location opportunities
- Formulation of approaches that will involve the broader safety net providers in prevention activities
- Development of system-level financial and service delivery incentives that will encourage specialty providers to offer services to children and adults who are uninsured or underinsured
- Articulation of the role Public Health - Seattle & King County can play in the planning and provision of health care services in King County

Implementation Approach

Health Care Access and Capacity Improvement Strategy Leadership Group

The individuals and organizations represented on this leadership group will use the assessment described in Recommendation #1 to assist Public Health - Seattle & King County in developing strategies to improve the capacity of the region's health care system and enhance access to care for uninsured and underinsured individuals.

Ideas for systems that would be strong contributors to the development of the access and capacity strategies appear in Appendix III.

Pursue All Promising Avenues to Increase Health Care Coverage for King County Residents

Expert Panel Finding: The Governor's Blue Ribbon Commission has put forth a set of recommendations that will, when implemented, significantly increase access to health care in King County. King County should work collaboratively with the Governor's Office and local health care organizations to achieve passage of these recommendations. However, implementation of these recommendations is at least five years away; local efforts to increase coverage should continue during the interim.

Public Health - Seattle & King County should join forces with local, state, and national coalitions to bring about immediate improvements in health care coverage for local children and adults. Likely coalitions for collaborative action include those working on behalf of children, veterans, the homeless, people with serious mental illnesses, and the working poor. In addition, this collaborative effort should include businesses, health plans, health care consumers, and health care providers. By working collaboratively with other groups, Public Health - Seattle & King County will be more likely to bring about significant changes in the health care system.
While additional advocacy opportunities to improve coverage for uninsured and underinsured children and adults will appear, the issues below are worthy of immediate attention.

Washington's Blue Ribbon Commission on Health Care Costs and Access

In 2006, a Blue Ribbon Commission convened by the Governor recommended that the State significantly expand its role in providing health insurance coverage. The Blue Ribbon Commission's recommendations for the State include:

- Provision of access to health care coverage for all Washingtonians by 2012 (children will be covered by 2010)
- Implementation of a Healthy Insurance Connector to maintain health insurance for individuals when they change jobs
- Extension of health care coverage for dependents up to age 25
- Partnership with the federal government to expand coverage in Medicaid and the Basic Health Plan
- Piloting of Health Opportunity Accounts

Implementation of the Commission's recommendations would result in a dramatic improvement in access to health care for the residents of King County. However, ensuring that these recommendations come to pass will require a significant level of support and advocacy. The Expert Panel believes the State's initiatives provide key opportunities and an important context for the Panel's recommendations. The panelist concur that financing health insurance coverage for uninsured populations is a State role and one that the Governor is treating as a high priority.

The Expert Panel urges the County to advocate that the State continue to expand insurance coverage and implement the Blue Ribbon Commission recommendations.

State of Washington Mental Health System Transformation Initiatives

The State of Washington is currently undertaking a broad set of initiatives to transform the mental health system. One of these initiatives, currently in the early stages of discussion, aims to redesign the structure of benefits in order to bring together mental health and primary care services. Local implementation of system transformation efforts will be led by the King County Community and Human Services Department.

The Expert Panel recommends that Public Health – Seattle & King County actively participate in and support this work.

King County Children's Health Initiative

Public Health – Seattle & King County is currently implementing an initiative to expand access to health care for uninsured children. The first component of the initiative is continued advocacy for the State to meet the goal of covering all children by 2010. At present, Public Health - Seattle & King County is also implementing the second component of the initiative, which focuses on identifying and enrolling children who are eligible for existing health insurance programs, e.g., Medicaid and the Basic Health Plan. Despite their uninsured status, many of these children are receiving care through the community health centers and Public Health – Seattle & King County clinics. However, as this care is uncompensated, it is placing an enormous financial strain on these organizations.

In addition to enrollment, Public Health – Seattle & King County is working with private sector partners to design and implement pilot projects to enhance system capacity and improve access to services for children. These pilot projects will focus on three areas: oral health, online enrollment, and behavioral health.

The Expert Panel recommends that Public Health – Seattle & King County continue its leadership of the Children's Health Initiative: the advocacy work; the enrollment of eligible children; and the design, implementation, and evaluation of pilot projects.

Additional Actions to Increase Access to Care

The Expert Panel identified a number of other advocacy issues that are critical to increasing access to health care for those who are uninsured and underinsured. Actions to achieve the successful implementation of the changes outlined below should begin immediately.

- Enrollment of adults who are eligible for existing health insurance coverage, e.g., Medicaid, BHP (the children's enrollment strategy is currently underway)
- Allocation of sustainable funding for Project Access in Washington State (particularly King County Project Access)
- Reauthorization of the State Children's Health Insurance Program (SCHIP)
- Use of employee health insurance provision as a rating criterion for bids on King County contracts
- Advocacy for increased Medicaid reimbursement rates

Implementation Approach

Health Care Coverage Advocacy

Public Health - Seattle & King County should work with the coalitions and organizations engaged in advocating for improved access to health care, including:

- Children's Health Initiative
- Veteran Health Administration
- King County Mental Health
- King County Committee to End Homelessness
- Washington State Hospital Association
- Washington State Medical Association
- Washington State Nursing Association
- The Greater Seattle Chamber of Commerce
- Business Sponsors of the Puget Sound Health Alliance
- King County Veterans Program

Next Steps

The Expert Panel has laid out an ambitious set of recommendations for Public Health – Seattle & King County to achieve. The immediate implementation of Recommendation #1 is essential to develop the in-depth knowledge and community-wide collaboration necessary to make significant improvements in the health care system.

Once the efforts on Recommendation #1 have produced sufficient information to inform strategy development, Public Health – Seattle & King County should convene the stakeholders to begin designing these access and capacity initiatives.

In addition, Recommendation #3 is ripe for action. Joining forces with other coalitions that are working on similar issues will increase the likelihood of bringing about improvements in access and capacity prior to the major expansion in coverage recommended by the Governor's Blue Ribbon Commission.

Appendix I

The Expert Panel identified the key sub-populations who are either without health insurance or who have inadequate insurance. For each of these populations, the group discussed the key barriers to health care access, potential strategies to address the barriers, and potential roles Public Health – Seattle & King County could play. The following matrix shows the key subpopulations, barriers, strategies, and potential roles for Public Health – Seattle & King County.

Sub-populations and System Change Examples

Sub-Population	Estimated Pop Size	Reasons for Access Limitations	Examples of System Change Levers	Public Health Roles
Children and adults with mental illnesses (including those with co-occurring chemical dependencies) – eligible for and enrolled in King County mental health system. Most have Medicaid.	*Approximately 9,200 children and 26,000 adults*	*Fragmentation between mental health, chemical dependency, and health care systems (including dental care)*	*Redesign primary care, dental care, and behavioral health practice models to integrate clinical services through combination of clinical, structural, and financing changes*	*Co-Convener with County Human Services and United Way* *Administrator, Provider, and Funder*
			Increase role of other safety net sectors in connecting consumers to primary care, dental care, and behavioral health services (e.g., food banks, shelters, etc.)	*Co-Convener with County Human Services and United Way*
		Low Medicaid reimbursement rates for health care and dental care	*Obtain sustainable state and federal financing for Medicaid*	*Advocate*
People with mental illnesses (including those with co-occurring chemical dependencies) – NOT eligible for King County mental health system and therefore not enrolled in Medicaid through the County, includes individuals with other types of insurance, e.g., those on GAU covered by the Community Health Plan. Also to be addressed are uninsured persons seen at Community Health Centers, uninsured persons presenting at hospital emergency departments, and prior military personnel not covered by VA benefits.	*Unknown, but best estimate is approximately 11,000 children and 37,000 adults*	*Fragmentation between mental health, chemical dependency, and health care systems (including dental care)*	*Redesign primary care, behavioral health, and dental care practice models to integrate clinical services through combination of clinical, structural, and financing changes*	*Co-Convener with County Human Services and United Way* *Funder*

Sub-populations and System Change Examples

Sub-Population	Estimated Pop Size	Reasons for Access Limitations	Examples of System Change Levers	Public Health Roles
		Lack of state funding for Basic Health Plan (BHP)	*Increase Basic Health Plan slots*	*Advocate*
		Lack of outreach/enrollment assistance for eligible people for available BHP slots	*Implement outreach/enrollment capacity in multiple safety net sectors, e.g., affordable housing, food banks, etc.*	*Co-Convener with County Human Services and United Way* *Funder*
Working Poor	*7% of King County residents: approximately 127,800*	*Employer does not provide health insurance or individuals cannot afford to purchase the insurance made available by their employer*	*Implement system-level incentives to increase employer health insurance for low-wage workers, e.g., voluntary subsidies to small businesses (either all or target those that are pay low wages, are seasonal, or part-time)*	*Advocate*
			Subsidize premiums for individuals with high expected or actual medical costs through Washington State Health Insurance Pool	*Advocate*
		Employee's wages insufficient to enable self-insurance	*Implement financial incentives for individual to purchase insurance (tax credits, vouchers, other subsidies)*	*Advocate*
		Lack of available slots in Basic Health Plan	*Increase BHP slots*	*Advocate*
		Lack of insurance during job transitions	*Subsidize COBRA premiums for individuals and families during job changes*	*Advocate*

Sub-populations and System Change Examples

Sub-Population	Estimated Pop Size	Reasons for Access Limitations	Examples of System Change Levers	Public Health Roles
		Lack access to specialty care (medical and surgical)	*Redesign financing model*	*Convener with health care sector* *Partner with King County project Access, PHPDA, CHC/PSNHC/PH Clinics*
			Encourage private sector to provide specialty care by assisting with case management and/or paperwork	*Convener with health care sector* *Partner with King County project Access, PHPDA, CHC/PSNHC/PH Clinics to design a workable specialty referral process (and to recruit physicians to voluntarily provide care free of charge*
Undocumented individuals (working and non-working)		*Medicaid restrictions due to lack of citizenship*	*Improve outreach at safety net health care sites and at community organizations where such individuals gather*	*Provider* *Administrator*
		Language barriers	*Improve interpretation and translation services*	
All Under/Uninsured	*178,000 uninsured adults 18-64* *63,000 Medicaid* *Others with inadequate insurance*	*Provider reimbursement is inadequate*	*Create matching fund program to cover care among participating health care and dental providers*	*Advocate*
			Create uncompensated care pools to enhance revenues for medical and dental providers disproportionately serving uninsured clients (either internal financing with pooled hospital charity care resources or external	*Advocate for state-level program* *Funder for county-level program*

Sub-Population	Estimated Pop Size	Reasons for Access Limitations	Examples of System Change Levers	Public Health Roles
			funding such as dedicated tax revenue distributed based on care to uninsured)	

Sub-populations and System Change Examples

Sub-Population	Estimated Pop Size	Reasons for Access Limitations	Examples of System Change Levers	Public Health Roles
			Create tax credit for non-profit hospitals serving the uninsured	*Advocate for state-level program*
		Inability to purchase minimal insurance	*Universal catastrophic coverage*	*Advocate*
		Lack access to specialty care (medical and surgical)	*Redesign financing model*	*Convener with health care sector*
			Encourage private sector to provide specialty care by assisting with case management and/or paperwork	*Convener with health care sector*
			Encourage private sector to provide dental care by assisting with case management and/or paperwork	*Convener with dental sector*
		Less than optimal efficiency of operations at safety net health care centers	*Implement state-of-the art electronic medical records and practice management technologies (similar to Oregon Community Health Information Network and San Diego Wireless System)*	*Advocate* *Partner*
			Build local constituency for improved health care services, including employers, local governments, school districts, etc.	*Convener*
All children without health care coverage	*14,900*	*Lack of Basic Health Plan and Medicaid funding*	*Outreach and enrollment in eligible programs*	*Convener, funder, and implementer*

Appendix II

Potential Systems and Organizations to Assist in the Establishment of an Ongoing Health Care Access and Capacity Assessment

System/Organization	Data Sources
Public Health - Seattle & King County	*Health care system, assessment processes, primary care provision*
Local jurisdictions (e.g., City of Bellevue, City of Kent)	*Sub-regional trends, access, resources, gaps*
King County Community & Human Services	*Behavioral health, broader safety net issues and services, developmental disabilities, veterans services*
United Way	*Broader safety net, resource issues*
State of Washington ▪ *Health Care Authority* ▪ *Health Resource Services Admin* ▪ *Department of Health* ▪ *Office of the Insurance Commissioner* ▪ *Office of Financial Management*	*Insurance coverage, including Medicaid, BHP, children's programs* *Strategies for enhancing capacity*
Health Care System ▪ *Primary care (including medical care,* ▪ *dental care, behavioral health),* ▪ *specialty, hospital representatives* ▪ *Puget Sound Health Alliance* ▪ *Health Plans* ▪ *VA Puget Sound Health Care System*	*Current capacity and service delivery approaches for publicly-funded and privately-financed systems* *Emergency room data*
University of Washington ▪ *School of Public Health* ▪ *and Community Medicine* ▪ *School of Medicine* ▪ *School of Dentistry*	*Role of health care systems in addressing access challenges* *Access issues for different populations*
King County's criminal justice system	*Health access issues for incarcerated individuals and those leaving criminal justice facilities*
Puget Sound Educational Service District *Seattle School District*	*Access issues impacting school- age children, health care services provided by schools*
Employers	*Workforce health issues and risks, access and insurance*
Sound Transit *Puget Sound Regional Council*	*Patterns in transportation, place of residence, access to care*
Private foundations ▪ *Washington Dental Foundation*	*Current capacity, financing*

Appendix III

Potential Systems and Organizations to Assist in the Development of Strategies to Improve Access and Capacity

System/Organization	Resources and Expertise
Public Health – Seattle & King County	*Health care system, assessment processes, primary care provision*
King County Community and Human Services	*Behavioral health, broader safety net issues and services, developmental disabilities, veterans services*
United Way	*Broader safety net, resource issues*
State of Washington ▪ *Department of Health* ▪ *Health Care Authority* ▪ *Health Resource Services Admin (?)* ▪ *Office of Financial Management*	*Insurance coverage, including Medicaid, BHP, children's programs* *Strategies for enhancing capacity*
Health Care System ▪ *Primary care (including medical care, dental care, behavioral health), specialty, hospital representatives* ▪ *Pacific Hospital Preservation & Development Authority (PHPDA)-for specialty access* ▪ *King County Project Access* ▪ *Puget Sound Health Alliance* ▪ *Health Plans* ▪ *Veterans Administration*	*Current capacity and service delivery approaches*
University of Washington ▪ *Schools of Public Health and Community Medicine, Dentistry, and Nursing*	*Health care systems* *Access issues*
Health care consumers	*Patterns of access, needs, gaps*

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VIII: Milne & Associates: Phase I Stakeholder Interview Report

Stakeholder Interview Report
Prepared by Milne & Associates, LLC
April 12, 2006

Executive Summary

King County contracted with Milne & Associates, LLC, to assist in producing a Public Health Operational Master Plan for Public Health-Seattle & King County (PHSKC).

- One of the early deliverables in the project (Deliverable E) is the production of a report reflecting initial stakeholder input, collected and analyzed according to an approved plan for soliciting input from a variety of local public health system stakeholders. This report documents the early engagement of stakeholders in the first phase of the project.

- The following purposes were accomplished during this initial engagement with selected stakeholders:
    1. To introduce the stakeholders to the OMP process
    2. To solicit initial opinions about broad policy related issues.
    3. To encourage their continued participation in the OMP process.
- Four categories of stakeholders were interviewed in accord with the approved plan: elected officials and their staff; selected community provider partners; PHSKC leadership and staff; and government partners, including federal, state and local entities.
- Open ended questions exploring general categories and using similar formats for overall consistency were used, allowing for variations tailored to each category of interviewee. There was no intention to analyze the input statistically; rather, the emphasis was on introducing the concept of the OMP, encouraging further engagement and listening for broad policy-related themes.

Themes among Stakeholder Opinions: Within the context of the methods used, the following themes among the stakeholder opinions could be discerned.

1. Potential positive outcomes of the OMP process

- Real potential exists for broad community support and more stable investments.
- This is an opportunity to explore the changing and expanded role of public health in the face of new challenges while at the same time rediscovering the historical roots of public health in promoting health and social justice.
- The process should build on PHSKC's role and widely respected capability to organize data into information and shine a light on key issues.
- The role of public health as convener and catalyst in support of community-based providers, system development and improvement should be expanded during and as a result of the OMP process.

2. Governance and policy development

- Achieving agreement on a broad policy framework will require clarity of roles and mechanisms for building trust among all players.
- Decision makers have a perceived need for objective information which is based on good science. Data needs to drive system policy more often.
- Engagement with the public is recommended before making policy decisions
- Improved relationships and communication among each of the cities and the County should confirm a common understanding about King County's responsibility under state law for governing and funding regional public health services.
- Cities have an interest in influencing policy related to public health services and practice because their residents benefit when the services are coordinated with other municipal services and because their residents are paying taxes (federal, sate and local) which make their way to the county for public health services.
- No magic bullet for funding is evident; a combination of strategies will likely be needed to achieve sustainable and flexible investments in public health.
- The Board of Health should play a more significant role in setting public health policy.
- The role of the Board of Health is confusing to many stakeholders.

3. General Challenges and Opportunities for Improvement

- There is a need for further clarity and agreement of what constitutes the public health system.
- Discussion is needed about how to measure results and hold the public health department and system partners accountable.
- PHSKC needs to be more nimble to respond effectively to rapidly changing environments.
- There is a general need for improved transparency and trust throughout the public health system.

Conclusions:

1. Very few definitive conclusions can be reached from this first cycle of stakeholder interviews. Those would include:

    - A high level of enthusiasm, concern and commitment to improvement
    - Consistent agreement that the Operational Master Plan process could assist in formulating public health's critical core mission and establish a value-based and need-driven health agenda
    - A spirit of support for improving the condition of the county's public health system
    - General commitment to work together with PHSKC to address the challenges faced in the community

2. No other definitive conclusions related to policy should be made as a result of this initial engagement. There are several reasons for this including: the intent of the interview and the methods used; questions were open-ended and exploratory in nature; more stakeholders need to be and will be engaged as the project proceeds; and neither time nor resources permitted detailed follow up and validation of the facts related to the opinions expressed.

3. The themes identified have value in guiding the methods in the next steps of the project and in identifying areas for possible future exploration.

4. Follow-up of the initial interviews should help build relationships and trust through the deliberate use of open communication.

Recommendations for next steps in the OMP project

1. Use the stakeholder process to build relationships and trust in the OMP process and outcomes.

   a. Consider circulating this draft report back to the interviewed stakeholders.
   b. Shift the future process of stakeholder engagement to a combination of soliciting written feedback, targeted surveys and focus group dialogue about specific points to obtain needed clarification.

2. Focus future inquiries on:
   a. Articulating what is working well and recommending policies, funding options and implementation options which assure that those strengths are maintained (and expanded as appropriate).
   b. Exploring how PHSKC's role in providing information, convening critical players and catalyzing positive action of the whole system for health can be enhanced.
   c. Clarifying the important role of the governing bodies and the executives in support of the convening role for the Department.
   d. Exploring and clarifying as appropriate the general challenges and opportunities for improvement listed above and in the body of this report.

Introduction

- King County contracted with Milne & Associates, LLC, to assist in producing a Public Health Operational Master Plan. One of the early deliverables in the project (Deliverable E) is production of a report reflecting initial stakeholder input, collected and analyzed pursuant to an approved plan for soliciting input from a variety of local public health system stakeholders.

- To assure that the two principal deliverables for this project – the policy framework and the operational master plan -- are maximally useful in guiding efforts to strengthen the local public health system in King County, stakeholder involvement has been honored and carefully considered. While significant focus was spent in engaging stakeholders during this phase, this report reflects only the beginning stages of stakeholder engagement and is not intended to imply this is a scientifically rigorous process for capturing all significant opinions of stakeholders and the public at large. Continued and more targeted stakeholder input will occur in Phase II of the project. However, resources available for this project do not allow for a rigorous process to test validity of stakeholder input. Rather, it is the intent of the stakeholder process to engage, build trust and keep communications open. More in-depth stakeholder involvement will require significant collaboration with the leadership and staff of PHSKC.

- The three purposes of the initial stakeholder interviews were:
    1. To introduce the stakeholders to the OMP process
    2. To solicit initial opinions about broad policy related issues.
    3. To encourage their continued participation in the OMP process.

In our judgment, all three purposes were accomplished, owing to the excellent work of Toni Rezab and the team of staff coordinating the project, to the flexibility and availability of the consultant team, and particularly to the conscientious participation of the stakeholder interviewees. Very busy people gave enthusiastically of their time and ideas in the context of a very tight timeframe. We trust you will find this report reflects the diverse views collected.

Please note: The Stakeholder Report should be viewed as a dynamic product reflecting information received to-date. A continuing flow of meetings, conversations, documents and new information is expected during the life of this project. Information is continuing to come in; further meetings are being scheduled in Phase II. The insights reflected in this

report will continue to evolve as stakeholders inform funding and implementation recommendations in the next phase of the project.

Process Used

- The method and schedule for stakeholder input developed by Milne & Associates (Project Deliverable D) was approved by the steering committee for the project in 2005. Four broad categories of stakeholders were included in the plan – elected officials, community partners, Public Health – Seattle & King County (PHSKC) staff, and governmental partners at the federal, state and local levels. Steering committee members as well as King County staff suggested several specific stakeholders to be interviewed. Additional contacts were identified as the interviews began.

- All interviews were conducted at locations convenient to the stakeholders, with at least one member of M&A present. In many instances additional M&A members participated, either in person or by telephone. An interview protocol was developed for each category of stakeholder; all questions were linked across the categories to assure a degree of consistency to the inquiry. Participants were assured that the content of the interviews would be confidential and that no specific comment would be attributed to individual participants. Opportunities to provide written comments were given to staff and other stakeholders who were unable to participate in oral interviews. An example of the interview protocols used is found in Attachment A.

- Detailed notes of all stakeholder interviews were made. The notes were reviewed for accuracy, and broad themes reflecting the comments were identified. Initially, a matrix was developed to place summarized, non-duplicative comment into each of the categories (y axis) by each of the four categories of stakeholders (x axis). Ultimately we exercised judgment to aggregate 14 categories of comments into 3: potential positive OMP outcomes, governance and policy development, and challenges and opportunities for improvement.

- While most of the interviews included in this report began in early February 2006 and concluded on March 22nd, a few were conducted between November 2005 and January 2006. We informed each interviewee that additional opportunities for input into the OMP process would be available during Phase II.

Results

The following table summarizes data related to the stakeholder interviews held during Phase I of the project.

Categories	Elected Officials and staff	Community Partners	PHSKC	Fed, State, Local Gov Partners	Total
Number of meetings	14	10	6	4	34
Participants (live & by telephone)	46	64	100 (approx)	15	225 (approx)
Written responses	2	5	8	4	19

Findings

The 34 meetings with over 200 participants yielded a great deal of information. Opinions ranged from highly supportive of what PHSKC does within the county to specific criticism about how things are done and recommendations about new approaches or ideas that should be considered. As with any process that seeks opinions in an open-ended fashion, some of the opinions were contradictory of other opinions on the same topic. Even highly critical comments were typically tempered with praiseworthy comments about the dedication, high caliber and competence of PHSKC professionals and were offered in the spirit of seeking improvement in the system.

The recorded opinions were initially clustered into topical areas and then organized into three general categories.

Topical Areas:

- Ideal outcome of OMP
- Significant health issues
- Policy development
- Improvement, opportunities & measurement
- Core mission of PHSKC
- Primary care safety net
- BOH
- Funding options
- Funding issues
- Preparedness
- Population based & prevention services
- Political environment
- Relationships
- Values

General Categories

1. Potential positive OMP outcomes: observations that provide a foundation for having optimism about the potential positive outcome of the OMP process.
2. Governance and policy development: opinions about governance and policy development
3. Challenges and opportunities for improvement: suggestions for improvement

It is not possible to record every observation that was made but we used our judgment in an attempt to note comments which were shared by many types of stakeholders (often with great intensity)and which should be explored further and possibly addressed in subsequent steps of the project.

1. Potential positive outcomes of the OMP process

A. Enthusiastic support for OMP Process: The combination of the enthusiasm of the participants and their focus on important large issues as desired outcomes from the OMP bodes well for the potential of the project.

   1. Most see the OMP as an opportunity to achieve agreement on public health's core mission and establish a value-based and need-driven public health agenda-an agenda that has focus, broad community support and attracts stable funding.
   2. Public health system partners, the county and PHSKC all want healthy communities and see the OMP as an important step to making that possible.
   3. The OMP is seen as an opportunity to explore the changing and expanded role of public health in face of new challenges and at the same time rediscover the historical roots of public health in social justice.
   4. Representatives of cities in the county expressed interest in the OMP as a means of influencing public health services and practice. In particular, the City of Seattle's public health policy guidance specifically cites the need to link its policies and support to the eventual outcome of the OMP.
   5. Participants saw a critical need to make investments based on present and future needs, and to explicitly link those investments to programs with accountability for a specific mission.

B. Opportunity to clarify the role and function of PHSKC

1. *Importance of Population-based Services Recognized*: It is widely recognized that public health must serve the entire population of the county. It is widely appreciated that PHSKC has a renewed focus on being culturally competent and focusing on health disparities. The stakeholders value an emphasis on prevention and prevention-based approaches with a population strategy linked to social justice. There is recognition that efforts to improve the population's health must be broad and community-based. Examples of system improvements suggested include:
   - A focus on shared issues such as education in schools and child health
   - regional communication
   - best practices
   - new models for environmental health (precautionary principle)
   - cultural competence standards (internally and externally)
   - expanded involvement in policy issues such as housing
2. *Epidemiology Critically Important*: King County is seen as a county within the state where epidemiology, the bedrock professional discipline of public health, is uniquely valued and deserving of secure funding.
3. *PHSKC as a Convener*: A major contribution of PHSKC to creating the conditions to be healthy is its outstanding ability to organize data into information and, as an honest broker, to shine a light on key issues and bring stakeholders together to find solutions. The role of public health as convener, source of information, and catalyst for action for providers, community centers and all system partners is strongly endorsed.
4. *Recognized Leader in Preparedness*: In the area of PH preparedness, King County and PHSKC are recognized as essential partners and on the forefront of innovative practices and proactive national leadership. Recent natural disasters have pointed out the need for highly competent local coordination of the health related resources in emergency planning and response.
5. *Safety Net*: Many felt the OMP provides an opportunity to better define who should do what in providing a safety net of primary care services, addressing the shortfall in specialty referral services for the underinsured and better integrating the strong services of PHSKC (such as newborn home visits, nutritional assistance, immunization and infectious disease services) with services provided by community primary care partners. The OMP was seen

by several as an opportunity to clarify PHSKC's role in directly providing safety net services.

6. *Health Impact Statements*: Some stakeholders proposed consideration of health impact statements for major policy decisions, even those which may not be easily recognized as having health implications. There is a growing trend in local jurisdictions to develop "Health impact assessment" statements for new land use decisions, analogous to "environmental impact statement." Health impact assessment statements may be a powerful tool to expand discussions beyond the traditional, supporting consideration of other important issues by asking broader design questions earlier in the process.
7. *Public health should take opportunities to be involved in more* policy issues such as housing (indoor air quality, mold prevention etc).
8. *Recognition of Good Management-Labor Relations*: Management and the unions have worked well together, communicate well, and use interest-based negotiations to solve problems.

2. Governance and policy development

A. Need for Policy Framework Recognized: There is a serious need for just the type of policy framework called for within the OMP. Stakeholders are concerned that current decision making, priority setting and resource allocation have not resulted in a focus clear enough to assure that coordinated policies and interventions are in place for county residents. An overarching policy framework also will help decision makers' efforts to provide more stable funding with an eye toward long-term return on investment.

B. Need to Clarify Roles and Build Trust: Achieving agreement among public and private stakeholders will require clarity of roles and mechanisms for building trust among all players. Decision makers need objective information based on good science. Data needs to drive future policy decisions aimed at improving the system's capacity to improve population health. More engagement with the affected public is recommended before moving toward making policy decisions.

C. Need for Improved Cities-County Relationships: Improved relationships and communications among each of the cities and the county should confirm a common understanding about King County's responsibility under state law for governing and funding regional public health services. Some feel that those paying the bills should be responsible for policy. At the same time, cities have interest in influencing public health services and practice because residents are paying taxes that make their way to the county. The joint agreement

and relationship between the City of Seattle and the county around public health requires attention. Both parties have similar values and common interests. State law states that public health is primarily a county responsibility. About one-third of county residents live in the City of Seattle, which does contribute public health funding. Consideration should be given to reconvening the joint committee called for in the agreement between the city and county.

D. Desire by Board of Health to be Actively Engaged: The Board of Health is interested in engaging the community in public health issues and playing a more active role in setting the agenda for health in the county and helping to align the interests of the cities with that agenda. The Board of Health was seen as having the potential to contribute significant value to policy development beyond its roles as a discussion forum and a body that sets fees and approves regulations. As a regional body with representation of elected officials from multiple jurisdictions and non-elected professionals, it brings varied insights and perspectives and can strengthen the voice for the public's health and can help find common ground. Many suggestions surfaced about the interests, functioning and role of the Board of Health (BOH) including:
   1. More connection with the budget process and approval.
   2. BOH appointments for suburban cities should be made by the suburban cities
   3. Should be involved in the selection process of new director
   4. Should be a collaboration builder
   5. More active in setting PHSKC direction
   6. Use information & community organizing to affect policy
   7. Conduct hearings around county
   8. Regional forum needed (suburban cities feel shut out of policy process/decisions)
   9. With decreasing funding perhaps suburban cities should contribute
   10. Address the question "what are the values that are being used to make decisions affecting the public's health?"

E. Need for Greater Public Health Advocacy/Leadership: Public health needs to be more proactive in setting agendas (including legislative and fiscal) and more of a leader in those areas, focusing on unmet needs in an anticipatory/proactive way. Stakeholders stated, "We are in a health crisis," and greater advocacy and leadership is needed on health issues. The public needs education about the major health challenges facing King County.

F. Clarify Department's Role in the Safety Net: Policy makers need clear and consistent data about the complex issues regarding uninsured, Medicare, Medicaid, and other health access issues. But they also need

a deeper understanding that coverage doesn't always equate to access or improved health status. Other issues such as transportation, poverty, language and culture often create barriers and can be greater influencers of poor health status. Policy makers themselves feel they need a clearer picture of public health's role in addressing the primary care safety net issue as well as the funding to support that role. They wonder about duplication of services (e.g., primary care, family planning). They believe that PHSKC should continue in the role of the convener to address the safety net issue.

G. Expand Public Health Boundaries: Policy efforts need to span boundaries beyond which public health typically or traditionally has not been involved. Some of the initial work between public health and the design community around the built environment should be sustained and expanded.

H. Importance of Relationship to UW and Other Academic Institutions: The relationships of the county and PHSKC with all the health-related schools of the University of Washington and with other academic institutions is of critical importance for several reasons:
   1. Joint appointments assist in recruitment.
   2. Innovative public health research and new strategies will more likely happen.
   3. Student interns are attracted to future employment.
   4. The health department can be the active training environment for students.
   5. Joint advocacy could be expanded at the state and federal levels

I. Funding: Several suggestions or observations were offered about funding:

   1. Talk with King County Foundation
   2. King County /PHSKC and cities should consider playing a larger role in state-level policy development
   3. A regional system with regional funding is needed to support the infrastructure necessary to respond to public health emergencies
   4. Local funding should be maximally used to support needed infrastructure
   5. Community collaborations can sometimes cobble together resources that provide services to community for 5-7 years
   6. Taxes are a potential solution
   7. Public Health Roundtable is addressing funding on a state-wide basis
   8. One legislator is interested in funding bird flu (while support for public health is helpful not useful for building capacity)

9. PHSKC expertise could be helpful in figuring how to move new money into ongoing capacity
10. Federal move to fund more mental health may be opportunity to address PH implications
11. With collaborative participation, opportunities for salary support from UW entities.
12. Federal funding is generally very threatened due to the deficit and constraint on discretionary spending
13. Public health is holding on to the notion of backfilling for MVET funds but the legislature has turned over-new legislators are questioning why there should be "string-free" funding. The public health case needs to be sold
14. To stabilize public health infrastructure, the county should consider levy of county-wide tax (there is no public health levy but as there is for mental health)

3. Challenges and Opportunities for Improvement

Several challenges facing public health in general and PHSKC in particular were identified by all four categories of stakeholders (including leadership and staff of PHSKC). When these challenges or criticisms were offered, they were offered in the spirit of improving the system and in recognition that public health and many of its partners are under significant stress due to expanding expectations and shrinking resources. They should be read with that in mind.

A. Health System Challenges: The following opinions were stated in a way which implied that they apply universally to public health in almost any community. They reflect, however, a challenge for PHSKC because they characterize the environment in which public health must be practiced:

1. Role/Definition of Public Health in a Dynamic Environment

- Need clarity and agreement on what constitutes the public health system in King County
- Need to build adequate public health capacity, including facilities, staffing, leadership and management for the future
- Need to recognize that some personal health services are also becoming population health services. For example, tuberculosis treatment is typically a personal health care interaction between a physician and a patient, but during an outbreak tuberculosis treatment can become a population health issue because untreated patients can spread the disease further.

- A better job of promoting the value of a healthy community to all needs to be done
- Public health needs to be much more nimble to deal with change

2. Funding

- Need adequate funding for and recognition of the value of population-based (upstream) prevention
- There is inadequate funding to address basic public health needs and to support infrastructure
- Foundation and federal funding have less security and predictability
- A majority of local taxes go to criminal justice activities
- Health care reimbursement/payment systems are slow and affect department cash flow
- Federal cuts, especially in Medicaid, will disproportionately affect King County.
- Federal centralization of decision-making, the continued focus on categorical funding, federal budget deficit, federal focus on security threats—all these pose significant continuing risks to overall public health funding from several federal agencies and erosion of support for basic infrastructure.
- There is no magic bullet for funding

3. *Partnerships/Coordination*

- There is a need for a coordinated effort to address broad health needs of the community, one where the process is clear, and collaboration is practiced.
- System partners and providers ought to be more informed about public health issues than the general public.
- The Institute of Medicine recommends greater communication with the public, legislature, and business by public health officials; regular stories about public health are needed in local media,

4. *Measurement*

- There is a need to measure differences being made in health outcomes and to determine how hold public health and system partners more accountable to achieving such outcomes.

- The effectiveness of approaches being used in public health practice should be evaluated.
- Evidence-based practices should be balanced with innovation, allowing new ideas and risks to be taken.

B. Local Health Challenges

The following opinions applied more directly to the local situation of King County and PHSKC but it must be emphasized that it was not possible to conduct follow-up to verify the details. Nevertheless, these opinions offer some insight into local challenges:

1. *Community/Regional Services with Partnerships/Collaboration*

- The concept of regional services is viewed by some as an opportunity for cities to opt out of responsibility for public health.
- There is a need a community engagement plan which connects PHSKC with the whole community.
- PHSKC needs to improve working relationships and coordination with system partners.
- PHSKC sometimes over-emphasizes their uniqueness in serving a large urban area compared to other health departments in the state, which keeps them from joining forces with other counties in the state. This uniqueness is fading as growth in other counties increases.
- Core services throughout the county need to be assured by PHSKC, with all communities contributing for additional services.
- Obesity and diabetes have huge regional economic implications.
- King County is seen as potential hotbed for security risks.

2. *Safety Net*

- Need to use bully pulpit to shine a light on the problem of access to specialty care
- Need to determine the role of public health in convening, advocating and assuring care vs. providing
- Need improvement in the safety net with focus on regional or state wide approaches

- Some stakeholders voiced a concern that PHSKC is in direct competition with other primary care safety net providers, creating a conflict of interest in providing oversight when they also compete for funds. Other stakeholders did not share this view

3. *Relationships/Trust:*
   - Trust is an issue; some feel PHSKC is self-serving bureaucracy with emphasis on protecting its programs
   - Relationship building needed. There is an opportunity to rebuild trust through new leadership of PHSKC
   - There is tension between cities and the county. The current structure decreased direct connection of City of Seattle to public health as well as the visibility of public health at the city
   - Relationships with the state legislature is not as good as it could be
   - Tension between county executive branch and legislative branch is visible and has an impact on public health
   - More trust needs to be built between PHSKC and the state Department of Health and local community health centers.
   - Improved relationships and trust are needed to understand the changes in South King County's population (greater number of poor, increase in problems); there is much higher mortality in South King County
4. *Workforce*
   - Some PHSKC employees commented that employees don't think of themselves as public servants, "We need to get out of our trenches to see, do and be public servants."
   - PHSKC needs to understand workforce issues, anticipate problems and plan for them
5. *Measurement*
   - Measuring effectiveness, who/how to hold accountable especially in the community system, is critical.
   - Consistent measurement of key statewide data (including fiscal) is essential
6. *Funding*
   - Encourage PHSKC to get out of categorical funding.

- The escalating cost of property impacts access issues through inability to afford location.
- Money is not the only issue; priorities need to be limited to a handful.
- PHSKC hasn't always followed through with getting resources they are eligible for (e.g. missed this years "drop-dead" date for state funding and lost funds as a consequence).
- Need a fair/equitable tax/funding system.
- The PHSKC budget is very complex, made more so with a large number of categorical grants.
- Chasing dollars may be necessary but can take away from the core public health mission.
- Cities feel they already contribute through their collection and remittance of property tax and sales tax.
- Because most community health center clients are from Seattle, there is a need for the funding entities to work well together.
- Funding must follow policy decisions or the OMP is for naught.
- Regional entities including suburban cities that currently do not directly support public health should contribute financially

Implications for next steps in the OMP project

In general, we recommend using the stakeholder process during the next phase of the project to improve relationships and continue to build trust.

1. We recommend that the Steering Committee consider circulating this draft report to solicit comments before transmitting it to the Board of Health and Council. Sharing the initial work early in this process and securing feedback will improve the work product while building trust, understanding of and enthusiasm for the OMP process.
2. We recommend that the process of stakeholder engagement shift its methods for the next steps in the OMP process. The initial method employed individual/group interviews structured in an open-ended format. We suggest shifting to a combination of soliciting written feedback, targeted surveys and focus group dialogue about specific points which have emerged, thus providing opportunities to clarify and/or get further information about key issues.

3. We recommend that the project fully use the OMP page on the County's website both as a source of updated information and as a mechanism to solicit comments from the public.
4. We recommend expanding the circles of stakeholders by the methods described in #2 and #3 above. The Steering Committee can assure that some key stakeholders who could not be engaged in the initial interviews (multiple community coalitions, diversity/minority groups, school systems, business and labor leaders, advocacy groups associated with public health service clients, and others) will have a voice that is heard in the process.
5. The focus of future inquiries should reflect the work summarized in this report. This would include examination of systems and approaches that are working well and recommend policies, funding options and implementation options needed to assure that those strengths are maintained (and expanded as appropriate). In addition, additional stakeholder perspectives are needed about the PHSKC role in providing information, convening critical players and catalyzing positive action of the larger public health system. Also important is clarifying the critical role of governing bodies and policy makers in support of this role for the Department. Lastly, some of the challenges and opportunities identified in the last section of this report warrant exploration during Phase II.

In conclusion, we acknowledge all those that contributed to this report by sharing their thoughts, concerns and hopes for a healthy King County. The commitment to improvement is consistent and provides reason for optimism as we enter Phase II. We look forward to continued engagement and work on this critically important project.

Attachment A
List of Interview Questions

Questions for Community Partners

Context for questions
- Health Environment
- Role Definition
- Funding/Policy
- Other

Health Environment
- What key public health issues do you see most impacting the health of King County in the next two or three generations?
- What key issues do you see most impacting your operations in the next decade?
- What opportunities do you see that the public health system might better collaborate on to create healthy communities? ….and with who?

Role Definition
- What do you see as critical roles for public health and the public health department?
- Describe the ideal public health system and how your (and public health's) role and relationships would be. What changes are needed to work toward the ideal?

Funding/Policy
- How do current funding policies and practices serve or not serve to improve the public's health status?
- How does current funding meet the responsibilities of public health…or not?
- What changes in funding would best serve the public's health?
- What opportunities to you see that need to be pursued?

Other
- How should population-based services be sustained?
- How might the public health system be more effective in improving the public's health status? How might community partners help?
- Is there anything more to say?

Questions for Elected Officials

Overarching
- What is your interest in public health?
- What outcome is most needed from the PHOMP process?

Role Definition
- What do you see as the critical roles for public health?
- What do you see as the core roles of an elected official?
- Is the role, responsibility or perspective of elected officials in transition? Please explain.

Policy Environment
- What works and doesn't work regarding the current environment surrounding policy development and enforcement?
- What is the scope of elected official's role in policy development? Should the scope change? Why or why not?
- What changes in policy do see needed? Why?

Funding
- How is current funding determined for public health? What is the impact short and long term for sticking with current practice.
- How does current funding meet the responsibilities of public health…or not?
- What changes in funding would best serve the public's health?

Health Environment
- What are the primary changes that have impacted public health in the last 5 years?
- What key public health issues do you see most impacting the health of the next two to three generations?

Other
- How are the varied interests addressed without compromising the public's health?
- What hasn't been asked that is important?
- Is there anything more to say?

Questions for Board of Health

Context for questions
- Overarching
- Role Definition
- Policy Environment
- Funding
- Health Environment
- Other

Overarching
- What is the BOH's interest in public health?
- What outcome is most needed from the PHOMP process?

Role Definition
- What do you see as the critical roles for public health?
- What do you see as the core roles of the BOH?
- Is the role of the BOH in transition? Please explain.

Policy Environment
- What works and doesn't work regarding the current environment surrounding policy development and enforcement?
- What is the scope of BOH's role in policy development? Should the scope change? Why or why not?
- What changes in policy do see needed? Why?

Funding
- How is current funding determined for public health? What is the impact short and long term for sticking with current practice.
- How does current funding meet the responsibilities of public health…or not?
- What changes in funding would best serve the public's health?

Health Environment
- What are the primary changes that have impacted public health in the last 5 years?
- What key public health issues do you see most impacting the health of the next two to three generations?

Other
- How are the varied interests addressed without compromising the public's health?
- What hasn't been asked that is important?
- Is there anything more to say?

Questions for Academia

Context for questions
- Overarching
- Role Definition
- Policy Environment
- Funding
- Health Environment
- Other

Overarching
- What outcome is most needed from the PHOMP process?

Role Definition
- What do you see as critical roles for public health?
- Describe the ideal public health system and how your (and public health's) role and relationships would be. What changes are needed to work toward the ideal?

Policy Environment
- What do you see as public health's role in policy development and enforcement?
- What changes in policy do see needed? Why?

Funding
- How do current funding policies and practices serve or not serve to improve the public's health status?
- How does current funding meet the responsibilities of public health…or not?
- What changes in funding would best serve the public's health?

Health Environment
- What key public health issues do you see most impacting the health of the next two or three generations?
- What opportunities do you see that public health might collaborate on to create healthy communities? ….and with who?

Other
- How should population based services be sustained?
- How might the public health system be more effective in improving the public's health status? How might academia help?
- Is there anything more to say?

Questions for Health Care Providers & Partners

Context for questions

- Overarching
- Role Definition
- Policy Environment
- Funding
- Health Environment
- Other

Overarching

- What outcome is most needed from the PHOMP process?

Role Definition

- What do you see as critical roles for public health?
- How do you see the medical care system's role and public health's role over lapping? How are they different? What would an ideal balance look like?

Policy Environment

- What do you see as public health's role in policy development and enforcement?
- What changes in policy do see needed? Why?

Funding

- How do current funding policies and practices serve or not serve to improve the public's health status?
- How does current funding meet the responsibilities of public health…or not?
- What changes in funding would best serve the public's health?

Health Environment

- What key public health issues do you see most impacting the health of the next two or three generations?
- What opportunities do you see that medical care and public health might collaborate on to create healthy communities?

Other

- How should population based services be sustained?
- How might the health care system and public health be more effective in improving the public's health status?
- Is there anything more to say?

Attachment B
List of Stakeholders Interviewed

Meeting list:

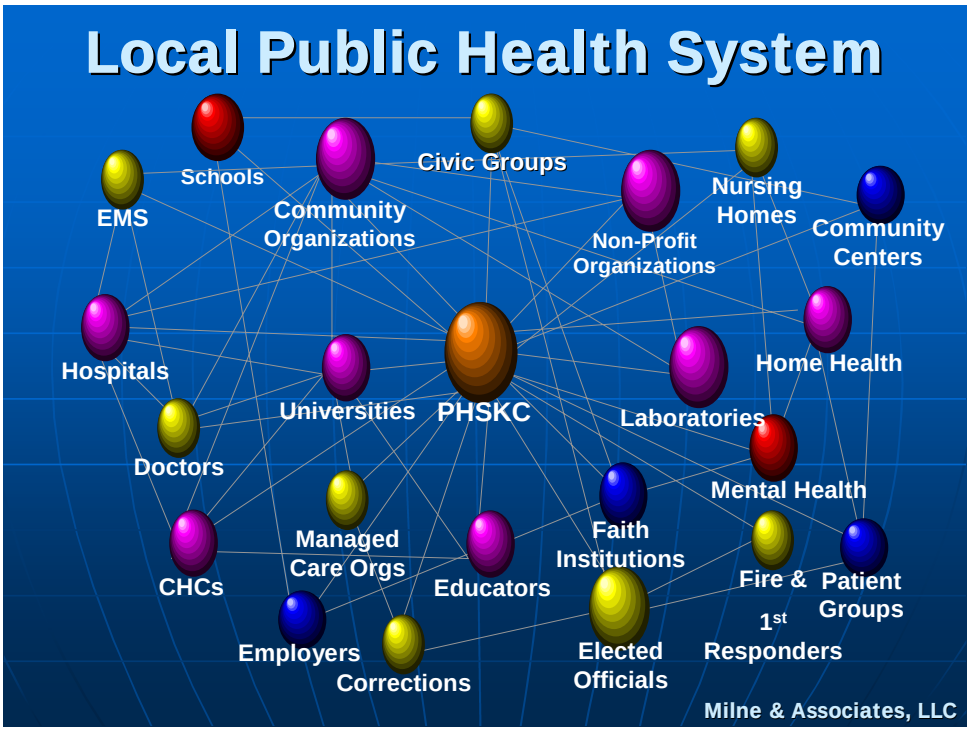
1. PHOMP Steering Committee (1:1's)
2. PHOMP Project Staff
3. King County Executive
4. City of Seattle Mayor
5. King County Council (8 – the only member not met with is von Reichbauer)
6. King County Council staff
7. Seattle Council (3)
8. Board of Health – (all 13 members were interviewed)
9. Harborview (2 meetings)-Three senior executive
10. Harborview Board (1 meeting)Nine in attendance
11. All PH Labor Unions were invited but only 1 showed up
12. City of Bellevue Leadership Group
13. Community Health Clinics Board
14. Seattle Human Services Department
15. University of Washington – Dean of Medicine, Dean of Nursing, Dean of Public Health
16. State Department of Health
17. South End Cities/Provider Meetings – invited were:
    a. Cities of Covington, Burien, Renton, Auburn, Kent
    b. Highline School District
    c. Providers: Holy Spirit, Children Therapy, and Valley Cities Counseling and Consultation
18. North East King County Cities/Providers Meetings – invited were:
    a. Cities of North Bend, Shoreline, Redmond, Mercer Island, Kirkland, Duvall
    b. Providers: Hopelink, Mt. Si Senior Center, Evergreen Health Care
19. Public Health Against Institutional Racism-Ph health staff group
20. Health of King County Staff
21. Public Health Employees (leadership group, expert meeting, plus written and verbal comments)
22. Patrick O'Carroll – HHS Regional Health administrator
23. Environmental Health – PHSKC staff and partners
    a. Steve Gilbert, Director, Institute for Neurotoxicology and Neurological Disorders (and UW)
    b. Ken Armstrong, Administrator, Local Hazardous Waste Management Program in King County
    c. Dave Galvin, Hazardous Waste Program Manager, King Co. DNRP, WLRD
    d. Bill Lawrence, Environmental Hazards Section Manager, PHSKC
    e. Ryan Kellogg, Public Health - Environmental Health

f. Carolyn Comeau, Program Manager , WA State Dept of Health

24. Aileen Gagney, Asthma and Environmental Health Program Manager for the American Lung Association of Washington
25. Health Disparities town hall meeting (5 panelists and 32 community residents
26. Public hearings held by Seattle City Council on the city's public health policy (10 people spoke)

Resources

A. Local Public Health System



This figure is for illustrative purposes only.

B. Ten Essential Services in English

Essential Services

Essential Service	"English" Version
1. Monitor	What's going on in my community? How healthy are we?
2. Diagnose & Investigate	Are we ready to respond to health problems or threats in my county? How quickly do we find out about problems? How effective is our response?
3. Inform, Educate & Empower	How well do we keep all segments of our community informed about health issues?
4. Mobilize	How well do we really get people engaged in local health issues?
5. Develop Policies & Plans	What local policies in both government and the private sector promote health in my community? How effective are we in setting healthy local policies?

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Essential Services (cont)

Essential Service	Non-Public Health Version
6. Enforce Laws & Regulations	When we enforce health regulations, are we technically competent, fair, and effective?
7. Link	Are people in my community receiving the medical care they need?
8. Assure	Do we have a competent public health staff? How can we be sure that our staff stays current?
9. Evaluate	Are we doing any good? Are we doing things right? Are we doing the right things?
10. Research	Are we discovering and using new ways to get the job done?

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C. Brief Glossary:

- **Personal health care**: encompasses the services an individual patient receives from a health care provider for the benefit of that individual patient. Examples include physical examinations, treatment of infections, family planning services, etc.
- **Population health care** represents the services that individuals receive that benefit both the individual and the population. Examples include immunizations (which benefit the individual, who won't get sick, and the population since the virus won't gain a foothold if enough of the population is immunized), health promotion, and environmental health.
- **Upstream**, used in a context of public health, means addressing the larger factors which ultimately result in health challenges to a population, including disposal of toxic wastes, unemployment, truncated education, and racism.
- **Categorical funding:** governmental funding, usually from the federal level, which is designed to be used in support of specific public health programs and activities. It typically is accompanied with tight limitations on how the funds can be used, even within programs.
- **Evidence-based practices:** public health activities which are designed based upon authenticated studies of efficacy and/or upon established practices.
- **Local Public Health System:** in any community, the local governmental public health agency and all organizations, agencies and individuals who, through their collective work, improve or have the potential to improve the health of community residents.
- **Essential Public Health Services:** established under the aegis of the federal Department of Health and Human Services in 1994, this list of ten sets of services comprises what needs to be in place in all communities to assure an adequate local public health system

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IX: Milne & Associates: Health Environment Background Report

Health Environment Background Report
Prepared by Milne & Associates, LLC
April 25, 2006

Please note: This background paper should be viewed as a dynamic product. It is likely that new information will continue to be provided during the life of this project. The reader should regard this paper together with the companion papers on role definition, policy environment and funding as initial guidance for the production of a broad policy framework.

Executive Summary and Implications for Next Steps

In this executive summary we provide our interpretation of the significance and meaning of the observations in this paper as they relate to a broad policy framework for public health in King County. First, the key observations:

- **The current health environment is tremendously precarious**. There is a remarkable concurrence of health related forces globally, nationally and locally. Four aspects of the local health environment contribute to a sense of crisis: persistent health inequities, growth of chronic diseases, re-emergence of old and new infectious disease threats and an extremely fragile safety net of care for vulnerable populations.

- **Global, national, state and local forces are playing out within King County's health environment, including:**
    - globalization
    - accelerating technological advances
    - huge demographic changes
    - widening gaps between haves and have-nots
    - re-emergence of the importance of infectious diseases, epidemics and pandemics
    - increasing prevalence of chronic diseases
    - complex and persistent health disparities
    - profound impact of social, built, and physical environment

- **A factor unique to the United States among modern industrialized counties is the absence of universal access to**

basic medical care. This fact stresses King County, its residents and the safety net providers serving the uninsured.

- **The OMP is an opportunity for King County and PHSKC to build on past success and face new challenges as national leaders in major metropolitan public health**.

Important implications for next steps based on this description of the health environment include:

- **Rapid change demands innovation and flexibility.** Ongoing support for public health is needed to establish and maintain the basic infrastructure as a foundation upon which innovation can flourish. Public health must have the capability to be flexible and nimble to respond to new and emerging problems. Innovation will be enhanced by progressive partnerships with universities, cutting-edge research institutions and communities.

- **State of the art technology should be a major tool for improvement.** Health related technologies (i.e. new HIV treatments, genomic-based screening and diagnostic tests, vaccines, etc,) and those which depend on advances in informatics and communications will need serious attention and investment in order to keep pace with the modern world. These investments should be based on evidence of best practice models.

- **Health disparities must be eliminated, BUT there is no "magic" solution.**
  Serious and persistent inequities in health status across race/ethnicity, gender, income groups, and geography are a reflection of broader inequities in the distribution of social resources. Unless underlying determinants of health are addressed, the health environment will continue to be defined by these patterns of inequity.

  It is certain that substantial advances in the elimination of disparities will require a completely fresh look. Because health disparities are now entrenched, no single action can reverse the problem. Organizations and leaders should avoid the temptation to address the issue with short-term and superficial efforts. Any serious effort to address health inequities will necessarily require a multi-faceted, multi-sector, long-term commitment.

- **Recent past accomplishments should not be taken for granted.** Overall, King County can be proud of the general health of its residents. To maintain the gains of the past is critically important while improvements are made and the challenges described in this report are addressed. Care should be taken to avoid dismantling successful programs and services in the pursuit of new issues.

  Experience has shown that the value of prevention and early intervention is sometimes, unfortunately, shown only after a program is stopped or weakened. Prevention techniques do not have the visibility they deserve when compared to new technologies. Yet it is important to balance promising technology advancements with the need for lower tech public health interventions such as outreach, social support and community building. These interventions are often less costly and more effective because they involve and empower people to act within their communities.

- **New and old infectious disease threats have emerged or re-emerged.** Naturally occurring epidemics and threatened bioterrorism demand a renewed vigilance. Given that public health infrastructure has been largely under-funded for decades, significant events such as natural disasters or acts of terrorism pose a substantial threat to local public health agencies and the communities they serve.

- **The environment must be leveraged for human health.** Focus on the environment should emphasize all aspects of the environment and encompass the human health implications of the social, physical and built environment. Procedures for defining and making major policy decisions (even if the decisions are perceived initially to be unrelated directly to health) should incorporate proactive precautionary measures to avoid potential health risks and formal health impact assessments which refine policy proposals so that they foster health.

- **Capitalize on the synergy between personal healthcare and population health services.** Policies which promote inclusion of a population health perspective in health care delivery systems can reconnect the personal health care system and population health. Both systems need to address the disparities in quality of health care by race, culture and income and contribute to the elimination of inequities in health status. Local coordination with and expansion of safety net providers should build on models which have worked in the past within King County and explore new ways of using current resources most efficiently while advocating collectively for new resources. The

interaction and close coordination between the personal and population health arena is a sleeping giant for prevention within King County.

- **Advocacy for universal access to healthcare needs reinvigoration** There is a tipping point at which widespread deficiencies in personal health care become themselves major public health problems. Many believe that we are already past that tipping point. Adequate population health cannot be achieved without making comprehensive and affordable health care available to every person residing in the United States. Key roles of public health in this collaborative effort are providing support, information and coordination with the health care providers in the community.

- **The public health workforce of the future will require new and varied skills.** There is no more important element of the public health infrastructure than the expertise and skills of the workforce.

Introduction

Purpose of this paper

In this paper we provide a high level overview of the health environment in which public health policy is formulated in King County. The paper is meant to complement three other related papers dealing with the role of public health, funding for public health and the policy environment. The focus of this paper is on health status, the determinants of health, selected aspects of health care and threats to health.

We focus on trends which provide future forecasts of health-related issues germane to policy. Policy is developed by asking the questions which set the agenda for the future. Thus, it is important to establish the context not only by understanding the current health environment, but also by anticipating trends in influential forces of change. These trends of influential forces include:

- globalization
- accelerating technological advances
- huge demographic changes
- widening gaps between haves and have-nots
- re-emergence of the importance of infectious diseases, epidemics and pandemics
- increasing prevalence of chronic diseases

- complex and persistent health disparities
- profound impact of social, built, and physical environment

Stepping back above the fray of current programs and priorities to observe trends in health and health drivers is an objective of this paper. This paper is not intended to produce a treatise on public health practice and the health environment, but rather to provide insight into what might help guide a broad framework for policy. Statistical analyses will be sparse and certainly not comprehensive. Quantitative data will be displayed only to illustrate general points, avoiding the tendency of abstract numbers to obscure the punch of the message about critical aspects of the health environment.

Key concepts

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (*World Health Organization*).

- How a community defines health greatly influences its approach to preserving and protecting health and the distribution of health-related investments to achieve good health outcomes for all segments of the population.

Social Determinants of Health are the economic and social factors that influence the health of individuals, communities, and jurisdictions as a whole. *(Source: Dennis Raphael, "Introduction to the Social Determinants of Health," Social Determinants of Health: Canadian Perspectives. Also see Attachment I for another model of broad determinants of health)*

- These factors determine whether individuals stay healthy or become ill (a narrow definition of health).

- These factors also determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment (a broader definition of health).

- These factors are directly impacted by the quantity and quality of a variety of resources that a community makes available to its members. These resources include – but are not limited to – conditions of childhood, income, availability of food, housing, employment and working conditions, and health and social services.

- A focus on the social determinants of health asserts that the mainsprings of health are how a community organizes and distributes economic and social resources. Such a focus emphasizes community conditions in contrast to the traditional focus upon biomedical and behavioral risk factors, such as cholesterol, body weight, physical activity, diet, and tobacco use. It directs attention to the important role economic and social policies have on health. *For example, policies that prevent suburban sprawl and dependence on the automobile will increase physical activity and decrease obesity.*

Healthcare is the preservation and restoration of mental and physical health by preventing or treating illness through the provision of services offered by health-related professionals to **individuals**.

- This working definition above is used in this paper since there is no standard definition of healthcare. One important element of healthcare is the medical service provided by physicians and other health professionals, but healthcare is broader than medical care.

- Healthcare is a personal health service which has the objective of enhancing, restoring, or maintaining an individual's health. Healthcare is the type of service where it is easy to identify by name the individual who benefits from the service.

- Healthcare has also been described as an industry associated with the provision of medical and ancillary care to individuals. As such, it is one of the world's largest and fastest-growing industries.

Personal healthcare encompasses the services provided to individual patients by health care providers for the direct benefit of the individual patient. For the purposes of this paper, there are several ways personal healthcare is delivered:

- **Primary Care** is clinical preventive services, first-contact treatment services, and ongoing care for commonly encountered medical conditions. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient's health problems, whether these are medical, behavioral, or social. The appropriate use of consultants and community resources is an important part of effective primary care. Such care is generally provided by physicians, but can also be provided by other personnel, such as nurse practitioners or physician

assistants. (*adapted from Public Health What It Is and How It Works, Bernard J. Turnock*) For example, the diagnosis and treatment of a sore throat or the management of high blood pressure are most often provided in a primary care setting.

- **Categorical clinical services** are personal healthcare services provided to individual clients/patients by any of a variety of health professionals, including physicians, nurses, dentists and others, to address specific health issues. Categorical clinical services may include treatment of illness or injury or prevention of health problems and can be delivered as elements of comprehensive primary care or as stand-alone services. Examples include providing family planning services or treatment for a sexually transmitted disease in clinics designed for these specific health problems.

- **Specialized and referral services** are personal health services such as:
    - laboratory, x-ray and pharmaceutical services
    - medical services for emergencies during transport (EMS)
    - emergency room care for " true" emergencies
    - specialty care of complex illnesses including mental health services
    - hospital services
    - long-term care services

Wrap around services are non-clinical services provided to individuals (usually by professionals other than physicians, nurses, dentists) in support of health and wellness. These services may be based in the community and need not be provided in a primary care or clinical setting although they may be. Examples include case management by social workers, nutritional counseling and health education.

Population-based health services are interventions aimed at disease prevention and health promotion that affect an entire population and extend beyond medical treatment by targeting underlying risks, such as tobacco, drug, and alcohol use; diet and sedentary lifestyles; and environmental factors (*adapted from Public Health What It Is and How It Works, Bernard J. Turnock*)

- Population-based health services have the objective of enhancing, maintaining and protecting the health of **populations**. Typically it is not possible to identify by name the individuals who benefit from

population health services. Examples include food safety programs, regulation of indoor air quality and environmental tobacco smoke, pandemic influenza preparedness, health impact analysis of policy initiatives, community based health promotion, etc.

Public Health is what we as a society do collectively to assure the conditions in which people can be healthy. (*Institute of Medicine*)

- Unlike healthcare, public health is concerned primarily with prevention, protecting health and promoting healthy conditions at the level of a population.

Risk factor is a behavior or condition that, on the basis of scientific evidence or theory, is thought to influence susceptibility to a specific health problem. (*from Public Health What It Is and How It Works, Bernard J. Turnock*) Examples of personal risk factors include stress, tobacco use, elevated cholesterol and risky sexual behavior; examples of population risk factors include poverty, homelessness, institutionalized racism, exposure to environmental toxins and unsafe food.

Health disparity (sometimes also called health inequities) is a difference in a health outcome or determinant of health across two populations, such that one population suffers a disproportionate burden of illness.

Overview

Dramatic changes

Our nation and all communities on the globe have experienced an astonishing change in the context and challenges of the health environment. The professional literature which examines the magnitude and rapid rate of changes in the national and international health environments over the past decade is vast and complex. At the same time, the popular lay press has intermittently reported many of these changes in dramatic personalized accounts; the general public may have become numbed into denial and inaction. Policy should be informed by a broad understanding of how profound these changes really have been.

In order to succinctly summarize these trends in a manner useful for policy formulation, this paper relies primarily on several key sources:

- *The Future of the Public's Health in the 21st Century*, a 2003 publication of the authoritative Institute of Medicine (IOM) describes the future opportunities for improvement in the health of the public and the contributions which Public Health can make. The Institute of Medicine acts under the responsibility given to the National Academy of Sciences by its congressional charter to be an advisor to the federal government and upon its own initiative to identify issues of medical care, research and education. It secures the services of eminent members of the appropriate professions in examination of policy matters pertaining to the health of the public.
- A more informal source relies on the reflections of Dr. William Foege of the University of Washington and the Bill and Melinda Gates Foundation. Dr. Foege is a renowned international thought leader about global public health.
- For the remainder of the report we rely heavily on the *Health of King County* report and also on the *Big Cities Health Inventory, 2003.* The *Big Cities Health Inventory, 2003: The Health of Urban USA* is the fourth edition of the Chicago Department of Public Health document published in collaboration with the National Association of County and City Health Officials and presents city-to-city comparisons of leading measures of health.
- The emphasis in this report is to extract and display observations that are particularly informative to the development of a broad policy framework. This paper is designed to be used in the first phase of the King County Public Health Operational Master Plan (PHOMP). The first phase focuses on the development of a broad policy framework to be used to make future decisions about funding and implementation.

International Overview

We start with a paraphrase of the wisdom of Dr. Foege extracted from his recent speeches. He points to overarching themes which inform our understanding of the health of the world, the impact of natural and human systems on health, and the forces shaping the international health scene. All have grown in prominence over the past decade and will remain potent forces into the foreseeable future:

- **An increasing consciousness of the whole by ever larger segments of society:** Communications have improved so that more people are aware of what is happening but also feel some obligation to respond. So the first requisite for improving the state of the world, namely "eye contact" between the problems and the people who can

make a difference, is increasingly possible. People actually are beginning to understand that we are part of a global system.

- **Unequal and diverging paths**. The benefits of science, wealth, knowledge, the marketplace, and government increasingly benefit those who are already more fortunate than others. The accident of birth determines whether you are on the wide, relatively healthy, relatively affluent, relatively barrier-free highway, or whether you are on the barely passable poor and sick rock-strewn footpath. Foege peppers his speeches with thought–provoking quotes about poverty. Samples include:
    - Willem de Kooning, 20th century abstract expressionist painter: "The trouble with being poor, it takes all your time."
    - W.E.B. Du Bois, early 20th century black intellectual leader: "To be a poor man is hard, but to be a poor race in a land of dollars is the very bottom of hardships"
    - Aristotle, ancient Greek philosopher: "Poverty is the parent of revolution and crime."
    - Mohammed Yunus, founder of the micro-lending Grammeen Bank, "We believe that poverty does not belong to a civilized human society. It belongs to museums."
- **The age of science and technology**. Technological advances have dramatically increased our ability to understand the world, and to measure and respond to health problems. We stand at the very edge of practical solutions, including vaccines for malaria, tuberculosis, cancer of the cervix, and even HIV/AIDS. Within a decade, any one of us may be able to have our entire genome mapped out.
- **Convergence of natural and self-inflicted problems**. Infectious diseases and malnutrition which have continued to be dominant global health factors are now joined by health threats from alcohol, drugs, fatalism, depression, and violence. The combined convergence of old and new threats describe the conditions of many inner cities in the U.S. as well as conditions of poor countries.
- **Infectious diseases.** During recent decades the scales *had been* tipping slowly away from the dangers of the natural world such as infectious diseases. *That is no longer the case*. Now, and quite suddenly, there has been a reversal in the trend. With the re-emergence of infectious diseases, we now worry about AIDS, tuberculosis, pandemic influenza, emerging problems from Ebola to SARS to Hantavirus and even to the previously unthinkable prospect of the deliberate release by humans of smallpox virus.

  - **Antibiotic resistance**. Once created, new antibiotics are widely advertised and market forces push them to the greatest use possible, which leads to misuse. In addition to inappropriate use, antibiotic resistance occurs when patients find it difficult to comply with recommended treatment regimens. So the combination of poor compliance, population pressures leading to tuberculosis spread and the marketplace pressure to misuse of antibiotics results in the emergence of drug-resistance diseases such as resistant tuberculosis. And this fact applies to many other infectious diseases.

- **Violence.** Violence (whether intentional or unintentional) has increased and now accounts for three of the top five reasons for premature mortality in the United States. Violence takes many forms, from automobiles and occupational injuries, suicide and homicide, to war and terrorism.
- **Environment.** Our health continues to be impacted by global warming, rainforest destruction, acid rain, pollution and natural disasters (droughts, earthquakes, tsunamis, hurricanes).

National overview

The 2003 IOM report amplifies the afore-mentioned international factors and describes additional specific national issues related to changes in the health environment within which public health must operate in the United States. The report cites the following:

- **Globalization** is the process of increasing economic, political, and social interdependence and global integration that takes place as capital, traded goods, persons, concepts, images, and values diffuse across national boundaries. Some of the many implications related to public health include:
  - The diversity of many American communities is illustrative of what has been occurring on a global scale.
  - Increased trade, travel, migration, demographics, food security, media communications, technology and patterns of consumption create new challenges for public health.
  - Direct health challenges include infectious diseases, ozone depletion, global environmental degradation, and lifestyle patterns that transcend national borders.

  - Socioeconomic determinants of health such as income and employment are profoundly influenced by globalization.
  - Information and communication technologies such as the worldwide web accelerate the rate of change.
  - As people, food and pharmaceuticals readily cross borders, improved surveillance systems for public health risks and implementation of cross-border agreements become even more essential.
  - Although the health of the public has historically been overshadowed by trade and military issues, in recent years health has gained prominence as a national security concern.

- **Scientific and technological advances**: In this age of technology, the acquisition of new scientific knowledge and capabilities occurs at unprecedented speed. There are many observations related to this development:
  - Advances in understanding the human genome will likely lead to the emergence of "designer drugs" tailored to individual genetic composition for prevention and treatment and, at the same time, raise controversial issues of balancing the positive value of early detection through screening against the risks of stigmatization and exclusion.
  - The lack of access to care will limit the diffusion of rapidly advancing medical technologies to all segments of our populations. Technologies may create great opportunities to improve individuals' health. However, because they are often inaccessible to those without health insurance, they actually may contribute to increased health disparities.
  - Information technologies will likely be as influential on population health strategies as are medical advances, because they are important sources of useful and accurate information and, unfortunately, of misinformation. We are in need of new tools for more sophisticated communication strategies, public health informatics and improved surveillance systems.
- **Population growth and demographics:** The U.S. population will become older and more diverse.
  - Services and social supports to promote healthy aging will be increasingly important as will the rising population needs for the prevention, care and management of chronic diseases and for community-based long-term care.

- All people, but particularly the elderly, the poor, the disabled, children and minorities, will require adequate housing, safe and appropriate urban design, accessible transportation, access to healthy groceries and places for positive social interaction to achieve their healthy potential.
- As the United States becomes more racially and ethnically diverse owing to immigration and natural growth, the proportion of the population accounted for by Hispanics, African Americans, Asian Americans and Pacific Islanders and Native Americans will rise from 28 per cent in 2000 to 32 percent by 2010.
- Our health systems, including services for individuals (e.g. medical treatment) or for populations (e.g. public health promotion programs), are marked by complex inequities and institutionalized racism leading to stereotypes, biases, unequal and ineffective service delivery. Similar inequities and barriers for newly arrived populations such as refugees are exacerbated by perceptions within those populations about government, the meaning of community and the definition of health.

- **Healthcare:**
  - While all other industrialized nations guarantee universal access to care, the US, in spite of health care expenditures which total nearly half of the world's health care budget ($1.3 trillion) and about 15 % of its GDP, fails to ensure such access to its population.

  - Personal healthcare is one of the determinants of health; others include genetic, behavioral, social and environmental factors. Even if it is not the strongest among these determinants of health, access to healthcare is very important. More than 41 million people in the U.S - more than 80 per cent of whom are members of working families - are uninsured. Being uninsured, although not the only barrier to obtaining health care, is by all indications the most significant one. Even when insured, however, limitations of coverage (benefits, cost-sharing, co-payments, etc.) and cultural barriers still impede people's access to care.

  - Limited access resulting in poor health can push individuals and groups into poverty, further contributing to the vicious cycle of disadvantage. The downstream costs of lack of access are well

documented (more hospitalizations, more ER use, poorer birth outcomes, more communicable disease, learning difficulties, lost productivity) – and this contributes significantly to today's health care disparities, the effects of which will continue to persist for generations.

- The Health Insurance Portability and Accountability Act of 1996 established national minimal standards for protected health information. Though well-intended, the implication of this act has been to create an undue burden on health care providers with little added benefit to patients.

- **Safety net providers:**
  - As defined in the IOM report, safety net providers are those providers who organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid and other vulnerable patients.
  - Nationally, there is a crisis for safety net providers.
  - The 2003 IOM report re-endorsed the conclusions of its earlier 2000 report entitled, *America's Health Care Safety Net: Intact but Endangered* which found the following:
    - Despite today's robust economy, safety net providers – especially core safety net providers – are being buffeted by the cumulative and concurrent effects of major health policy and market changes.
    - The future viability of the safety net is severely threatened because even the most resilient and resourceful safety net providers will be challenged to survive the current environment which includes
      - Growth in Medicaid managed care enrollment (which removes a source of payment for safety net providers)
      - Retrenchment or elimination of key direct and indirect subsidies which help finance uncompensated care
      - Continued growth in the number of uninsured people
    - Combined, these forces and dynamics demand the immediate attention of public policy officials.

- The 2003 Report concludes that it is the responsibility of the federal government to lead a national effort to solve this problem.

- **Physical environment as a determinant of health**
  - The importance of "place" to health status is increasingly clear, whether "place" is where we work, live, study or recreate.
  - All aspects of the human environment (social, economic, natural and built) are critically important to health.
  - In urban areas, the negative environmental factors – toxic buildings, proximity to industrial parks and lack of green space – disproportionately affect those who are already living with economic and social disadvantage.
  - Aging and deteriorating buildings, crowded and unsanitary conditions, and poor indoor air quality commonly lead to exposure to lead and other environmental toxins and to asthma and other respiratory illnesses.
  - The physical space in which people live makes a profound impact on the health of populations.
  - Urban sprawl contributes negatively to health status through its effects on obesity and air quality.

State/Local Health Risk and Needs

National and international forces come into sharp focus when we examine state and local public health reports. In the case of King County and the State of Washington, reports from each reach similar conclusions about health and, therefore, we concentrate on the most recently released PHSKC report for depicting the health environment in King County.

Public Health - Seattle & King County (PHSKC) provides a number of excellent, detailed and sophisticated reports. PHSKC has a well-earned national reputation for producing and contributing to scientifically sound and cutting-edge characterization of health status and social determinants of health. These reports include among others: the *Health of King County*; the *Communities Count* report; *Data Watch*; the *Core Indicators project*; and *Epilog* (a monthly epidemiological report). Importantly, these reports have been used as springboards for focused interventions executed within a complex health environment - interventions which address asthma, pandemic influenza, obesity, health disparities and the built environment.

Below is a brief summary of some of the more salient observations from these reports:

- Chronic diseases such as cancer, heart disease, stroke, chronic lung diseases (including asthma, emphysema and chronic bronchitis) and diabetes are the largest contributors to ill health in King County
- Risk factors for chronic diseases are common and affect a growing proportion of the population
- The prevalence of diabetes among adults has doubled in the past decade
- HIV has now become a chronic condition as HIV mortality has dropped precipitously
- The risk of an influenza pandemic and other emerging infections is increasing
- Access to health care has declined notably in the past five years, with a record proportion (15.5%) of the population age 18-64 lacking health insurance (190,000 people) and a reliable source of medical care. In spite of declines in the uninsured rate in King County from 1993 to 2001 (and in Washington State between 1991 and 2000), in 2004 King County experienced its highest rate of uninsured people since data were first recorded in 1991.
- The safety net in King County is threatened by the increasing expense of private health insurance coverage that causes people to drop coverage, the persistent overall growth of medical costs (especially pharmaceuticals), the federal and state limits on payments for Medicaid, and the lack of funding for new community health centers and other safety net providers where needed. In contrast to other areas of the country, growth in Medicaid managed care enrollment by itself does not financially threaten the safety net providers within King County because the providers receive a fee for case management.
- Over the past ten years, the percentage of uninsured people in King County has generally mirrored, but remained slightly less, than that of Washington State
- Medicare coverage is almost universal for people aged 65 and over.
- Within King County, wide disparities in insurance coverage exist by level of education, income, age and race.
- Lack of coverage for eyeglasses, dental health, mental health and prescription drugs is considerably more common than lack of medical coverage.
- The increasing diversity of the population requires that the public health and medical care systems address health issues in a growing number of cultural contexts

Several health status indicators are, however, showing improvement in King County as a whole:

- The overall death rate continues to fall.
- Mortality from the most common cancers (lung, colorectal, breast and prostate) is declining.
- Smoking rates have steadily declined.
- Motor vehicle injury deaths and hospitalizations are dropping and seat belt use is increasing.
- The epidemic of firearm deaths in Seattle during the early-mid 1990s has reversed.
- Infant mortality is at its lowest overall rate ever.
- Hepatitis A and B rates have declined dramatically.
- Outdoor air quality has steadily improved.
- Important risk factors for chronic diseases include smoking, obesity and physical inactivity, and these are associated with leading causes of death such as heart disease, cancer and stroke. Overall, the level of these risk factors among King County residents was more favorable than among residents of Washington or the United States as a whole. Below is an abbreviated version of a table presented in the Health of King County 2005 report, highlighting selected risk factors compared to the national objectives:

Behavioral Risk Factor Prevalence (%) Among Adults in King County, Washington State, and the United States (Health of King County, 2005)

	King County	Washington State	United States	HP 2010 Objective
Current smoking 2004	15.2	19.2	20.8	12.0
Obesity 2004	17.7	21.7	22.2*	15.0
No physical activity 2004**	14.5	17.2	22.8	20.0

* The US rate is for 2002
** King County and Washington state have already reached the US Healthy People 2010 objective for this indicator

The following important concerns persist:

- Deaths from unintentional injuries have not declined in the past decade.
- The mental health status of residents (including suicide) is not improving.
- Excessive alcohol use is higher in King County than the rest of the state and the nation and the pattern of drug-related deaths has changed.
- Improvements seen in access to timely prenatal care in the early and mid 1990s have ended.
- Poor indoor environmental quality, usually related to substandard or poorly ventilated buildings, is a concerning environmental health issue.
- The reported rates of Chlamydia and early syphilis (sexually transmitted infections) have increased in recent years.
- Because specific individual choices about risk factors may explain only 25 to 30% of the differences of mortality among comparison groups, further accomplishments in changing the prevalence of risk factors are likely to await addressing root causes of ill-health, such as those factors identified as "determinants of health"

    - Indeed, the Atlantic regional office of Health Canada notes the current tendency of chronic disease prevention strategies to focus on changing individual risk behaviors despite evidence suggesting that efforts to address social and economic root causes could be more effective. Interventions to change individual behaviors are typically more successful among higher income groups, where people have a greater degree of options and control over their lives.

- Limitation in access to care generally (for the un- and under-insured), and to specific types of care, such as clinical preventive services, mental health care, substance abuse treatment and oral health care, limit the effectiveness of the health care system. Additionally there are serious concerns around quality of care and the capacity of the current health care system to effectively serve a diverse and aging population.

- Health issues related to the physical environment highlighted in the Health of King County report include asthma, air quality, West Nile

virus, water quality and waterborne illness and the Tacoma smelter plume.

- The childhood asthma hospitalization rate has seen the most dramatic reduction. But children living in high poverty areas are 3 times more likely to be hospitalized for asthma.
- Most people spend as much as 90% of their time indoors where much less attention is focused on air quality as compared to that for outdoor air. Potential hazards in the indoor environment include mold, pesticides, chemicals, airborne particles, tobacco and fireplace smoke, lead dust and noise.
- Appropriate surveillance for West Nile virus has revealed no evidence of the infection in King County.
- Water quality influences how communities can use water for activities such as drinking, swimming or commercial purposes.
- While environmental studies show widespread contamination for lead and arsenic related to the Tacoma smelter plume, thus far no immediate health emergency exists at the levels detected, but more testing needs to be done in areas where children play frequently.
- Research done on the health of Puget Sound waters document that contaminated water and marine life have direct implications for human health through exposure which disproportionately affects specific populations.
- Exposure to environmental pollutants and the physical/chemical environment within King County along with the built environment act in concert with other determinants of health which give rise to disparities in health status.

- Homelessness is an important issue in King County, recognized by both the Executive and the Council, and the County has undertaken a Ten Year Plan to End Homelessness. Homelessness as a condition has a major impact on health, yet the number of people losing their homes have been consistently getting higher in King County.

- The impact of globalization on the health of King County residents is not specifically highlighted in the *Health of King County* but warrants specific mention.

    - Because of King County's important role in the economy and culture of the Pacific Rim, there are few if any regions in the country where the health implications are more important.

Worth highlighting are tuberculosis (TB), HIV/AIDS, pandemic influenza, and newly recognized infections such as SARS. For example, as many as 100,000 people have latent TB in King County and the majority contracted the condition in their country of origin. International outbreaks are only a plane flight away from the Pacific Northwest.

Health Disparities

Most striking and challenging are the serious and persistent health disparities within King County:

- As described earlier, a health disparity is a difference in a health outcome or determinant of health across two populations, such that one population suffers a disproportionate burden of illness.

- Health disparities have persisted for years as a result of the complex interaction of the social determinants of health. It is telling that even when there have been improvements in the trends of some indicators of health, most disparities have tended to persist. This suggests either a systemic or an "upstream" cause for the disparity

- There are large and persistent disparities in health indicators and access to health care in King County across racial/ethnic groups, income groups and geographic areas of the county. While some disparities are diminishing, many are increasing. There are different patterns of disparities depending upon the groups being compared.

- Racial and Ethnic Disparities

    - When health indicators are compared between African Americans and American Indians/Alaska Natives on the one hand, and whites on the other, disparities are found across a very wide spectrum of health indicators, including death rates, birth outcomes, chronic disease rates and risk factors for chronic disease (e.g. smoking, overweight and physical inactivity, lack of screening), injuries, HIV, mental distress, alcohol use and drug-induced deaths, and access to medical care. Hispanic/Latinos are also affected by disparities, including high rates of adolescent births, physical inactivity, mental distress, HIV, and access to care. These observations strongly suggest that deeply entrenched systemic contributors, including those identified in the IOM report, are present in King County.

- Income Disparities
    - Low income residents also have disparities in health indicators relative to high income residents. Disparities occur in death rates, birth outcomes, adolescent births, all chronic diseases and risk factors (such as physical inactivity, overweight, smoking, and lack of screening), HIV, mental health, alcohol use, drug-related deaths, and access to care. While the *Health of King County* report documents disparities across racial/ethnic groups and geographic areas of the county, the largest disparities generally occur between the lowest and highest income groups. For example, new cases of HIV occur *thirteen* times more frequently and unmet health care needs *five* times more frequently among low income residents. Disparities associated with income affect not only residents of high poverty areas. Residents of medium poverty areas are also affected, although to a lesser degree. These observations highlight the central role of livable wages, tax policy and social structure as critical health strategies for the future of King County.

- Geographic Disparities
    - A decade ago, primarily Central and Southeast Seattle were disproportionately affected by poor health. Now, the regions of the county experiencing the poorest health have expanded south. The South Seattle/South County Area, which includes Downtown, Central and Southeast Seattle, Beacon Hill, Delridge, White Center/Boulevard Park, Tukwila/SeaTac, Kent and Auburn, experiences lower health status and more limited access to health care than other regions. This region has:
        - The highest death rate and the lowest life expectancy in the county. While the death rate in this region is decreasing, the rate of decline is slower than in other parts of the county.
        - Poorer maternal and child health indicators than the rest of the county. Infant mortality is increasing only in the South Region and the rate of inadequate prenatal care (either not occurring or provided late in pregnancy) in the South Region is not declining as it is in other regions. The South Seattle/South Region Area also has the highest rates of low birth weight, very low birth weight, preterm delivery, adolescent birth and late or no prenatal care.

    - Disparities also appear in other areas of the county. These areas also have clusters of poor health indicators, although none include

such a wide range of conditions as found in the South Seattle/South Area.

- Southeast County and to a lesser extent Federal Way are notable for relatively high rates of chronic illnesses and risk factors for chronic disease, such as deaths from cancer, heart disease and diabetes and risk factors including smoking, physical inactivity, obesity, hypertension and lack of health insurance.

- Downtown Seattle is notable for its concentration of unintentional injuries, HIV and AIDS cases, mental health problems, drug and alcohol problems (including deaths from liver disease, drug-induced deaths, hospitalizations for illicit drug use and alcohol-induced deaths) and access to care issues.

- Disparities among sexual minorities
    - Rates of smoking, binge drinking and heavy drinking among homosexual and bisexual people are nearly twice as high as among heterosexuals.
    - Breast cancer screening by mammography is completed less commonly among lesbian and bisexual women compared to heterosexual women.
    - HIV and AIDS still predominantly affect gay males but, are slowly increasing in other groups.
    - Frequent mental distress is twice as common among sexual minorities as among heterosexuals.

Comparison to Peers

Three different comparisons to peer counties and their health departments were considered for this report:

- First, the websites of seventeen selected major metropolitan health departments were examined to compare the number, scope, modernity and sophistication of health status reports produced and made accessible to the public. This broad-brush review supports the conclusion that PHSKC is a leader in the country with regard to its outstanding capacity

and performance in producing cutting-edge reports. It is particularly noteworthy that the PHSKC-related reports cover much more than the traditional public health measurements and specific programmatic analysis, but also address the challenges of the safety net issues and the evolving and cutting-edge science of the social determinants of health. During phase II of the PHOMP, we will explore a comparison of innovative responses to these reports.

- We attempted to compare data presented in the PHSKC reports with that available from the five MMHDs (listed in Attachment II) which have been selected to undergo more in-depth review as a part of the PHOMP process. We concluded that the comparison of readily available data was problematic. There are a number of reasons for this: use of different indicators; varied currency of data; varied methods of adjustment of data; and different timelines for trend analysis. To use primary data sources from each county and reconstruct comparable indicators for epidemiologic analysis is beyond the scope of this report and would have little utility in the formulation of the broad policy framework desired for this phase of the PHOMP. Such an analysis may even be of questionable utility for future phases of this project, particularly if the desired outcomes include recommendations about best practices, funding options, policy strategies and implementation. The latter items can be informed by other methods of information collection.

    - We were able to document that the comparison counties face similar challenges in their communities and, in particular, they are seriously grappling with the urgency to eliminate health disparities (inequities), whether they are described by race/ethnicity, income status or geography. (See Attachment II for descriptive examples of health disparities in the comparison counties.*)* Later phases of the PHOMP will explore evidence of best practices as these counties seek to eliminate health disparities.

- Despite the limited value to policy development of the previously mentioned comparison, we do present a brief third comparison using the *Big Cities Health Inventory, 2003* which is the only available published report specifically focused on comparison health measurement at the population level in cities in the U.S. The report has many advantages: standardized datasets, collaborative development, periodic updates and a focus on improvement through comparisons. However, one major disadvantage of using this report is that the data is limited to the boundaries of the largest city within or closest to the county and therefore must be used with caution because our paper focuses on the whole of King County. Also, some of the information is relatively old,

using data from the late 1990's and no later than 2000. Nonetheless, since health statistics of large metropolitan counties such as King County are greatly influenced by the health measurements of the largest core city, some use of this report is indicated.

- Attachment III displays the rank of the five cities (Columbus, Miami, Nashville, New York, Oakland and Seattle) which are the major cities associated with the counties selected for comparison in the PHOMP. Depicted are the ranks these six cities had among the 47 cities in the report for each of 20 health indicators. For each indicator the rank which is the best (meaning favorable towards health) and second best among the six cities can be compared in the table. **Seattle fares the best in this comparison; in twelve out of 18 comparisons Seattle is either best or second best ranked of six cities**. The comparable numbers for the other cities is as follows: Columbus (5 of 17); Miami (2 of 15); Nashville (4 of 20); NYC (10 of 20); Oakland (4 of 18). The *Big Cities Health Inventory* indirectly confirms the assertion by the *Health of King County* which highlights progress in health status.

- Data from the *Big Cities Health Inventory* depicted in Attachment IV also confirms the need to focus on health disparities in King County. We selected the four indicators for which sufficient data was available for each of the six cities to compare the rate ratio for non-Hispanic black and non-Hispanic white rates of the indicators. (It should be noted that these were the four indicators and the two categories of race/ethnicities recorded in the report which were available for all six cities). We also compare the rate ratios of the six cities to average rate ratio of all of the 47 cities described in the report. The higher the ratio the greater the disparity. **Seattle's ratio was the highest or nearly the highest in three of the four indicators suggesting that the health disparities in Seattle may be worse than the other comparable metropolitan areas.** By inference from data the *Health of King County* report, this observation may also apply to King County as compared to the other five counties.

Conclusions

In this concluding section we provide a summary of our interpretation of the significance and meaning of the observations in this paper for a broad policy

framework for decision making about public health in King County. First, the key observations:

- The current health environment is tremendously precarious. There is a remarkable concurrence of health related forces globally, nationally and locally. Four aspects of the local health environment contribute to a sense of crisis: persistent health inequities, growth of chronic diseases, re-emergence of old and new infectious disease threats and an extremely fragile safety net of care for the vulnerable populations.

- Global, national, state and local forces are playing out within King County's health environment, including:
    - globalization
    - accelerating technological advances
    - huge demographic changes
    - widening gaps between haves and have-nots
    - re-emergence of the importance of infectious diseases, epidemics and pandemics
    - increasing prevalence of chronic diseases
    - complex and persistent health disparities
    - profound impact of social, built, and physical environment

- A factor unique to the U.S. relative to other modern industrialized counties is the absence of universal access to basic medical care. This fact stresses King County, its residents and the safety net providers serving the uninsured.

- Development of the OMP presents an opportunity for King County and PHSKC to build on past success and face new challenges as a national leader in major metropolitan public health.

Important implications for next steps based on this description of the health environment include:

- **Rapid change demands innovation and flexibility.** Ongoing support for public health is needed to establish and maintain the basic infrastructure as a foundation upon which innovation can flourish. Responses to new problems must be flexible and nimble. Innovation will be enhanced by progressive partnerships with universities, cutting-edge research institutions and communities.

- **State of the art technology should be a major tool for improvement.** Health related technologies (i.e. new HIV treatments, genomic-based screening and diagnostic tests, vaccines, etc,) and

those which depend on advances in informatics and communications will need serious attention and investment in order to keep pace with the modern world. These investments should be based on evidence of best practice models.

- **Health disparities must be eliminated; BUT there is no "magic" solution.**
  Serious and persistent inequities in health status across race/ethnicity, gender, income groups, and geography are a reflection of broader inequities in the distribution of social resources. Unless underlying determinants of health are addressed, the health environment will continue to be defined by these patterns of inequity.

  It is certain that substantial advances in the elimination of disparities will require a completely fresh look. Because health disparities are now entrenched, no single action can reverse the problem; accordingly, organizations and leaders should avoid the temptation to address the issue with short-term and superficial efforts. Any serious effort to address health inequities will necessarily require a multi-faceted, multi-sector, long-term commitment including but not limited to the following:

  - Strengthening the political will to act
  - Major policy initiatives which both government and the private sector must undertake to reverse the underlying social determinants of the health disparities
  - Continued monitoring of health disparities using sound epidemiology grounded in science and social systems understanding, and comprehensive public health surveillance systems
    - Community health assessments need to expand to include information about:
      - Mental health issues and services
      - Additional analysis of the impact to vulnerable populations, especially those who do not speak English
      - Systematic community level environmental health data
      - Health status about sexual minorities
  - Innovative outreach and community empowerment techniques

  - Services focused both on whole communities experiencing unhealthy conditions and services for individuals in need
  - Advocacy for, convening and coordinating safety net providers of care
  - World class cultural competence not only in personal health services but also in health promotion, health protection and public health preparedness
  - Marketing and communication strategies which reverse the current denial of the problem and point toward a broader concept of health and its determinants.
  - Active exploration of organizing the next generation of health improvements around the social determinants of health with greater emphasis on health and well-being.

- **Recent past accomplishments should not be taken for granted.** Overall, King County can be proud of the general health of its residents. To maintain the gains of the past is critically important while improvements are made and the challenges described in this report are addressed. Care should be taken to avoid dismantling successful programs and services in the pursuit of new issues.

  Experience has shown that the value of prevention and early intervention is sometimes, unfortunately, shown only after a program is stopped or weakened. Prevention techniques do not have the visibility they deserve when compared to new technologies. Yet it is important to balance promising technology advancements with the need for innovative lower tech public health interventions such as outreach, social support and community building. These interventions are often less costly and more effective because they involve and empower people to act within their communities.

- **New and old infectious disease threats have emerged or re-emerged.** Naturally occurring epidemics and threatened bioterrorism demand a renewed vigilance including:
  - incident management systems for a large scale health emergency
  - coordination of the health and emergency response
  - sophisticated disease surveillance
  - optimal availability of vaccines and antiviral agents
  - robust healthcare system preparedness
  - outbreak containment measures
  - timely, accurate and effective public communication

Given that public health infrastructure has been largely under-funded for decades, significant events, such as natural disasters or acts of terrorism, pose a substantial threat to local public health agencies and the communities they serve.

- **The environment must be leveraged for human health.** Focus on the environment should emphasize all aspects of the environment and encompass the human health implications of the social, physical and built environment. Procedures for defining and making major policy decisions (even if the decisions are perceived initially to be unrelated directly to health) should incorporate proactive precautionary measures to avoid potential health risks, and formal health impact assessments which refine policy proposals so that they foster health.

  Examples of issues and concerns include:
  - Enhanced efforts and new approaches must address the factors that result in profound inequities in the risk of exposure to environmental pollutants for low-income, people of color, immigrant and non-English speaking communities.
  - Urban and suburban sprawl have contributed to overweight/obesity and decreasing air quality.
  - Intensive public education and messaging will help the public understand new concepts about the implications of the built environment for health
  - Multiple sources of environmental pollutants (including the residual from methamphetamine labs) exist throughout the county. Body burdens of toxics are rising in the population.
  - Poor indoor air quality, due to mold and other hazards, is a major cause of preventable chronic disease.

- **Capitalize on the synergy between personal healthcare and population health services.** Policies which promote inclusion of a population health perspective in health care delivery systems can reconnect the personal health care system and population health. Both systems need to address the disparities in quality of health care by race and income and contribute to the elimination of inequities in health status. Local coordination with and expansion of safety net providers should build on models which have worked in the past within King County and explore new ways of using current resources most efficiently while advocating collectively for new resources.

  - The interaction and close coordination between the personal and population health arena is a sleeping giant for prevention within

King County. For example, the efforts of the King County Health Action Plan with its Kids Get Care program and renewed effort to "Cover All Kids in King County"; the Puget Sound Health Alliance with its focus on this intersection for improving quality help drive down costs. The public/private Collaborative on Diabetes, Asthma, Children's Preventive Health are getting underway.

- **Advocacy for universal access to healthcare needs reinvigoration** There is a tipping point at which widespread deficiencies in personal health care become themselves major public health problems. Many believe that we are already past that tipping point. Adequate population health cannot be achieved without making comprehensive and affordable health care available to every person residing in the United States. Key roles of public health in this collaborative effort are providing support, information and coordination with the health care providers in the community.

    - National, state and local leaders in the private and public sectors alike need to re-examine their role in building a consensus about the value of access to primary care and critical referral services

    - Also important to public health is not only the growing number of uninsured but also new barriers on the horizon (i.e., citizenship verification needed for access to Medicaid services as of 7/01/06.) As insurance coverage no longer guarantees access to needed services, and as the numbers of uninsured (or insured but unable to access services) grows - the population effects of disease and lack of access to care becomes a public health problem.

- **The public health workforce of the future will require new and varied skills.** There is no more important element of the public health infrastructure than the expertise and skills of the workforce.

    - Reduction or elimination of health disparities calls for a diverse workforce which better reflects the population served by King County.
    - Aggressive and innovative recruiting and retention strategies of high quality public health professionals are needed to replace an aging public health workforce.
    - Shortages, both nationally and locally, of clinical service providers, environmental health workers, nurses, family practice

physicians, and pharmacists exacerbate recruiting and retention problems.

- The demands of public health preparedness force the need to cross-train many in the workforce to new functional responsibilities.
- Increasing mental health problems among the population served calls for an expanded capacity to adequately serve this population.
- Rapid growth in the knowledge base for public health practice makes it very challenging for the department to keep up with literature and current guidelines
- The challenges facing a modern urban health department require a population of workers who can engage community residents using non-traditional methods and innovative approaches.

Attachment I
One Model for the Determinants of Health

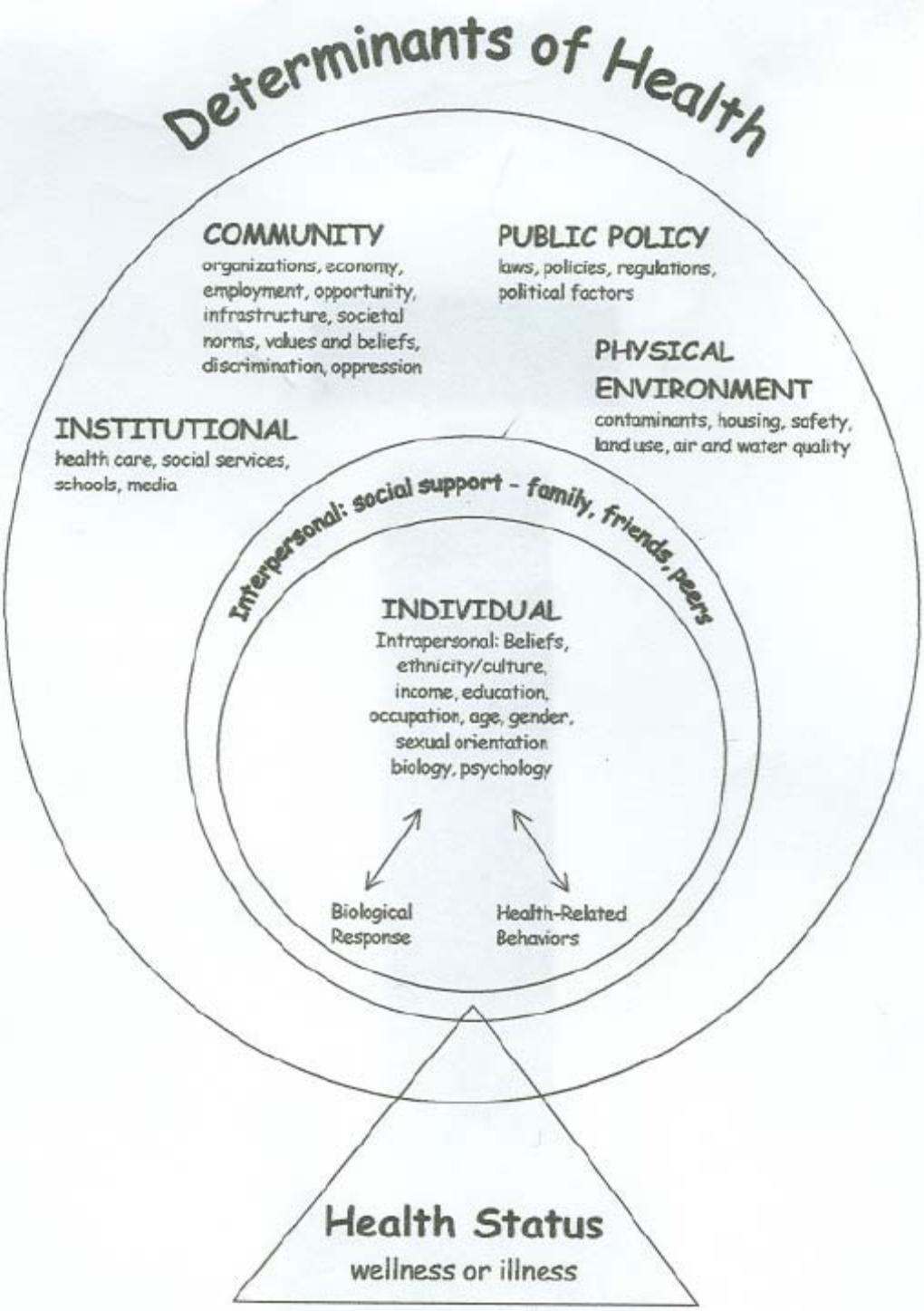
A model adapted from the one developed by the Detroit Urban Research Center is reproduced on the following page. It may be useful to provide a summary of a way to think about this model in the context of a paper on the health environment.

The triangle at the bottom of the figure can be seen as a fulcrum on top of which is balanced a system of inter-related determinants of health. If this system tips to the right illness is more likely to occur: tipping to the left fosters wellness (or health).

The circles depict factors influencing health within three categories of determinants: individual intrapersonal factors, interpersonal social support factors and overarching upstream factors. Individual health is influenced by an interaction between the interpersonal factors with the person's biologic response based in genetics and individual health–related behaviors. But these individual factors are operative within the context of an interpersonal network of social support which, in turn is greatly influenced by overarching factors within institutions, the community, the physical environment and by policy. Thinking of health in this way opens up many opportunities for improving health beyond simple paradigm of avoiding risk factors and illness.

Framing the determinants of health broadly should include the influences across the lifespan of genetic and biological processes, individual behaviors and lifestyle, and the social and physical environments in which people live. This sets the stage for the discussion on the environment and human health. For instance, access to personal health care services is thought to contribute 10% to a population's overall health, the social and physical environment 20%, genetic endowment 20% and health behaviors 50%. . How the balance moves toward wellness or illness is, therefore, not only determined by individual choice and biology but also by the social support for healthy choices and the upstream context of policy, community, environment and institutions which promote healthy choices.

Individuals and families are embedded within social, political, and economic systems that shape behaviors and constrain access to resources necessary to maintain health. Greater emphasis is needed on public health interventions that involve communities, with the goal of collectively identifying resources, needs and solutions.



Adapted from a model by the Detroit Urban Research Center.

Attachment II

Observations about Health Disparities: Comparison MMHD

Alameda County (Excerpted from: Alameda County Health Status Report 2003)

- The findings of this report demonstrate the persistence of large racial and ethnic health disparities in Alameda County.
- Inequities in income and education level exist in Alameda County. Poverty has changed little during the past decade.
- Examples of existing disparities:
  - African Americans clearly bear a larger burden of disease and death than other racial/ethnic groups for almost all the indicators examined.
  - Latinos and Native Hawaiian/Other Pacific Islanders had birth rates in 2000-2001 that were substantially higher than those among other race/ethnic groups.
  - The CHD (coronary heart disease) death rate was substantially higher among African Americans than among other racial/ethnic groups.
  - African Americans had a significantly higher cancer death rate than Asians, Latinos, or Whites.
  - African Americans were ten times more likely to die as a result of a homicide than all other racial and ethnic groups combined.

Columbus Health Department (Excerpted from: 2002 Franklin County Health Assessment)

- Examples of existing disparities:
  - Access to healthcare remains particularly difficult for certain sub segments of the population, including low-income and African American residents.
    - Among uninsured adults in Franklin County, 40.3% report that they are uninsured because they cannot afford the insurance premiums.
    - More than one-third of adults living at or near poverty and 24.3% of Non-Hispanic African Americans lack prescription drug coverage.
    - Among low-income adults, nearly 50% had not visited a dentist in the previous year and over 40% were without dental insurance.

- Overall, Franklin County rates are much higher than those reported both state and nationwide for primary/secondary syphilis, gonorrhea, and Chlamydia. For each of these, African American rates dramatically exceed those reported among Whites and Asian/Pacific Islanders.

Miami-Dade County Health Department (Excerpted from: Miami-Dade County CATCH Report)

- Examples of existing disparities:
  - This [Far South Community] has the youngest population, the second highest percentage of black persons (26.7%), and the lowest per capita income ($14,211). It also has the highest percentage of live births, and the highest age adjusted death rates from all causes. Its population is 48% Hispanic.
  - This [Northeast Community] has the highest percentage of blacks (48%) and lowest percentage of Hispanics (35%), and is home to the majority of Miami-Dade's Haitian population. It has the second lowest per capita income ($16,861) and the highest percentage of Medicaid births. It had the most unfavorable rates for the Infectious Disease category.

Metro Public Health Department of Nashville and Davidson County (Excerpted from: Health Nashville 2002, Davidson County Mortality Report, 2003)

- On too many of the national benchmarks, Nashville comes out exceedingly below. On too many of the issues, the disparity gap has been evident for the past decade with no evidence of changing. (Health Nashville 2002)
- Examples of disparities (DCMR, 2003):
  - The infant mortality rate was 6.0 for Whites and 11.9 for Blacks.
  - Blacks experienced higher death rates for heart disease, cancer, stroke, diabetes, influenza and pneumonia, Alzheimer's disease, and nephritis. Whites had higher death rates for CLRD, accidents, and suicide.
  - The death rate for diabetes among blacks was 2.4 times that of Whites.
  - The death rate of nephritis was 2.6 times higher in the Black segment of the population than it was in the White population.

Nassau County Health Department (Excerpted from: Nassau County Community Health Assessment 2005-2010)

- There are substantial health disparities and inequities between racial and ethnic groups, and in different communities in Nassau County.

Minority groups bear a disproportionate burden of illness and premature death.

- Likewise, a disproportionate burden of illness and premature death is concentrated in certain communities.
- Social and economic factors associated with poorer healthcare are more common in the selected communities and among racial/ethnic minorities.
- Examples of existing disparities:
    - The difference in the infant death rate is decreasing but is still substantial. In 1993 it was 4 times greater in non-Hispanic blacks compared to non-Hispanic whites and in 2002 it was 2 times greater.
    - The estimated prevalence of HIV in blacks is over 20 times greater than whites and 3.5 times greater in Hispanics than whites.
    - The average homicide mortality rate from 1999-2002 in blacks was nearly 9 times greater than for whites.

Attachment III – City Rank by Indicator, Big Cities Health Inventory 2003*

Health Indicator	Columbus	Miami	Nashville	New York City	Oakland	Seattle
AIDS Incidence	---	---	17	5	11	---
Syphilis Incidence	15	---	3	26	---	---
Chlamydia Incidence	18	---	24	22	19	29
Gonorrhea Incidence	16	---	12	24	18	27
Tuberculosis Incidence	---	---	19	7	6	22
Overall Mortality	19	4	28	43	34	38
Heart Disease Mortality	31	4	30	10	34	41
Cancer Mortality	17	5	28	45	32	33
Lung Cancer Mortality	13	23	12	44	35	25
Female Breast Cancer Mortality	16	5	37	36	19	31
Motor Vehicle Injury Mortality	40	1	3	47	37	38
Homicide	36	7	16	30	12	39
Suicide	42	4	14	46	40	15
HIV/AIDS Mortality	37	1	20	7	15	27
Fertility	42	1	38	37	28	44
Infant Mortality	15	39	13	30	35	45
Low Birth weight	14	20	17	27	38	46
Prenatal Care	17	13	7	37	1	25
Mothers Under Age 20	28	27	32	42	33	46
Mothers Who Smoke	3	39	18	33	---	23

* Based on ranking of 47 cities; 1 corresponds to highest rate

Attachment IV

Ratio of Select Black to White Mortality Rates, by MMHD Major City

	City Average	Columbus	Miami	Nashville	New York City	Oakland	Seattle
Overall Mortality	1.26	1.25	1.24	1.43	1.23	1.45	1.43
Heart Disease Mortality	1.21	1.21	1.07	1.39	.98	1.69	1.45
All Cancer Mortality	1.25	1.20	1.28	1.60	1.12	1.35	1.37
Lung Cancer Mortality	1.22	1.14	.93	1.29	.96	1.42	1.09

Big Cities Health Inventory 2003

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X: Milne & Associates: Role Definition Background Report

Role Definition Background Report
Prepared by Milne & Associates, LLC
April 12, 2006

Caveat

Please note: This White Paper should be viewed as a dynamic product reflecting information received to-date. There has been a continuous flow of documents and other information; it is likely that new information will continue to be provided during the life of this project. Moreover, interviews with the 5 metropolitan health departments have taken longer than planned, owing to variable availability of those being interviewed. It has not been possible in all cases to align our schedule with theirs. Accordingly, the reader should regard this paper as a draft that will be used to guide production of the policy framework and that will continue to evolve to inform policy recommendations in the next phase of the project. It should also be noted that while the RFP for the project specified information to be considered in the development of the White Papers, we are also considering other information that we deem important in development of the Operational Master Plan.

Role Definition Executive Summary

Distinguishing Features

- Wide variation exists among major metropolitan health departments (MMHD) in terms of their scope and complexity, yet still there are some commonalities:
    - MMHDs typically act more independently within their state-local public health system and have more complex day-to-day relationships with communities within their jurisdiction as the focal governmental public health agency.
    - Similar demographic and socioeconomic characteristics, major drivers of health status and health department focus, are present among MMHDs.

- King County is a demographically typical metro area, not unusual in most major respects to other metro areas and the five comparison MMHD jurisdictions.

  - Health inequities and its determinants are very important overarching challenges for all MMHDs

- Certain highlighted features about King County populations include:
  - Weekday population swells by an *additional* 400,000 workers.
  - Numerous vulnerable populations which are often outside the reach of regular health care provider and traditional public health and other emergency response systems need services.
  - Annually approximately 32,000 individuals experience homelessness.
  - A rich and diverse culture and language base are prominent.
  - King County compares relatively favorably on overall socio-economic status (SES) characteristics with 5 comparison MMHDs and is somewhat in the middle on median household income, unemployment and poverty but has sharp disparities in the latter factors.

- Jurisdictional and governance oversight is complex in all MMHDs in the country, but almost three quarters have "county only" health departments.
  - A city-county governance structure is the least common arrangement, representing only about 10% of MMHDs.
  - PHSKC appears to have a relatively complex jurisdictional and governance arrangement.
- MMHDs have an important preparedness role to play in the case of natural or man-made disasters and deal with very complex emergency preparedness needs and systems.
  - PHSKC has the responsibility to connect King County's 19 hospitals, over 7,000 medical professionals, 27 community health centers, several specialty care facilities, and numerous primary care organizations to its public health preparedness network. The network of preparedness planning includes 30 fire departments, 8 HAZMAT teams, and 29 local law enforcement agencies.

- King County's geography has some unique features including urban, suburban and rural communities. Bordered to the east by the Cascade mountain range and to the west by the waters of Puget Sound, King County covers an area (2,126 sq. miles), slightly larger than the state of Delaware. Earthquakes, volcanic eruptions and tsunamis pose a risk for King county

- Seattle/King County is an international port of entry and trade with a high level of threat not only for acts of terrorism but also for infectious diseases such as SARS and Norwalk virus. Each year 1.1 million arriving airline passengers originate their flights from international destinations, and 100 cruise ships carry nearly 200,000 people who disembark.
    - Major cities such as Seattle are potential targets for terrorism.

Role, Mission, Goals and Services in the Community

- Statements of the role, mission and goals of MMHDs, including PHSKC, reflect remarkably similar philosophies, purposes and functions.

- Differences in the types and organization of services provided by MMHDs tend to reflect the unique characteristics of their jurisdictions, including traditions, history, and community values.

- The service array provided by MMHDs including PHSKC is aligned with the Ten Essential Service framework, and all essential services are addressed.

- PHSKC provides a highly comprehensive array of services. Over 90% of the public health services recorded in profiles collected by the National Association of County and City Health Officials (NACCHO) are provided within the PHSKC jurisdiction. These include all of the core communicable disease control services, environmental health, population based prevention, and basic health services.

- Functional comparisons of local public health agencies, as might be done for hospitals and other healthcare organizations, are challenging because local public health agencies (LPHA) including MMHDs are noted for their diversity in function and structure.
- Public health services can be made available in a community by: (a) direct provision of services by the LPHA or other public agency of the local government, (b) indirectly through funding by the LPHA of delegate agencies which deliver services, (c) indirectly through other agencies that are not funded by the LPHA but the LPHA regulates, coordinates or facilities this third party service delivery. PHSKC employs all of these methods of service delivery

- MMHDs including PHSKC share similar jurisdiction characteristics but demonstrate considerable diversity in organizational characteristics, specific service configuration, governance, response to community needs, and relationship to the larger health care system. Typically this diversity is driven by the following factors:
    - Health related needs of those in the community
    - Prevailing beliefs about the appropriate role of a health department
    - Local tradition and history
    - Incremental decision making over time
    - Threats and crisis including unique risks
    - Opportunities, such as federal grant programs
    - Politics and stakeholder advocacy
    - Current MMHD leadership
    - Division of responsibility between state and local governmental public health agencies.

- LPHAs (including MMHDs) are moving toward doing less service delivery directly and more through networks of delegate agencies and shared arrangements with other governmental agencies. PHSKC appears to be moving in this direction but at a slower pace than other MMHDs.

- Most of the five comparison MMHDs see legislative mandates as a reality that must be accommodated but not necessarily embraced by stringent conformity. PHSKC may find mandates as more influential in setting strategic direction than do other MMHDs

- Division of responsibility between the state and local public health agencies was not in itself seen as an important determinant of strategic direction, but PHSKC appears to share less of the public health burden with the state than do comparable metropolitan health departments (CMHDs).

Conclusions

We find that there are no major gaps in functions or services provided by PHSKC when compared to the profession's definition and expectations as well as to other MMHDs. Indeed, PHSKC is perhaps one of the most comprehensive metro-size health departments in the country. This comprehensiveness appears to derive from a confluence of factors including a strong tradition of governmental public health in the PHSKC region, a dedicated and highly competent public staff,

seemingly extensive mandates, along with support and expectations from stakeholders in the authorizing environment.

This situation, however, may prose challenges to PHSKC in setting strategic direction. While PHSKC, like other CMHDs engages in strategic planning, a traditional strategic planning process alone may not be sufficient to overcome some of the external drivers for direction setting such that PHSKC can make strategic choices and set priorities. One consequence may be a service array that outstrips available resources.

Introduction and Overview

King County contracted with Milne & Associates, LLC, to assist in producing a Public Health Operational Master Plan for Public Health-Seattle & King County (PHSKC). One of the early deliverables in the project is the production of a report describing the purpose and role of a governmental public health agency in a major metropolitan health area and to describe how PHSKC carries out that role. Specifically, we were asked to address:

- Distinguishing factors of Major Metropolitan Health Departments (MMHD)
- The role, mission, and goals of MMHDs in their communities
- The basic role of a governmental public health agency in any community and the differences from the basic role and the role and purpose of an MMHD
- Compare several MMHDs and PHSKC on the distinguishing factors, roles, mission, and goals.

The complexity of large urban public health departments can be grasped by examining three perspectives that reveal factors which offer some insight into what these public health departments do and why they do it: (1) the general analytic framework of what separates a public health department from other health-related organizations, (2) the distinguishing factors of a public health department's external environment, and (3) a public health department's response to these factors in the community through established roles, mission, and goals.

General analytic framework
The first perspective is the broadest and addresses those considerations that separate a public health department from other health related organizations, such as a hospital or social service agency, whether governmental or not. These factors form a mental model or template which provides a broad framework for defining what constitutes a public health department, especially a large complex urban public health department. These factors describe the prototypical health department and are largely derived from the evolved tradition of the public health field and more recent thinking of national leadership organizations, both governmental and professional. Public health departments are expected to carry out certain specific activities as opposed to others. While these factors are not completely uniform or fixed, they do provide the broadest framework for establishing the identity of a public health department.

Distinguishing factors of a public health department's external environment Public health departments, like most organizations, are influenced in a strategic way by key features of their external

environments. This second perspective, while related to the first, gets defined by the specific distinguishing features of the jurisdiction that might influence a large public health department's size, structure and service array.

A public health department's response to the external environment in terms of their roles, mission, and goals

The third perspective relates to the role, mission and goals of the public health department, which in essence is the strategic response that a public health department adopts in adapting to external demands. In adopting a specific response, a large urban public health department is likely to blend the distinguishing characteristics of its jurisdiction with some readily identifiable framework or model to establish its specific role and mission in the community.

In focusing on these three overarching perspectives and the factors which they reveal, this analysis attempts both to provide a descriptive overview of what public health departments are, for the purpose of providing context, as well as to highlight how PHSKC stands against these perspectives and in relation to peer major metropolitan health departments.

This report highlights distinguishing features of Major Metropolitan Health Departments (MMHDs) generally and more specifically those of Public Health-Seattle & King County (PHSKC). In some instances, more detailed comparisons are made with the jurisdictions served by the five comparable MMHDs (hereafter abbreviated as CMHDs) selected as comparables for the policy framework: Alameda County (CA), Columbus City (OH), Nashville-Davidson County (TN), Miami-Dade County (FL), and Nassau County (NY).

Like other MMHDs, PHSKC presents a range of interesting features which are of significant importance to various PHSKC stakeholders. To help create a policy focus for decision makers, we have singled out those elements of PHSKC which we believe are most relevant to this analysis.

- Of the 3,000 local public health agencies (LPHAs) in the United States, only 200 (or approximately 5%) are designated Metropolitan Health Departments (MHDs). While these agencies represent only a fraction of the total number of LPHAs in this country, individual MHDs are responsible for providing public health services to populations of 350,000 or more, and as a group provide services for nearly 60% of the U.S. population.

- Self-defined by their members as a "new and evolving classification," the largest 25 MHDs in the country, or Major Metropolitan Health Departments (MMHDs), are further distinguished from other urban health agencies on the basis of "population served," and serve populations of nearly one million people or more. But MMHDs are hardly a homogenous group; there is wide variation in terms of their scope and complexity and as much as a tenfold difference in terms of population served. PHSKC is an MMHD serving 1.8 million people in King County.

Types of public health departments				
Category:	Local public health agencies	Metropolitan health departments	Major metropolitan health departments	Comparable metropolitan health departments*
Acronym:	LPHA	MHD	MMHD	CMHD
Number in the U.S.:	~3,000	200	25	5
Size of population served:	500 individuals to 9 million	350,000 to 9 million	1.2 million to 9 million	500,000 to 2.3 million
* The CMHD's in this report consist of the five following health departments: Alameda, CA; Columbus, OH; Davidson/Nashville, TN; Miami-Dade, FL; Nassau; NY.				

- MMHDs often have different relationships with their state health departments and communities than do other LPHAs. MMHDs frequently act more independently within their state-local public health system and have more complex day-to-day relationships with communities within their jurisdiction as the focal governmental public health authority.

- While the public health community has been wrestling for the past twenty years to develop a somewhat standard framework for determining the appropriate service configuration of a local public health department, only recently has a consensus started to emerge on what such a framework should include.

- It is difficult to make functional comparisons of local public health agencies, as might be done for health care organizations like hospitals. Local health departments are noted for their diversity in function and structure. The national public health leadership, including federal public health agencies and national professional

bodies, have expressed concern about how this extreme diversity confounds efforts to define LPHA functions in a standardized way that might communicate the functions of public health to the broader public or permit functional comparison of public health agencies.

- The Ten Essential Public Health Services, formulated in 1994 by a workgroup convened by the U.S. Surgeon General, has emerged as the basic framework which the national public health leadership has used to define public health and the functions of public health systems at the state and local levels. The Ten Essential Services are cast in the language of public health professionals which is often not understandable to those who do not work in the field. Presented below are the Ten Essential Services along with a more common sense interpretation of what each means. (The description in italics are taken from Milne & Associates, LLC document "10 Essential Services in English".)

1. Monitor health status to identify community health problems
   - *What's going on in my community? How healthy are we?*

2. Diagnose and investigate health problems and health hazards in the community
   - *Are we ready to respond to health problems or threats in my county? How quickly do we find out about problems? How effective is our response?*

3. Inform, educate and empower people about health issues
   - *How well do we keep all segments of our community informed about health issues?*

4. Mobilize community partnerships to identify and solve health problems
   - *How well do we really get people engaged in local health issues?*

5. Develop policies and plans that support health and ensure safety
   - *What local policies in both government and the private sector promote health in my community? How effective are we in setting healthy local policies?*

6. Enforce laws and regulations that protect health and ensure safety

- *When we enforce health regulations are we technically competent, fair and effective?*

6. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
   - *Are people in my community receiving the medical care they need?*

8. Assure a competent public health and personal health care workforce
   - *Do we have a competent public health staff? How can we be sure that our staff stays current?*

9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
   - *Are we doing any good? Are we doing things right? Are we doing the right things?*

10. Research for new insights and innovative solutions to health problems
    - *Are we discovering and using new ways to get the job done?*

- The Ten Essential Services descriptions are at a generic level and, while they do serve to somewhat narrow the definition of public health, they are not sufficiently detailed as to *functionally* define the *specific* services that should be delivered by a LPHA. For example, there are several ways that any particular public health service can be made available in a community: (a) direct provision of services by the LPHA or other public agency of the local government, (b) indirect provision through funding by the LPHA of delegate agencies which deliver services, (c) indirect provision through other agencies that are not funded by the LPHA but the LPHA regulates, coordinates or facilities this third party service delivery.

- A more recent effort to define Local health departments in a more standardized functional way is underway, led by the National Association of County and City Health Officials (NACCHO) and based on the Ten Essential Services. The Operational Definition project (as it is called) is now into its second year and has recently released a report that attempts to more specifically define LPHA functions and 25 standards for how these functions might be conducted. NACCHO developed the operational definition of a local governmental public health agency to be "… the basis of future efforts to develop a

shared understanding of what people in any community, regardless of size, can expect their governmental public health agency to provide at the local level…" The creation of this framework will allow for more direct comparison of functions and services among Local health departments. A more complete description of the Operational Definition elements is presented in Attachment I

- In addition, while the Ten Essential Services are now generally accepted as a functional public health system framework, other frameworks have been adopted by individual states. Noteworthy, Washington State has independently adopted *Proposed Standards for Public Health in Washington State* in 2000. The Washington State standards were developed to provide guidance in clear language on the basic capacity of every jurisdiction to offer public health protection in five areas:
    - Protecting people from disease,
    - Understanding health issues,
    - Assuring a safe and health environment for people,
    - Promoting health living, and
    - Helping people get the services they need.

  The Washington State Public Health Improvement Plan from 1993 influenced the development of the Ten Essential Services and the Ten Essential Services influenced Washington State's most recent efforts. The Washington State standards appear to be closer in purpose to the Operational Definition – to facilitate implementation and action rather than simply to define functions. Washington State's efforts in this area are grounded in state legislation; a fuller description is provided in Attachment I.

- Functional diversity is somewhat narrowed when LPHAs are clustered by jurisdiction size. As might be expected, the largest agencies have more in common with each other than they do with smaller LPHAs. For example, while the Ten Essential Services are recommended by the Institute of Medicine (IOM) as a common framework for local public health departments of all sizes, the largest public health departments are more likely to offer a greater number and a greater intensity of the Ten Essential Services in their jurisdictions than do smaller public health departments. This distinction has proven to be functionally useful; NACCHO has formally organized its membership into three groupings roughly corresponding to size. The Metro Forum, to which PHSKC belongs, is comprised of the largest LPHAs that are usually associated with a metropolitan area. While these LPHAs share similar jurisdiction characteristics including population

size and diversity, health status conditions, community role, basic functions, and finance and management challenges, they still exhibit considerable diversity in organizational characteristics, specific service configuration, governance, response to community needs, and relationship to the larger health care system.

I. Basic Role of a Public Health Agency - Distinguishing Factors of the External Environment

Political and Operational Factors

- An examination of most large health departments across the nation suggests the ten factors below play an influential role in determining specific LPHA roles, missions, and functions. These factors were derived from the experience of the Milne & Associates team in the areas of public health department functions, structure and financing. The relevance of these factors was validated through the interviews conducted with executive leadership and senior management of the five comparable health departments (CMHDs) and is presented in Attachment II.
    - **Community need** as determined by epidemiologic analysis of the overall demographic characteristics and health status conditions
    - **Prevailing beliefs** about the appropriate function of a LPHA, especially in relationship to the larger health care system
    - **Local tradition** and history
    - **Incremental decision making** over time that tends to layer-on functions
    - **Threats** and crisis including unique risks
    - **Opportunities**, such as funding opportunities (e.g. federal grant programs such as Model Cities and Ryan White)
    - **Politics** and stakeholder advocacy including elected official and community expectations
    - **Current LPHA leadership** which can set overall direction, create emphasis and drive change
    - **Jurisdictional division of responsibility** between the state and local public health agencies
    - **Statutory authority** from which the local health department derives its powers.

- LPHAs as a class of public agencies are moving toward doing less service delivery directly and more through networks of delegate agencies in following the public management trends of doing more

"steering" and less "rowing", a concept advanced in the "reinventing government" movement (Osborn and Gabler), more recently termed "government by network". This approach is formally taking hold in public health through the concept of the public health *system* -- the network of organizations and agencies in a community that actively contributes to improving the health of the community. The public health system has played a more prominent role in local public service delivery since the most recent IOM Report, "The Future of the Public's Health" (2002)and is being advanced by the Centers for Disease Control & Prevention (CDC). The principal recommendation in this report and advanced by the CDC suggest that the focus of public health action at the local level should shift from the public health agency to the public health system which includes:

- Community based organizations and the community at large
- The Health care delivery system
- Employers and business
- The media
- Academia
- The governmental public health infrastructure

Under this construct, local health departments become key enablers and form the core of the public health system but recognize that the health of a community depends on the participation and action of a variety of players beyond health departments.

- Used in tandem, the Ten Essential Services and a comparison of PHSKC to comparable MHDs/CMHDs, provides both a general and specific analytic framework for the examination of PHSKC's role and functions.

While PHSKC and all CMHDs reported in their interviews that each of the influential factors listed above played a policy role for their public health department, there was some variation in the degree of influence exerted by each factor and the response of each public health department.

- **Community need**, as defined by population demographics and health status conditions, was rated as being a very important driver of strategic direction and LPHA functions for PHSKC and four of the five MMHDs. Each was able to identify specific population demographic changes and community health status conditions for which their health department was specifically tracking and responding. Three CMHDs had developed sophisticated mechanisms for obtaining and analyzing data on community needs. Even the one CMHD that rated community need overall as a lower priority driver was able to identify several specific community conditions of concern

to the CMHD and did so in making the point that responding to community needs was very important but depended on funding. PHSKC assesses community health, system capacities, community assets and values to carry out strategic priority setting. The highly diverse demographics of its jurisdiction present both opportunities and challenges.

- Three of five CMHDs rated **prevailing beliefs** about the appropriate function of a LPHA as a very important driver but several noted that beliefs did not always fit the reality. The public is more concerned with *medical care* services than with a broad vision of *public health* and tends to mischaracterize the CMHD's primary role as a health services provider for the poor. One CMHD was actively trying to counter that through "re-branding." The one CMHD that rated prevailing community beliefs as not important saw itself as being somewhat insulated from overall public pressure largely due to solid support among specific community stakeholders. PHSKC rated this factor as neither important nor unimportant.

- The role of **local tradition** and history as a driver of strategic direction varied among CMHDs. Two noted that it was very important, with others seeing it being rather neutral. There was a general recognition that history provides a sense of tradition that can be drawn upon and used to set the stage for current and future action. However, there was also awareness that tradition can "bog you down" and be used to resist needed change. PHSKC rated this factor as rather neutral, noting that tradition can hold the public health department back but did not stop it from moving forward.

- All of the CMHDs and PHSKC had much to say about mandates as a policy driver and four of five CMHDs rated legislative mandates as important or very important. Most saw legislative mandates as a reality that must be accommodated but not necessarily embraced. Only one CMHD saw legislative mandates as fully determining strategic direction and functions ("95% of our programs are mandated by the state"). Other CMHDs looked for ways to lessen the burden of mandates, especially unfunded mandates, through:
    - negotiation with the mandate source,
    - absorbing mandates into existing operations,
    - using the agency strategic plan to determine how to address the mandate,
    - advocacy for either commensurate funding or removal of the mandate by working through the board of health or community stakeholders.

Grants and contracts were seen as a more manageable form of mandate because there was greater choice on the part of the CMHDs regarding how or even if a grant was to be pursued or a contract entered into. Three of the five CMHDs mentioned specifically the federal bioterrorism preparedness grant administered by states was particularly burdensome due to overly rigid requirements, intrusive monitoring, or insufficient funding from the state. PHSKC has benefited from the federal dollars available for public health disaster preparedness.

PHSKC rated mandates as very important, noting that mandates define much of what it does. PHSKC seems to find mandates of such significance that it has set up a compliance office, a response not reported by other MMHDs.

- Four CMHDs acknowledged that **incremental decision making** over time can layer-on functions leading to "mission creep," and for that reason rated it important to very important as a factor in strategic direction. Drivers of incrementalism mentioned by CMHDs included union contracts, evolving grant-funded programs and successive mandates. The overall view of this factor was negative but one CMHD noted that making incremental changes can be useful in helping staff see how a larger vision can be achieved. Only one CMHD rated this factor as largely unimportant. PHSKC rated this factor as neither important nor unimportant, noting that everything is reviewed each year so functions are less likely to get layered on.

- **Threats and crises** affecting the jurisdiction were seen as important to all five CMHDs, but only one rated it very important. This is surprising given the strong recent national emphasis on public health emergency preparedness. One possible reason offered by four of the five was a keen awareness of potential crisis coupled with effectiveness in integrating emergency preparedness into their routine operations so that they seldom had to operate in a crisis mode. PHSKC rated this factor to be very important, noting the complexity involved in preparedness planning.

- All CMHDs, and PHSKC, rated **funding** opportunities as important to very important determinants of strategic direction. All but one also noted that, important as new resources are, grants are only pursued for which there is a strategic fit, at least in the long run.

- **Politics and stakeholder advocacy** was a driver of strategic direction acknowledged by all five CMHDs, but only one CMHD rated this as very important due to community stakeholder interests, not from elected officials. The five CMHDs appear to be striking a balance of maintaining the interest of elected officials while managing their demands. Several strategies for dealing with elected officials were offered:
    - Regular meetings with elected officials
    - Including elected officials in the strategic plan development
    - Using the board of health as a buffer between elected officials and the public health department
    - Using community based organizations to influence elected officials

  One CMHD noted that there was little community or elected official interest in the public health department, possibly because that same CMHD also reported that state mandates largely determine the public health department's functions and programs. Another CMHD, touching on the same theme, noted that there was little elected official "interference" because the small level of local funding seemingly made the effort of little worth.

  PHSKC rated this factor as important, emphasizing that the views of the many elected officials served by PHSKC were very influential, perhaps more so than may be the case with other CMHDS that do not serve as many jurisdictions. PHSKC did not see the role of politics and advocacy as a negative influence, noting that the dynamic between elected officials' influence and community advocacy often helps identify acceptable middle ground.

- **Leadership** within the local health department was seen as important or very important to strategic direction by PHSKC and four of the five MMHDs. Leadership was exercised usually through the strategic plan and involved a top level management team in routine decision making. Leadership was seen as important for high level organizational purposes such as direction setting, establishing the public health department's agenda, driving change, developing policy, and establishing management tone and organizational culture. At least one CMHD noted that resources are dedicated to internal leadership development. The one CMHD that did not see leadership as important was the same one that reported its direction as being largely set by state mandates. This CMHD also reported that many of its senior managers were either unionized or were long-standing employees, not selected or promoted by the health

officer. PHSKC noted that having too much emphasis on leadership or too high a profile can make leadership a target for criticism.

- **Jurisdictional division of responsibility** between the state and local public health agencies was not in itself seen as an important determinant of strategic direction. Only one CMHD rated this as very important -- the same CMHD which reported the determining role of state mandates. Three CMHDs noted that they are independent of the state and can set their own direction. The fifth CMHDs is part of a centralized state-local public health system. Four CMHDs noted areas of friction with the state including: a lack of state leadership, the state's inclination to take a "one size fits all" approach in relation to LPHAs, rigid "silos" in the state health agencies' organizational structure, resistance to new ideas, and an unfair sharing of state-wide public health resources. PHSKC was similar to other CMHDs in rating this factor, noting that the relationship with the state was good at present but has not always been that way.

- Having **statutory authority** for action was viewed as very important by PHSKC and all but one CMHD. But several noted that having broad authority was more useful than specific authority as it provided flexibility to address concerns not specifically covered in the statutes.

- Finally, an overarching issue discussed by all CMHDs across these determinants was the importance of **health inequities** within their population. Indeed, this is a challenge faced by all CMHDs in the country. This issue will be addressed in greater detail in the White Paper on Health Environment.

Demographic and Geographic Factors

Several features of the jurisdiction that have an influence on an MMHD's role, mission and service configuration are examined below. These include: size and complexity of the population, jurisdictional complexity, geographic and topological characteristics, impact of ports-of-entry, risks and potential threats, and overall population health status characteristics. Focusing public health efforts at a population level is one of the principles of public health, and a number of demographic characteristics influence population health status. The age structure of the population influences both health status and health services utilization. Older populations tend to have poorer health status and have higher health services utilization rates. Income and socio-economic status is another important characteristic and has been found to be the single best predictor or health

and illness. Not surprisingly, lower income populations tend to have poorer health status and lack access to health care services due to having lower levels of health insurance coverage. Poverty also is a major contributing factor in homelessness, chronic illness, and many communicable diseases. Ethnic composition is important because health behaviors are strongly influenced by cultural beliefs; cultural competency is necessary for health care providers and health educators to effectively communicate with individuals and the community. Key public health demographic characteristics such as fertility and birth rates vary by income and ethnicity. Unfortunately, ethnicity and socio-economic status can interact negatively and result in disparities in health status that affects the several larger minority groups including African Americans, Hispanics and Native Americans.

Size and complexity of the population

- The 25 MMHDs in the U.S. are responsible for providing public health services to nearly 60 million people. The smallest MMHD, Contra Costa County (CA) Health Department, serves approximately one million people, while the Los Angeles County Health Department serves a population of nearly 10 million people. Most MMHDs serve populations in the 1-3 million range.

- Demographic and socioeconomic characteristics -- major drivers of health status and health department focus -- vary widely within the counties served by MMHDs.

    - *US population* grew by 13% in last censual decade with greater growth noted among non-white, non-Hispanic racial and ethnic populations, a trend which is generally mirrored in the jurisdictions served by MMHD.

    - *Ethnic diversity* is usually greater in metro areas but can vary greatly. Minority populations (non-white) among the CMHDs range from over 80% in Miami-Dade County to 17% in Allegheny County, Pennsylvania.

    - *Age composition* also varies. According to 2000 Census figures, population under age 18 ranges from 16.8 % in New York County to 32.3% in San Bernardino County. At the other end of the age scale, persons over age 65 ranges from 7.4% in Harris County, Texas to 23.2% in Palm Beach County, Florida.

- Characteristics of socio-economic status (SES), also an important correlate of health status, show significant variation among MMHDs. Poverty (2004) ranges form from just over 5% of the population in Nassau County, New York to 25% in Philadelphia County.

- PHSKC is the 10th largest MMHD in the nation, serving nearly 1.8 million people and a third of the state's population. Additional distinguishing features of the King County population include:

  - The population swells each weekday by an *additional* 400,000 workers.

  - The existence of numerous vulnerable populations of significant scale, including people with disabilities, people with serious mental illnesses, minority groups, non-English speakers, children, and frail elderly. Many do not have a regular health care provider and are beyond the reach of traditional public health and other emergency response systems.

  - A homeless population on any given night of about 8,000 individuals in shelters or sleeping outside; on an annual basis approximately 32,000 individuals experience homelessness.

  - A diverse language base, in which as many as 80-100 languages are spoken in schools and at least 10 language groups require regular translation and interpreter services in public health clinics alone.

  - King County is a demographically typical metro area (please elaborate), not unusual in most major respects to other metro areas and five CMHD jurisdictions (see Attachment III).

  - King County compares relatively favorably on characteristics of socio-economic status with 5 CMHDs (see Attachment III): it is somewhat in the middle on median household income, unemployment and poverty.

Jurisdictional complexity

- Jurisdictional complexity can influence public health organization and service delivery by complicating the ability of jurisdictions to come together and make collective decisions that affect the community's health. Decisions regarding public health mission, program focus

and funding are complicated when multiple decision making bodies are involved.

- Depending on the model of governance, MMHDs may be responsible for serving city-only, county-only or city-county combined populations.
    - Nearly 75% of MMHDs represent single political jurisdictions in the form of "county only" health departments.
    - A city-county governance structure, as is the case of PHSKC, is the least common arrangement, representing about 15% of all local public health agencies nationally. Only about 10% of MMHDs fall into this category.
    - The number of municipalities served by MMHDs ranges from 1 to 150. PHSKC is responsible for providing public health services to 39 municipalities, a relatively high number compared to CMHDS.

Geographic characteristics

- Geographic characteristics that may influence a MMHD's role and service configuration include proximity to state, multi-state or international borders, topographical complications that challenge transportation (e.g. vast distance or barriers such as mountains for rivers), climate conditions, coastal location, and geological factors (active volcanoes, geologic faults).

- The twenty-five MMHDs are concentrated in ten states: California (9), Florida (3), Texas (3), New York (2), Michigan (2), Pennsylvania (2), Arizona (1), Illinois (1), Nevada (1) and Washington (1). With the exception of four interior health departments, the remaining MMHDs are located along the periphery of the U.S. border and either directly, or indirectly, shares a border with one of the following significant bodies of water - the Great Lakes, the Atlantic Ocean, the Gulf of Mexico or the Pacific Ocean. The majority of these counties also meet the criteria for designation as "coastal counties" by the National Association of Counties (NACO).

- Counties containing MMHD vary in total area from 135 square miles in Philadelphia County to 20,062 square miles for San Bernardino County, and in their proximity to shared political borders. Only San Bernardino and Riverside counties in California border another state, and none of the MMHDs share multi-state borders. San Diego County Health Department is the only MMHD whose jurisdiction is directly contiguous with an international border (Mexico).

- King County's geographical variety includes 39 cities and suburban cities, and rural communities in the eastern portion of the county. Bordered to the east by the Cascade mountain range and to the west by the waters of Puget Sound, King County covers an area (2,126 sq. miles) slightly larger than the state of Delaware.

Ports of entry

- Ports of entry have been of traditional concern to public health officials as a points of entry for disease. The public health practice of quarantine started with a an effort to prevent disease from embarking with those sailing into ancient ports. And today, with global travel comes the risk that the emerging infection in some distant country is just a plane flight away from becoming rooted in the United States.

- The definition of ports of entry has broadened in this age of globalism beyond the typical boarder points of national entry and exit. Ports of entry now include interior international airports, major points along interstate highways, and communities with large concentration of immigrant populations.

- As MMHDs are located in large metropolitan areas, all have at least one international airport either within their home county (this is true for the majority of MMHDs) or in a neighboring county, and in some cases, multiple airports serve MMHD counties. Given the distribution of the MMHDs along the United States periphery as noted above, most of these health departments are located in counties with access to major sea or lake ports, or border counties with immediate such access.

- Seattle/King County is an international port of entry with a high level of threat, not only for acts of terrorism but also for infectious diseases such as SARS and Norwalk virus. Each year nearly 30 million passengers travel through SeaTac Airport with over 1.1 million of these originating from international destinations. During the five month summer season this year, over 100 cruise ships carrying nearly 200,000 passengers disembark in King County.

- Raising additional security concerns, King County is reachable also as a major transcontinental transportation hub for Amtrak, Burlington Northern, and Union Pacific railways, and Seattle is homeport for the U.S. North Pacific fishing fleet and a U.S. Naval base.

Risk

- While the U.S. has become sensitized to risks posed by acts of terrorism, emerging infectious disease and natural disasters, public health risks include these and other sources that while not as prominent in the public mind, do pose potential threats to the health and safety of an urban population. These include reemerging infections such as drug resistant TB, chemical spills, toxic substance releases, and population characteristics, including density that create an elevated exposure potential or predisposition.

- It is commonly assumed that major cities are potential targets for terrorism; those with special risk might be those with key governmental functions (e.g. Washington D.C., other state capitols); or with symbolic factors (e.g. Statue of Liberty, Wall St., tallest buildings, major landmarks like bridges (Golden Gate) or features (Space Needle).

- Cities that on a somewhat regular basis are exposed to significant weather, tide or other meteorological issues are at greater risk. Seattle's position at the base of an old and major volcanic, Mt. Rainier or its geographic proximity to a more recent volcanic threat, Mt. St. Helens is one such example. More significantly, Seattle lies on a major geologic fault line where earth quakes have been a real threat.

- Given their central role and responsibility for significant portions of a state's population (as much as one-half, in some cases), MMHDs have an important preparedness role to play in the case of natural or man-made disasters and must be able to deal with more complex emergency preparedness needs and systems. MMHDs have the direct responsibility for planning and coordinating with hospitals, community health centers, multiple first responders, community based organizations, and ethnically and linguistically diverse populations to establish preparedness capacity. The extent of risk posed by any given event may be complicated by the diversity of their populations and disparities in communications and other essential infrastructure necessary to mount an effective response.

- PHSKC has the responsibility to connect King County's 19 hospitals, over 7,000 medical professionals, 27 community health centers, several specialty care facilities, and numerous primary care organizations to its public health preparedness network. Similarly, first response organizations are included in this network of

preparedness planning--30 fire departments that provide Basic or Advanced Life Support response throughout the county, 8 HAZMAT teams, and 29 local law enforcement agencies that have jurisdictional authority for response to criminal acts, including acts of bioterrorism.

Health status

- Public health authorities use a variety of indicators to profile a population's collective level of health (health status). These include indicators of morbidity (death rates), mortality (the presence of disease), disability, health care utilization, behavioral risk factors (e.g. smoking), and components of population change (e.g. birth and mortality rates).

- According to the Big Cities Health Inventory (2003), which provides a ranking of the nation's 47 largest cities (those with populations ≥ 350,000) across 20 health indicators, the city of Seattle ranks relatively favorably vis-à-vis its peers: it performs in the upper quartile of big cities for nearly half of the 18 indicators for which data is available, and is in the middle quartiles for the remaining indicators. Seattle receives its lowest ranking (15) for its suicide rate.

- Select health indicators for Seattle and the major cities served by the five CMHDs are detailed in Attachment IV. Seattle performs the best in three indicators (heart disease mortality, homicide, and infant mortality), and is among the top three in the remaining indicators (overall mortality, cancer mortality, and motor vehicle mortality).

Basic Role of a Public Health Agency - Role, Mission and Goals in the Community

- Nearly all CMHDs have mission statements and strategic goals that express at the highest levels the role and mission of the health department in the larger community. This is the case for PHSKC and for all the five CMHDs examined here. While these statements of purpose and strategic intent may use different language and be formatted in different ways, they largely reflect similar philosophies,

purposes and functions. Their differences tend to be more a reflection of the unique characteristics of their jurisdictions, including traditions, history, and community values. The role and mission of a MMHD is most concretely expressed in the services that are provided and how these are organized.

- The configuration of public health services provided within a jurisdiction can be examined from two perspectives. First is the service array itself, regarding type and number of services, and second is how the services are organized or delivered. While there is no standard taxonomy of public health services, NACCHO has developed a service listing of 75 services, grouped in 11 categories that are reported on by public health services across the nation in NACCHO's local health department profile survey. While the Ten Essential Services (and the Operational Definition) prescribe what a public health department should do, the NACCHO profile survey attempts to gather information on what public health agencies actually do. The NACCHO profile survey also provides some insight into how services are offered in a jurisdiction, presenting five possibilities:
    - Performed directly by the local public health agency (LPHA)
    - Contracted by the LPHA
    - Provided by a state agency
    - Provides by another local government agency
    - Done by some other agency in the community

This service taxonomy will be used for this analysis, and the results for PHSKC are presented in Attachment V.

- As an MMHD, PHSKC provides a highly comprehensive array of services. Over 90% of the NACCHO profile public health services displayed in Attachment V are provided within the PHSKC jurisdiction. These include all of the core communicable disease control services, environmental health, population based prevention, and basic health services. A few regulatory related services regarding mobile homes, campgrounds/RVs, cosmetology, food processing are not offered in the jurisdiction, most likely because they are of very low relevance to this jurisdiction. This is comparable to the other CMHD for which we have data

- Over 88% of public health services provided in King County are provided either directly or indirectly by PHSKC; however, agencies other than PHSKC play a major role in the delivery of public health

services as well, as only 21% of all services provided are delivered by PHSKC alone. About one quarter of all services provided are done so either by contract to PHSKC, or by a state agency or another local governmental agency. Another 31% are provided independently by other agencies in the community. (Attachment V) PHSKC directly provides or funds a comparatively high number of public health services compared to other CMHDs, and PHSKC directly provided or contracts with others for delivery of the highest number of services compared to other CMHDs

- PHSKC contracts for nearly 25% of public health services available. For each of the contracted services, no contractor is the sole provider of that service and, in fact, PHSKC provides those services directly as well. (Attachment V) This is not an unusual situation compared to the other CMHDs.

- In King County, the State is most likely to provide regulatory and environmental health services. Other local governmental agencies provide mental/ behavioral health services, some population prevention services, a few regulatory and environmental health services, and most prominently other related public health services including animal control/veterinary service, occupational safety, laboratory services, hazardous waste disposal, school health and medical insurance outreach and enrollment. Non governmental community agencies share much of the core public health and clinical services. But PHSKC, compared with the CMHDs, was among the lowest for the number of public health services provided by the state, providing only about 50% of the number of services provided in the jurisdictions of the two CMHDS where the state played the greatest role.

- Contracted services include mental/behavioral health and several regulatory/environmental health related service which are provided by a state agency. While services in PHSKC are delivered through a wide collection of agencies other than PHSKC, PHSKC is directly involved (either by direct provision or by contract) in nearly 80 public health functions within the jurisdiction, a far higher number than other CMHDs which range from 64 to 43 services. Compared to the CMHDs, other entities including the state, other local government agencies, and other non-contracted organizations are more involved in providing services in the jurisdiction than in Seattle/King County.

- One way to gauge the adequacy of an MMHDs' service array is to examine the NACCHO service array against the Ten Essential Services framework which has been used by PHSKC and all five comparable MMHDs. In addition to examining the actual services provided, this assessment considered the resources available to PHSKC, as reported by PHSKC in NACCHO's 2006 Profile survey, other documents and interview information.

  a. Monitor health status to identify community health problems
     - PHSKC services include epidemiology for communicable/infectious disease, chronic disease, injury, and environmental health performed by 20 staff epidemiologists and other staff
     - The CMHD also perform these services, but appear to share the responsibilities with the state health department or other local governmental agencies more than does PHSKC.

  b. Diagnose and investigate health problems and health hazards in the community
     - PHSKC services include adult and child immunizations, screening for HIV/AIDS, sexually transmitted diseases, TB, cancer, cardiovascular disease, hypertension, pediatric blood lead, animal control, occupational health, and laboratory The CMHDs all provide these services in a similar manner to PHSKC, both as a direct provider and in conjunction with other agencies in the community and at the state level
     - PHSKC and CMHDs all provide, directly or indirectly, treatment for HIV/AIDS, sexually transmitted diseases and TB.
     - PHSKC along with all CMHDs has developed or made updates in an emergency preparedness plan, reviewed relevant legal authorities, participated in exercises/drills, participated in an actual public health emergency

  c. Inform, educate and empower people about health issues
     - PHSKC assures or provides population based primary prevention services in injury, unintended pregnancy, obesity, violence, tobacco use, substance abuse and mental illness, and has dedicated staff in health education and nutrition

- Other CMHDs also provide or assure these services in largely similar arrangements to that of PHSKC

d. Mobilize community partnerships to identify and solve health problems
   - PHSKC has completed a recent community health assessment and health plan and reports significant involvement of other entities in the community in public health service delivery
   - Other CMHDs also have sophisticated health assessment and planning functions which involve members of the public. One has developed an extensive community planning and participation manual. Two others have piloted a national community strategic planning process, Mobilizing Action through Planning and Partnerships (MAPP) which features extensive community participation.

e. Develop policies and plans that support health and ensure safety
   - PHSKC routinely provides reports on the health of the Seattle-King County area, serves as a resource to governing bodies and policy makers, advocates for policies that lessen health disparities and improve health, and engages in organizational strategic planning.
   - To one degree or another, other CMHDs develop policies and plans, issue reports on health needs and attempt to influence policy. Nearly all have organizational strategic plans.

f. Enforce laws and regulations that protect health and ensure safety
   - Regulation, inspection and/or licensing activities for: solid waste disposal, septic tank installation, schools/day care, swimming pools, tobacco control, lead/housing inspection, drinking water, food protection, and health facilities are provided within the PHSKC jurisdiction by either PHSKC or other governmental agencies
   - Other environmental health activities including: indoor air quality, vector control, land use planning, ground water protection and noise pollution are also provided by PHSKC

- The CMHDs examined also appear to provide a comparable range of inspection and regulatory functions with some differences in the involvement of other governmental agencies (e.g. state vs. local).
- Based on the NACCHO Profile survey data (Attachment V), for regulatory and environmental health activities, other CMHDs appear to share responsibility more with other local governmental agencies than does PHSKC. Of the 27 regulatory and environmental health related services in the NACCHO profile survey, PHSKC is among the lowest in having services offered in the jurisdiction provided by the state or other local agencies.

g. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
    - PHSKC services include comprehensive primary care(the most basic medical service), oral health, emergency medical services, school based clinics, correctional health and outreach/enrollment for medical insurance
    - Other CMHDs also provide or assure a similar range of services but seem to rely more on an indirect role in working though other agencies than does PHSKC. PHSKC seems to be unique among the five CMHDs in directly providing obstetrical and primary care
    - While CMHDs in general are involved in connecting those in need to behavioral health services, very few actually provide mental health services, relying instead on networks of community mental health agencies. Only one comparable CMHD was a direct mental health provider

h. Assure a competent public health and personal health care workforce
    - PHSKC conducts training using a broad variety of training sources and formats with specific training for evidence–based health promotion, applied epidemiology, core competencies for public health workers and public health informatics. PHSKC has assessed staff competencies and provided training in emergency preparedness.

- All other CMHDs report involvement in training to one degree or another, but PHSKC appears to have made a greater investment in this area

i. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
   - PHSKC routinely conducts internal program evaluation activities, evaluates the effectiveness of public health services provided in the jurisdiction and encourages partner agencies to engage in program evaluation
   - Other CMHDs report evaluation activities which range from formal department wide initiative to more sporadic program focused evaluation. One CMHD as formed a unit with specific responsibility for evaluation.

j. Research for new insights and innovative solutions to health problems
   - PHSKC has relationships with area universities and academic public health programs and participates in clinical trials where appropriate
   - Most CMHDs report relationships with academia which vary in depth and comprehensiveness. PHSKC may have a relatively greater and more formalized research involvement than do the CMHDs.

Conclusion

Based on the available information, the following initial conclusions can be made and implications drawn from the analysis. These conclusions are provisional and subject to further testing and refinement as additional work on the Operational Master Plan proceeds.

- While all large health departments have unique characteristics, from a demographic and geographic perspective, PHSKC appears to be typical, with few features that would overly influence its role, mission and service array, compared to other large metropolitan health departments.
- PHSKC appears to have a relatively complex jurisdictional arrangement to serve and to provide some accountability to a large number of jurisdictions and oversight bodies. This arrangement may complicate PHSKC's ability to make strategic decisions, as many stakeholders must be consulted and satisfied. PHSKC leadership rated the influence of politics and stakeholder advocacy as very important as a driver of strategic direction.

- For PHSKC, mandates or the perception of mandates may play a highly influential role in setting strategic direction. Mandates can come from actual legislative or contract requirements, but also appear in the form of stakeholder expectations, particularly from elected officials or strong interest group pressure. Several CMHDs seemed to more critically examine or challenge what appeared on the surface to be mandates. (This issue will be explored in greater depth in both the policy and funding papers.)
- A pattern that clearly emerges in examining the PHSKC service array against the Ten Essential Services framework is that all essential services are addressed within the PHSKC jurisdiction in a very comprehensive manner. Using this framework, from an overall perspective, PHSKC looks much like other CMHDs, as those examined appeared to provide or assure all Ten Essential Services.
- For some services, particularly treatment-related services, PHSKC may be more inclined to directly provide the service as opposed to providing the service indirectly though other agencies.
- The division of responsibility for assuring some services may be more concentrated within the health department in the PHSKC jurisdiction compared to other CMHDs, which seem to share the responsibility more widely with other agencies of local government or with the state.

From this analysis we find that there are no major gaps in functions or services provided by PHSKC when compared to the profession's definition and expectations as well as to the services provided by other MMHDs. Indeed, PHSKC is perhaps one of the most comprehensive metro-size health departments in the country. This comprehensiveness appears to derive from a confluence of factors, including a strong tradition of governmental public health in the PHSKC region, a dedicated and highly competent public health staff, seemingly extensive mandates, along with support and expectations from stakeholders in the authorizing environment. This situation may pose challenges to PHSKC in setting strategic direction. While PHSKC, like other CMHDs, engages in strategic planning, a traditional strategic planning process alone may not be sufficient to overcome some of the external drivers for direction setting noted above, to the degree that PHSKC can make strategic choices and set priorities. One consequence may be a service array that outstrips available resources. Implications include streamlining decision making to concentrate policy authority in a single oversight body, developing a more tailored strategic planning process, assuming a more aggressive posture toward mandates and burden sharing, and strengthening the role of the PHSKC executive leadership to help clarify and drive strategic direction.

As we move into Phase II of the OMP, we expect to more closely study and analyze the department's array of services, specifically focusing on how the department is best structured to provide these services and on opportunities for greater effectiveness and efficiency in service delivery well into the future.

Attachment I – Other Public Health Frameworks

The Operational Definition of a Local Health Department. The summary below is taken from a brochure produced by the National Association of County and City Health Officials which describes the Operational Definition and proposed standards that are not under review. This brochure is available at the following web site: http://www.naccho.org/topics/infrastructure/documents/OperationalDefinitionBrochure.pdf

All local health departments exist for the common good and are responsible for demonstrating strong leadership in the promotion of physical, behavioral, environmental, social, and economic conditions that

- Improve health and well-being;
- Prevent illness, disease, injury, and premature death; and
- Eliminate health disparities.

A functional local health department:

- Understands the specific health issues confronting the community, and how physical, behavioral, environmental, social, and economic conditions affect them.
- Investigates health problems and health threats.
- Prevents, minimizes, and contains adverse health effects from communicable diseases, disease outbreaks from unsafe food and water, chronic diseases, environmental hazards, injuries, and risky health behaviors.
- Leads planning and response activities for public health emergencies.
- Collaborates with other local responders and with state and federal agencies to intervene in other emergencies with public health significance (e.g., natural disasters).
- Implements health promotion programs.
- Engages the community to address public health issues.
- Develops partnerships with public and private healthcare providers and institutions, community-based organizations, and other government agencies (e.g., housing authority, criminal justice, education) engaged in services that affect health to collectively identify, alleviate, and act on the sources of public health problems.
- Coordinates the public health system's efforts in an intentional, non-competitive, and non-duplicative manner.
- Addresses health disparities.

- Serves as an essential resource for local governing bodies and policymakers on up-to-date public health laws and policies.
- Provides science-based, timely, and culturally competent health information and health alerts to the media and to the community.
- Provides its expertise to others who treat or address issues of public health significance.
- Ensures compliance with public health laws and ordinances, using enforcement authority when appropriate.
- Employs well-trained staff members who have the necessary resources to implement best practices and evidence-based programs and interventions.
- Facilitates research efforts, when approached by researchers, that benefit the community.
- Uses and contributes to the evidence base of public health.
- Strategically plans its services and activities, evaluates performance and outcomes, and makes adjustments as needed to continually improve its effectiveness, enhance the community's health status, and meet the community's expectations.

Washington State Standards for Public Health Washington State law mandates the establishment of basic standards for public health as a part of the biennial Public Health Improvement Plan, a process designed to strengthen the public health system in order to improve the health of people. (See: RCW 43.70.520 and RCW 43.70.580) *Standards for Public Health in Washington State* was developed in a collaborative process involving more than 100 public health professionals who work at state and local health departments. They shared their scientific knowledge and practical experience to define standards for the governmental public health system. According to the Department of Health, "*Standards for Public Health in Washington State* provides a common, consistent and accountable approach to assuring that basic health protection is in place." (http://www.doh.wa.gov/standards/default.htm

"The standards cover five key aspects of public health, selected because they represent basic protection that should be in place everywhere:

- Understanding health issues
- Protecting people from disease
- Assuring a safe and healthy environment for people
- Promoting healthy living

- Helping people get the services they need."

"The standards focus on the capacity of our public health agencies to perform certain functions, and not on specific health issues. A public health system that is well organized, meeting a common set of basic standards and adopting best practices, is better prepared to help bring about improvements in health." (http://www.doh.wa.gov/standards/default.htm)

Attachment II – Protocol for CMHD Interviews

Health Director: first interview (1 hr)

I am interested in obtaining three things from this interview:

- Observations about what issues are most important to the health department's long range strategic thinking and how these issues are being dealt with.
- The names and contact information of 3-5 key leaders within the health department staff who can participate in phone interviews and provide more details about the issues and decision processes.
- Guidance on how we can obtain documents related to these issues and categories.

Key Leader interviews (1.5 hour):

- Observations about what issues are particularly important to the health department's long range strategic thinking and how these issues are being dealt with.
- Identify and provide documents related to these issues and categories.

Health Director: final interview (1 hour)

- Review summary of what we have learned.
- Clarify and identify the most important observations.
- Inquire whether or not they would be open to a site visit.

Topical Questions

I. Distinguishing Factors

1. What characteristics of your jurisdiction most influence the mission and services configuration of your LHD?

2. How have the ten essential services influenced the mission and goals of your health department? e.g. explicitly used as a strategic framework, used by programs, used to communicate to stakeholders, use to gauge performance, etc.

3. What characteristics of your LHD are not apparent from your web site and other public information materials? What one source would you recommend to someone wanting to understand your health department?

4. What do you think most distinguishes a public health department serving a major urban metropolitan area from smaller LHDs in terms of mission, service configuration?

II. Health Environment.

1. Metro area LHDs face a greater variety of challenges from national, state and even international sources. How important are the following challenges to your LHD: I'd like you to:
   a. rate them on a scale of 1 to 5 (1= not very important **to** 5=very important)
   b. explain why they are important; what is the local impact?
   c. describe how your health department has responded to these challenges
   d. describe how your LHD made that decision: e.g. strategic planning, legislative mandate, funding opportunity, etc

2. List of challenges:
   a. emerging, re-emerging and "globalized" infectious diseases
   b. increasing chronic disease

c. new mandates such as HIPPA and emergency preparedness
d. increasing numbers of un- or under-insured people
e. decreasing and different types of funding for public health services
f. increasing health inequities,
g. diversity and complexity within the populations you serve.
h. impact of national and international ports of entry

3. What methods have you used to assess and report on the health status of the community and the services deployed to meet the needs?

III. Policy Environment

1. For most large LHDs, a variety of factors play a role in determining strategic direction and specific LHD functions: How important are each of these factors below on a scale from 1 to 5 (1= not very important **to** 5=very important) to your LHD? Why?
2. Community needs as determined by overall demographic characteristics and health status conditions, e.g. aging population
3. Prevailing beliefs about the appropriate function of a LHD especially in relationship to the larger health care system
4. Local tradition and history
5. Legislative mandates and contracts
6. Incremental decision making that tends to layer-on functions over time
7. Threats and crisis including unique risks
8. Opportunities such as funding opportunities (e.g. federal grant programs such as Model Cities and Ryan White)
9. Politics and stakeholder advocacy including elected official and community expectations
10. Current LHD leadership (which can set overall direction, create emphasis and drive change)
11. Division of responsibility between the state and local public health agencies
12. Statutory authority

Let's explore a few of these in greater depth:

Government Mandates

a. What local, state, and federal mandates most define your health department programs?
b. Describe the policy challenges in addressing mandates and needs:
a. National, state, and local mandates
b. Grants and contracts
c. How do you develop programs in response to government mandates?
d. What governance relationship does your health department have with cities, the state, and the federal government?
e. How would you change these relationships if you could?

Strategic Management

a. How are policy decisions made for non-mandated programs and services?

b. What is driving your role, mission and goals?

c. How do you engage elected officials? What role do they play? Frequency of meetings?

d. What approaches are used to determine the array, configuration, and investment level for the functions and services your LHD provides?

e. What tools are used to make policy decisions (i.e. MAPP, formal strategic planning)?

Operations and Accountability

1. What policies and tools are used for:
    a. Performance measurement. How does your health department track your progress over time? What performance measurement process do you use (e.g. NPHPS, balanced scorecard, etc)?
    b. Program evaluation
    c. Financial and budgetary accountability

IV. Funding and general risks to current funding levels

Most metro health departments face complex fiscal environments characterized by issues such as:

- Shortfall in funding amid expanding expectations
- Integrating categorical and general funding
- Accountability/performance management
- Efficiency and cost-effectiveness
- Changing Medicaid financial policies]

1. How would your characterize you current fiscal challenges?

    a. trends in funding sources e.g. ratios between federal, state, local
    b. core discretionary vs. categorical *revenues*
    c. overall agency fiscal condition and trends
    d. looming risks for revenue sources

Funding Stream	Risk of Major Decrease	Risk of Minor Decrease	Stable	Chance-Minor Increase	Chance-Major Increase
Local General Funds					
Local licenses and Permits					
Local user fees, insurance and other					
State general fund support					
State categorical fund grants					
Federal grants through state					
Federal direct grants					
Federal/State: Medicaid					
Federal: Medicaid Match					
Other					

2. What are your top funding concerns and why?

3. How have you tried to address those concerns?

4. What opportunities for improved funding streams are you exploring?

Attachment III – Population Characteristics

% Change population, 1990 – 2000

MMHD	1990 total (1990 census)	2000 tot (2000 census)	%Δ 1990 – 2000
PHSKC (King Co)	1,507,319	1,737,034	15.2%
Alameda Co	1,279,182	1,443,741	12.9%
Columbus City, OH	632,910	711,470	12.4%
Davidson Co.	510,784	569,891	11.6%
Miami-Dade Co.	1,937,094	2,253,362	16.3%
Nassau Co.	1,287,348	1,334,544	3.7%

US Census Bureau, Census 1990, Census 2000

% Change population by race, 1990 – 2000

MMHD	White alone	Black or African American alone[1]	American Indian & Alaskan Native alone	Asian & Pacific Islander[2]	Other races[3]
PHSKC (King Co)	2.9%	23.1%	-8.7%	65.6%	700.7%
Alameda Co	-8.2%	-6.3%	2.8%	58.1%	242.6%
Columbus City, OH	2.6%	21.9%	42.3%	65.8%	1013.9%
Davidson Co	0.01%	23.8%	44.5%	93.2%	1639.7%
Miami-Dade Co.	11.1%	14.9%	42.4%	23.7%	195.1%
Nassau Co.	-5.4%	21.3%	28.6%	61.7%	374.3%

US Census Bureau, Census 1990, Census 2000

[1] 1990- Black; 2000 – Black or African American alone
[2] 1990 – Asian and Pacific Islander; 2000 – combined "Asian alone" & "Native Hawaiian and Other Pacific Islander alone"

4. 1990 – Other races; 2000 – combined "Some other race alone" & "Two or more races"

Socioeconomic Status

MMHD	Median household income in 1999 (dollars)[1]	Unemployment rate (annual averages)[2]		Poverty (% pop below poverty)[3]
		2000	2004	
PHSKC (King Co)	53,157	4.0	5.1	10.4
Alameda Co	55,946	3.6	6.0	11.4
Columbus City, OH	37,897	3.2	5.4	12.8 (county)
Davidson Co.	39,797	3.2	4.4	16.3
Miami-Dade Co.	35,966	5.1	5.6	17.0
Nassau Co.	72,030	3.3	4.5	5.2

[1] US Census Bureau, Census 2000
[2] US Dept of Labor, Bureau of Labor Statistics; 2000/2004 Annual Averages by county; Columbus rate is for Columbus, OH Metropolitan Statistical Area
[3] US Census Bureau, 2004 American Community Survey

MMHD	Overall mortality			Heart disease mortality			Cancer mortality			Motor vehicle mortality			Homicide			Infant mortality		
	Rate/ %	Rank [1]	% Δ	Rate/ %	Rank	% Δ	Rate/ %	Rank	% Δ	Rate/ %	Rank	% Δ	Rate/ %	Rank	% Δ	Rate/ %	Rank	% Δ
Seattle (King Co)	840.1	38	-7.9	211.6	41	-18.9	204.5	33	-4.7	8.7	38	-25.6	5.3	39	-42.3	4.6	45	-43.2
Oakland (Alameda Co)	902.7	34	-15.8	249	34	-24.1	207.1	32	-14.8	8.8	37	-39.3	19.1	12	-43.4	5.9	35	-52
Columbus City, OH	1006.1	19	-5.3	267.	31	-21.2	235.5	17	-5.6	8.4	40	-10.6	6.4	36	-38.4	9.9	15	-16.8
Miami (Dade Co)	1257.7	4	5.3	391.2	4	12.6	263.1	5	8.7	30.4	1	-16.5	22.5	7	-39.2	5.4	39	-14.3

Attachment IV – Health Indicators

Nashville-Davidson (Davidson Co)	942.9	28	-11.4	267.1	30	-26.0	212.8	28	-11.5	21.9	3	.9	14	16	8.7	10.2	13	8.5
New York (Nassau Co)	794.7	43	-24.2	323	10	-18.8	176.9	45	-17.2	5	47	-53.3	8.4	30	-69.4	6.4	30	-44.3

Overall mortality: age adjusted death rate from all causes (e.g. number of deaths per 100,000 population)
Heart disease mortality, Cancer mortality, Motor vehicle mortality, and Homicide is the age adjusted death rate for that cause of death
Infant mortality rate is the number of infant deaths per 1000 live births.

Big Cities Health Inventory 2003

[1] Rank within US 47 largest cities (population ≥ 350,000); a rank of 1 corresponds to the highest rate or percent

Attachment V - PHSKC SERVICE ARRAY

SERVICES MATRIX – PAGE 1 OF 4

Key: KC = King County ALA = Alameda County CC = City of Columbus ND = Nashville-Davidson NC = Nassau County

	Performed by LPHA directly				Contracted by LPHA				Done by state govt agency				Done by another local govt agency				Done by someone else				Not available in jurisdiction			
IMMUNIZATIONS	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND
Adult	X	X	X	X		X	X								X	X	X		X	X				
Childhood	X	X	X	X		X	X								X	X	X		X	X				
SCREENING FOR DISEASES/CONDITIONS	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND
HIV/AIDS	X	X	X	X	X	X	X									X	X		X	X				
Other STDs	X	X	X	X	X		X			X						X	X		X	X				
Tuberculosis	X	X	X	X	X		X	X									X		X	X				
Cancer	X	X		X	X	X	X			X				X			X	X	X	X				
Cardiovascular Dx	X	X			X	X	X							X			X	X	X	X				
Diabetes	X	X		X	X	X	X							X			X	X	X	X				
High blood pressure	X	X	X	X	X	X	X							X			X	X	X	X				
Blood lead	X	X	X	X			X	X				X				X	X		X	X				
TREATMENT FOR COMMUNICABLE DX	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND
HIV/AIDS					X	X								X		X		X	X	X				
Other STDs	X		X	X	X	X								X		X	X	X	X	X				
Tuberculosis		X	X	X								X		X		X	X	X	X					

MATERNAL AND CHILD HEALTH	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND
Family planning	X		X	X	X		X					X		X		X	X	X	X	X				
Prenatal care	X		X				X					X		X		X	X	X	X	X				
Obstetrical	X											X		X		X	X	X	X	X				
WIC	X	X	X	X	X		X										X	X						
EPSDT	X						X					X				X	X		X					
OTHER HEALTH SERVICES	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND
Comprehensive PC	X				X		X							X			X	X	X	X				
Home health care					X												X	X	X	X				
Oral health	X	X	x	X	X		X							X			X	X	X	X				
Behavioral/mental health services				X								X	X	X		X	X	X	X	X				
Subst abuse services				X									X	X		X	X	X	X	X				

SERVICES MATRIX – PAGE 2 OF 4

	Performed by LPHA directly				Contracted by LPHA				Done by state govt agency				Done by another local govt agency				Done by someone else				Not available in jurisdiction			
EPIDEMIOLOGY & SURVEILLANCE	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND
Communicable/ infectious disease	X	X	X	X							X	X			X	X				X				
Chronic disease	X	X	X	X	X					X	X	X			X	X	X	X	X	X				
Injury	X	X	X							X		X					X		X	X				
Behavioral risk factors	X	X	X	X			X			X	X	X			X				X					
Environmental health	X	X	X	X						X	X	X	X	X	X									
Syndromic Surveil.			X	X								X										X		
POPULATION-BASED PRIMARY PREVENTION SERVICES	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND
Injury	X	X	X	X								X			X	X			X	X				
Unintended pregnancy	X	X		X										X		X	X	X	X	X				
Obesity	X	X	X	X	X						X	X	X	X	X	X		X	X	X				
Violence	X	X		X				X					X		X	X	X	X	X	X				
Tobacco	X	X	X	X								X				X	X	X	X	X				
Substance abuse	X	X	X	X								X	X	X				X	X	X				
Mental illness				X								X	X			X			X	X				

SERVICES MATRIX – PAGE 3 OF 4

	Performed by LPHA directly				Contracted by LPHA				Done by state govt agency				Done by another local govt agency				Done by someone else				Not available in jurisdiction			
REGULATION, INSPECTION &/OR LICENSING ACTIVITIES	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND
Mobile homes			X	X						X						X				X				
Campgrounds & RVs			X	X						X		X												
Solid waste disposal	X		X							X		x		X		X				X				
Solid waste haulers	X									X			X	X	X	X								
Septic tank installs	X		X	X						X			X	X										
Hotels/motels				X						X	X				X									
School/daycare	X		X	X						X														
Cosmetology bus.										X	X	X												
Swimming pools (pub)	X		X	X						X				X										
Tobacco retailers	X			X						X	X	X		X		X								
Smoke-free ord. ND = unknown	X		X											X										
Lead inspection	X		X	X								X		X										
Food processing			X							X	X	X												
Milk processing									X	X	X	X												

Public drinking water									X	X	X	X				X								
Private drinking H_2O	X		X						X	X		X		X										
Food service estabs.	X		X	X						X				X										
Health-related facil.	X		X						X	X	X	X												
Housing (inspections)	X			X								X	X	X	X									
OTHER EH ACTIVITIES	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND
Indoor air quality	X		X	X					X	X		X								X				
Food safety edu.	X		X	X					X			X		X										
Radiation control									X	X	X	X		X										
Vector control	X		X	X					X	X				X	X	X				X				
Land use planning	X								X	X					X	X		X						
Groundwtr protect.	X			X					X	X	X	X		X										
Surface wtr protect.									X	X	X	X			X	X		X						
HazMat response	X		X	X					X	X		X		X	X	X				X				
Haz waste disposal	X		X						X	x		X	X	X	X	X			X					
Pollution prevention	X		X	X							X			X	X									
Noise pollution	X		X								X				X	X								

SERVICES MATRIX – PAGE 4OF 4

	Performed by LPHA directly				Contracted by LPHA				Done by state govt agency				Done by another local govt agency				Done by someone else				Not available in jurisdiction			
OTHER ACTIVITIES	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND	KC	ALA	CC	ND
Emergency medical services	X				X	X									X	X								
Animal control	X			X									X	X	X					X				
Occupational safety & health	X		X	X					X	X			X			X			X	X				
Veterinarian PH activities	X		X	X					X				X					X		X				
Laboratory services	X	X	X	X		X		X	X		X	X	X		X									
Outreach & enrollmnt f/med insur	X	X	X	X	X				X	X		X	X	X		X	X		X	X				
School-based clinics	X				X	X							X					X	X	X				
School health	X	X	X	X	X										X				X	X				
Correctional health	X			X				X											X					

Attachment VI – Glossary

- **Local public health agency (LPHA)** is a single governmental organization, regardless of size, providing public health services to the residents of a political jurisdiction; also known as a "local health department."
- **Metropolitan health department (MHD)** is a local public health agency that provides services to a political jurisdiction with a population of 350,000 or more.
- **Major metropolitan health department (MMHD)** is a local public health agency which is one of the 25 largest metropolitan health departments in the U.S.; while the size of the population served by MMHDs is widely variable, most provide services of close to a million or more people.
- **Comparable metropolitan health department (CMHD)** is a term used specifically for this project and describes one of the five MMHDs to which PHSKC was compared. They include the health departments serving Alameda County (CA), City of Columbus (OH), Miami-Dade County (FL), Nashville-Davidson County (TN), and Nassau County (NY).
- **Personal health care**: encompasses the services provided to individual patients by health care providers for the direct benefit of the individual patient. Examples include physical examinations, treatment of infections, family planning services, etc.
- **Clinical services** are provided to individual clients/patients by any of a variety of health professionals, including physicians, nurses, dentists and others, to address specific health issues, including treatment of illness or injury or prevention of health problems.
- **Primary care** constitutes clinical preventive services, first-contact treatment services, and ongoing care for medical conditions commonly encountered by individuals. Primary care is considered "comprehensive" when the primary care health provider assumes responsibility for the overall provision and coordination of medical, behavioral and/or social services addressing a patient's health problems.
- **Population-based public health services** are interventions aimed at promoting health and preventing disease or injury affecting an entire population, including the targeting of risk factors such as environmental factors, tobacco use, poor diet and sedentary lifestyles, and drug/alcohol use.

- **Health Status**: The current state of health for a given group or population, using a variety of indices including illness, injury and death rates, and subjective assessments by members of the population.
- **Categorical funding:** governmental funding, usually from the federal level, which is designed to be used in support of specific public health programs and activities. It typically is accompanied with tight limitations on how the funds can be used, even within programs.
- **Evidence-based practices:** public health activities which are designed based upon authenticated studies of efficacy and/or upon established practices.
- **Local Public Health System:** in any community, the local governmental public health agency and all organizations, agencies and individuals who, through their collective work, improve or have the potential to improve the conditions in which the community population can be healthy.
- **Essential Public Health Services:** established under the aegis of the federal Department of Health and Human Services in 1994, this list of ten sets of services comprises service categories that must be in place in all communities to assure an adequate local public health system.

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XI: Milne & Associates: Policy Environment Background Report

Policy Environment Background Report
Prepared by Milne & Associates, LLC
May 10, 2006

Please note: This background paper should be viewed as a dynamic product. It is likely that new information will continue to be provided during the life of this project. The reader should regard this paper together with the companion papers on role definition, policy environment and funding as initial guidance for the production of a broad policy framework.

Executive Summary and Implications for Next Steps

In this executive summary we provide our interpretation of the significance and meaning of the observations in this paper as they relate to a broad policy framework for public health in King County.

In comparison to the CMHD included in this analysis, PHSKC is more complex in its mandates, the mix of services provided, and its governance structure.

In general, PHSKC exists within a policy environment that mandates services from the Federal government (via state directives), state statutes (RCW) and regulations (WAC), and local ordinances via King County Government, the City of Seattle, the King County suburban cities, and the King County Board of Health.

Mandates provide considerable structure and direction for what programs and services are provided. Yet PHSKC retains a certain amount of flexibility within which they have created structures for setting programming and funding priorities. For example, the department has responded to mandates and requirements by:

- organizing and delivering services along the framework of the ten essential public health services;
- using a quality management framework;
- focusing leadership in specific areas through strategic planning;
- providing measurable targets within a performance management framework.

PHSKC provided us with an analysis of the impact of the policy environment on its ability to improve the health of King County. This analysis, organized by the 10 Essential Services and cross-walked with the Washington State Public Health Standards, is found in Attachment F.

Key observations from this report are summarized below and followed by our interpretation of their significance and meaning for a broad policy framework for public health in King County. First, the key observations:

- **This analysis of the policy environment for public health includes an examination of government mandates; governance structures; functions and services; and policies and tools for operations and accountability.** We examined these factors from the perspective of national norms and through a comparison of how they influence the policy environment for PHSKC and the CMHD selected for comparison.

- **Policy environments differ from community to community.** The policy environment of the comparable metropolitan health departments (CMHD) is influenced by a number of factors including the historical context, local capacity, and community dynamics. Therefore, as would be expected, there are some notable differences between PHSKC and the five CMHD. This is also due, in part, because these CMHD were not chosen for their service mix. Rather they were chosen for their potential value to the overall project by virtue of the make-up of their populations, evidence of best practices, innovation and policy issues they are facing.

- **Washington State has moved from a "service formula approach" to a "functions and essential services approach".** The categorical "service formula" approach for mandating public health programs in most other states allows very limited flexibility for local and state response to emerging public health problems, particularly when compared to the "functions and essential services" approach used in Washington. Washington's "functions and essential services" model for defining mandates facilitates responsiveness because the focus is on broad activities such as surveillance which can be marshaled to address any disease outbreak.

- **State allocation of Grant funding is usually based on population.** Allocation methods by DOH often are designed to assure core capabilities across the state rather than allocating resources on a basis of risk, vulnerability and levels of complexity. For example, state

funding policies distribute resources evenly by county population, so King County gets 40% of the funding yet it has 60% of the statewide tuberculosis cases. With half the statewide total of hospital beds located in this one metro county, resources are still allocated on a per capita basis. This distribution of funds has an impact on the ability of PHSKC to coordinate preparedness efforts across the entire health care system.

- **Government mandates impacting all major metropolitan health departments (MMHD), are numerous.** Mandates impacting PHSKC include
  - federal statutes and regulations
  - state statutes and regulations
  - local ordinances from King County governments
  - local rules from the King County Board of Health
  - interlocal agreements with the City of Seattle
  - the state Public Health Improvement Plan which sets forth practice standards.

- **The Ten Essential Public Health Services guide policy about core functions and responsibilities of local public health agencies and their system partners.** Based on this framework, public/private entities and coalitions have promulgated frameworks for quality management, strategic planning, leadership development, and performance management using quantitative targets for measuring accountability. While not mandates, both the essential services and these tools have become accepted national norms for public health practice.

- **While PHSKC is similar to CMHD in many ways, there are notable differences.** PHSKC plays a larger role than the other CMHD in
  - Conducting inspection and licensing activities
  - Providing primary care services directly
  - Operating school-based clinics
  - Providing correctional health services
  - Providing emergency medical services
  - Doing work related to the built environment
  - PHSKC does not provide behavioral/mental health services, but its comparison CMHD either provide them directly or contract for them.

- **The governance of PHSKC is perhaps more complex than in other CMHD.** PHSKC is considered a city-county health

department, one of five types of health departments. The department is governed by King County and the Board of Health, each with different authorities. Further, the City of Seattle and the suburban cities in the county all play roles in governance. The result is a complex model of governance.

- **Financing public health presents significant policy challenges.** Among the factors associated with financing public health, many are related to the challenges in obtaining accurate assessments of what constitutes an adequate infrastructure to address public health responsibilities and core programs. This will be a topic of the background paper on funding.

Important implications for next steps based on this description of the policy environment include:

- **The concept of a local public health system is very important, but system effectiveness has not been measured in King County.** Policies regarding what roles should be performed by PHSKC might be more clearly determined if system capacity and effectiveness were measured. Consideration of the NACCHO Operational Definition will also help identify service gaps within the system and help policy makers assign specific roles to the health department.

- **Some mandates are vague and need clarification.** Some services and activities are provided by PHSKC because they are considered to be mandates. However, room for greater flexibility in service selection may exist with some "mandates" because of unclear legal language, use of outdated language (as in the Joint Executive Committee Agreement), and questionable interpretation of the language. Competing demands for limited resources suggest that mandates be clarified.

- **Services that are "core" to the health department's mission are undefined.** The Seattle agreement is based on the WAC in place in the late 1990's. The WAC was widely interpreted as constituting mandates for local health departments and is the basis for the King County responsibility for "core services" with Seattle. The WAC was replaced by the Washington State Public Health Standards. Perhaps owing to this set of circumstances, the staff, when asked by Milne & Associates, could not identify what services are core to their mission.

- **King County's and PHSKC's participation in state level policy planning, development and review is important.** A significant

portion of the mandates that affect PHSKC are generated within the state, by the legislature, State Department of Health and State Board of Health. Information from stakeholder interviews suggested that PHSKC does not always play an active role in those efforts. Since a significant portion of the mandates that affect PHSKC are generated within the state, the health department's level of participation in state level policy planning, development and review is important.

- **Lack of activity by the Joint Executive Committee might be problematic.** The agreement between the City of Seattle and King County was based, at least in part, on state laws then in place. Given subsequent changes in law, there is a need for clarity regarding state mandates and to assure that the City-County agreement remains current with changing law.

- **Reexamination of policy options related to the PHSKC emphasis on providing direct services to individuals should be considered.** The rationale for PHSKC's placing emphasis on providing services directly to individuals is explained in part because of continued limited access to care for individuals and families in King County. There are waiting lists for the State's Basic Health Plan and concern over the widening disparities in health care for minority and immigrant children. For these and other reasons, PHSKC provides primary care through direct access and through coordination with community partners including community clinics. However, PHSKC seems to play a limited role in convening, facilitating, coordinating, and/or contracting to improve access to the broader healthcare system. It was noted that CMHD contract with external organizations for more services than is the case with PHSKC, particularly for primary care. These CMHD discontinued the direct delivery of primary care services, providing instead an indirect role of assuring funding and/or fulfilling the role of convening, organizing, and catalyzing action.

  Some stakeholders perceive a possible conflict of interest in PHSKC's "competing" for primary care services with clinics with which it contracts. That perception alone justifies a reexamination of the options but care should be taken not to dismantle existing capacity without a thorough analysis of the impact of policy change.

- **Application of the PHSKC "Public Health Priorities and Funding Policies" document is unclear.** The public health priorities and funding policies for PHSKC are described in the 2003 King County budget proviso. Developed by PHSKC and approved by the King

County Council, this document outlines the mechanism that PHSKC uses to strategically manage toward service priorities and make decisions about service provision given their need to serve the whole of King County. It is not clear if the policy is employed in making choices between competing demands or in considering new program opportunities.

Introduction

King County contracted with Milne & Associates, LLC, to produce a Public Health Operational Master Plan. One of the early deliverables in the project (Deliverable E) is production of a white paper defining the policy environment in which Public Health Seattle-King County (PHSKC) operates. Specifically, we were asked to describe:

- Mandates and needs for PHSKC as compared to other CMHD (national, state, local, grants, contracts, emergent events and priority issues).
- Types and intensity of functions and services CMHD and PHSKC provide, including level and range of service, in response to these mandates and the impact on the role of the CMHD in the community
- Approaches CMHD and PHSKC use for determining the array and configuration of, and investment level for, functions and services.
- Compare the governance structure of PHSKC with that of other CMHD including structures and processes for management, oversight, and accountability. For purposes of comparison, the following metropolitan health departments were used: Alameda County (CA), Columbus City (OH), Davidson County (TN), Miami-Dade County (FL), and Nassau County (NY). (hereafter abbreviated as comparison metropolitan health departments (CMHD).

Numerous documents were reviewed in our development of this paper including national and state reports and articles on public health policy and infrastructure, data and staff input from PHSKC, and information from the five CMHD. At this point in time our data on the CMHD is limited to website reviews, leadership interviews and some of their NACCHO profiles. As we continue to gather data, the analysis on the policy environment will become more refined.

To guide our thinking about the different components that make up a health department policy environment, Table 1 (next page) was constructed that outlines the major forces defining the approaches to public health system mandates, functions, services, investment levels, and governance structures. The paper itself describes these forces in additional detail. We have included a glossary of public health terms (Attachment A) and a number of appendices that provide additional information about some of the public health frameworks.

Table 1: Policy Environment

	Normative	Comparative with CMHD	Descriptive (PHSKC)
	• National Public Health Frameworks • Federal government requirements • Public Health Law	Description of each of the five comparison metropolitan health department in relation to the normative. • Nassau • Miami-Dade County • Columbus • Nashville-Davidson • Alameda County	Description of Public Health Seattle King County's "practice" and experience in relation to mandates, strategic management and operations and accountability.
Government Mandates What is mandated or expected within governmental public health?	• 10 Essential Services (ES) • Healthy People in Healthy Communities • Federal grant requirements • Model Public Health Statutes	• 10 ES used by all to varying degrees • Legislative mandates important but not sole determinant for most • Grants and contracts	• 10 Essential Services • Federal, state and local mandates • Grants and contracts
Functions and Services How are policy decisions made on non-mandated services?	• Strategic planning • MAPP • APEX/PH • PACE-EH • Model Standards. • Healthy People 2010 • National Public Health Leadership Program	All but one do strategic planning • MAPP used by most • Leadership is most important • all use community assessment to set direction	• PHSKC uses strategic planning processes that include elements similar to those in the MAPP process, such as assessment of community health, assessment of systems capacities, assessment of community assets and values. • Full array of public health services are provided including some that are contracted or delegated.
Policies and Tools for Operations and Accountability • Performance measurement • Program evaluation • Fiscal accountability	• NPHPS • TQM/CQI • CAST-5	• Baldridge process • Health Report Card	• Quality management framework • Performance management framework • State Standards/PHIP • Budgetary Accountability

Acronyms used:

IOM = Institute of Medicine
MAPP = Managing Action through Planning and Partnerships (NACCHO)
APEX/PH = Assessment Protocol for Excellence in Public Health (NACCHO)

PACE-EH = Protocol for Assessing Community Excellence in Environmental Health (NACCHO)
NPHPSP = National Public Health Performance Standards Program (CDC)
CAST-5 = Capacity Assessment for State Title V (Maternal & Child Health) (HRSA)
TQM/CQI = Total Quality Management/Continuous Quality Improvement

Section 1: Government Mandates for Public Health

Overview

Historically the US public health system has developed over time to protect the public from a variety of diseases, hazards, and behaviors, primarily through prevention, protection, and health promotion strategies mandated by the federal, state, and local government. The ways in which these mandates have been defined, as well as ways functions, programs, and policies have been created, vary dramatically across the US. In addition, the term "mandate" has not always been clearly understood and has caused confusion among public health leaders. Questions arise, for example, about what programs are absolutely required by federal, state, and local statutes, and what programs are essential because of specific community-based health problems and needs. Programs that are essential to fulfilling the mission of the health department may not be mandated, but fill an identified need are usually considered core programs.

For the purposes of this paper, we have defined mandates as "those programs, services, and activities which are explicitly required by federal, state, or local laws and regulations." For example, a local health department must provide certain services such as inspecting restaurants or reporting communicable diseases to be in compliance with a law or regulation. The language in the Washington Administrative Code (WAC) and the Revised Codes of Washington (RCW) can also be confusing and subject for varying interpretation. But in general, If the language of a law or regulation states that a program or service "may" or "should" be provided, the service is not considered to be legally mandated, as opposed to language that states the program "shall" be provided.

Policymakers are charged with the task of developing and adopting a broad array of legislative mandates related to the operation of public health. However, they may have limited knowledge and understanding about the nature of public health's challenges, resource limitations, health status trends, and other factors that confront the day to day delivery of public health services within local and state public health agencies. As a result, legislative mandates that direct the provision of public health services are often specific to a problem, such as healthcare for the homeless, rather than

defining a mandated set of general services or functions are in place to take care of a range of problems.

What we often see at the federal level are policy initiatives (as opposed to mandates) designed to guide federal, state, and local public health organizations toward specific goals. For example the series of "Healthy People"[1] reports were created within the US Department of Health and Human Services and are now published every ten years to outline a set of national goals and objectives for health improvement. The reports are accompanied by national data showing current health status data for each of the Healthy People objectives. Most states have created state-level companion documents to Healthy People that reflect state level goals and priorities. For example, the first Washington State Public Health Improvement Plan (1994)[2] contained health status targets for 39 key public health problems. Data compared health status in the state with US data. In 2005 the Key Health Indicators Committee of the Public Health Improvement Partnership process issued a report card on the status of in Washington State[3]. The committee intended that the report card would inform policymakers and the public about important public health issues and would stimulate discussion and improved public health policy by providing solid information. Ultimately, it was intended that more focused actions would result, leading to improved health.

In an effort to define public health, the Institute of Medicine[4] in 1988 recommended the development of a set of public health core functions. These include:

- Assessment: the obligation of every public health agency to monitor the health status and needs of its community regularly and systematically;
- Policy Development: the responsibility of every public health agency to develop comprehensive policies that are based on available knowledge and responsive to communities' health needs; and
- Assurance: the guarantee of governments that agreed-upon, high-priority personal and community health services will be provided to every member of the community by qualified organizations[5].

While the core functions have been very useful to public health in defining general roles and responsibilities, more specificity was needed, especially at the local level, to match programs and services to the core functions. Beginning in 1995, efforts led by the major public health agencies and organizations in the United States - including the Centers for Disease Control and Prevention (CDC), the American Public Health Association (APHA), the Association of State and Territorial Health Officials (ASTHO), and the National Association of County and City Health Officials (NACCHO) - created

the Ten Essential Public Health Services[6] (Figure 1). These functions and services provided a guide to policymakers and public health officials about how public health could be organized through a systems approach, and what services ought to be in place to assure basic prevention, protection, and health promotion capacities. The public health system at the local level was envisioned as the governmental public health agency and all other public and private organizations whose actions together can create an environment in which people can be healthy.

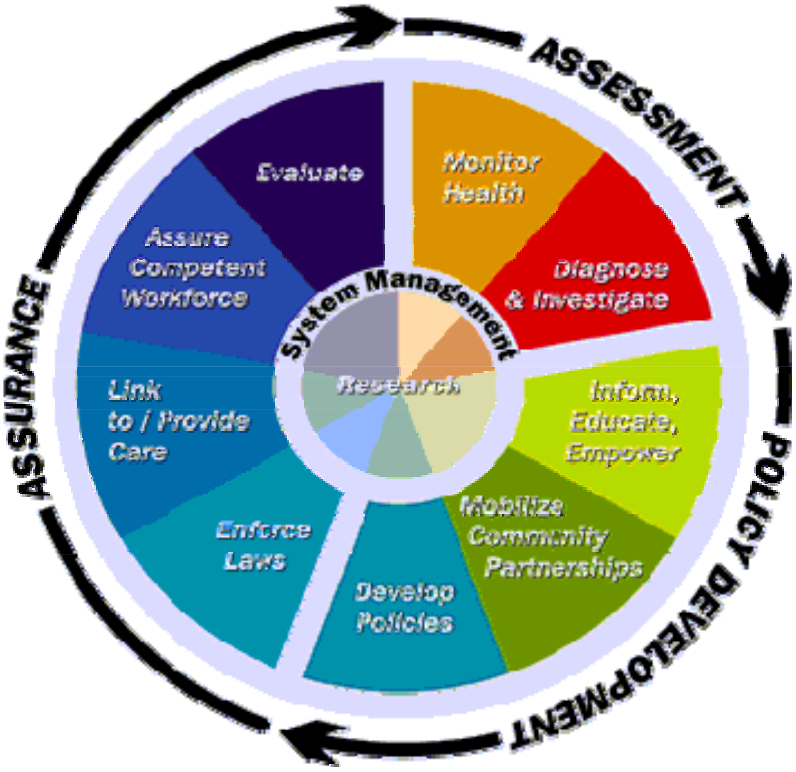

Figure 1: Public Health Core Functions and Ten Essential Services
Public Health Functions Steering Committee (July 1995)

The ten essential services have helped to define the *practice* of public health[7] (Attachment B & C) Many of these services are invisible to the public. Typically, the public only becomes aware of the need for public health services when a problem develops such as an epidemic of influenza or a foodborne disease outbreak at a local restaurant. What is important for the public to know is not so much what these component parts of the public health system are, but rather that the health department and its partners have in place the capacity to meet the criteria defining a public health system.

Over time, the core functions of public health and the ten essential services have become the "norm" for defining public health and its associated programs and activities. These functions and services have been incorporated into public health performance measures, health statutory language, and have been used to guide funding decisions. In many places, including the communities served by CMHD, the concept of local public health system has taken hold and collaboration between governmental public health departments and community partners has intensified. However, the extent to which the core functions and essential services have been successful in communicating the role of public health to the public is less well understood.

In response to these communication challenges, in November 2005, the National Association of County and City Health Officials[8] published an operational definition of and standards for a functional local health department (LHD) (Table 2).

The introduction of this document states that " each community has a unique "public health system" comprising individuals and public and private entities that are engaged in activities that affect the public's health" Further as NACCHO introduces its recommended standards it states "…. regardless of the particular local public health system, the LHD has a consistent responsibility to intentionally coordinate all public health activities and lead efforts to meet the standards" The standards in Table 2 which have particular emphasis on building systems are highlighted in bold type.

According to NACCHO, "Over the past 15 years, several large-scale efforts have significantly influenced local public health practice by defining public health (Public Health in America, also known as the "10 essential services"), measuring the performance of public health entities (National Public Health Performance Standards Program), setting public health goals (Healthy People (2010), and identifying components of public health systems (The Future of Public Health and The Future of the Public's Health in the 21st Century, both from the Institute of Medicine). All of these activities have evolved in the absence of a commonly-held notion of what constitutes a functional local public health agency."

NACCHO developed the operational definition of a local governmental public health agency to "be the basis of future efforts to develop a shared understanding of what people in any community, regardless of size, can expect their governmental public health agency to provide at the local level." NACCHO suggests that the Operational Definition be used with policymakers and stakeholders to review a local health department's activities in "light of the Operational Definition"[10.]

Table 2: NACCHO's Operation Definition of a Functional Local Health Department[9]

- Understands the specific health issues confronting the community, and how physical, behavioral, environmental, social, and economic conditions affect them.
- Investigates health problems and health threats.
- Prevents, minimizes, and contains adverse health effects from communicable diseases, disease outbreaks from unsafe food and water, chronic diseases, environmental hazards, injuries, and risky health behaviors.
- **Leads planning and response activities for public health emergencies.**
- **Collaborates with other local responders and with state and federal agencies to intervene in other emergencies with public health.**
- Implements health promotion programs.
- **Engages the community to address public health issues.**
- **Develops partnerships with public and private healthcare providers and institutions, community-based organizations, and other government agencies (e.g., housing authority, criminal justice, education) engaged in services that affect health to collectively identify, alleviate, and act on the sources of public health problems.**
- **Coordinates the public health system's efforts in an intentional, non-competitive, and non-duplicative manner.**
- **Addresses health disparities**.
- **Serves as an essential resource for local governing bodies and policymakers on up-to-date public health laws and policies.**
- Provides science-based, timely, and culturally competent health information and health alerts to the media and to the community.
- **Provides its expertise to others who treat or address issues of public health significance.**
- Ensures compliance with public health laws and ordinances, using enforcement authority when appropriate.
- Employs well-trained staff members who have the necessary resources to implement best practices and evidence-based programs and interventions.
- Facilitates research efforts, when approached by researchers that benefit the community.
- Uses and contributes to the evidence base of public health.
- **Strategically plans its services and activities, evaluates performance and outcomes, and makes adjustments as needed to continually improve its effectiveness, enhance the community's health status, and meet the community's expectation.**

(*Emphasis added*)

Approaches to Mandates and Policy

Federal Mandates and Policies:

At the national level, Congress and administrative bodies set policy, mandate provision of public health services and make available grant programs which address problems of national concern. While these grants provide critically important resources, they also, in most instances, dictate how services will be provided. The administrative entities include the U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, the Health Resources and Services Administration and the Department of Agriculture. Directives from the federal government can impose unfunded mandates for health services that add to the costs of providing services and which may have an unintended consequence of decreasing access to services and/or interest of some providers in serving vulnerable populations.

An example of a problem created by federal rule promulgation relates to the area of public health preparedness**.** In spite of the infusion of mammoth amounts of federal resource in this arena, there is no uniform preparedness strategy in place to guide the establishment of goals and objectives, allocation of resources, and identification of policy issues that impact all local health departments. Priorities for disaster preparedness activities and allocation of resources are determined exclusively at the federal and state level with little input incorporated from local health departments and other local first responders. Those priorities have largely focused on targeting and enhancing specific, new capabilities exclusively for bioterrorism response. This approach does not address community health care systems' or public health systems' abilities to respond to all emergencies. Instead, a systematic approach to strengthening the preparedness capabilities of a community's health care system would be of value. Moreover, many feel the allocation of federal resources for public health and hospital preparedness is not proportional to the risk, complexity, or vulnerability of local jurisdictions.

Additional examples of conflicts created by mandates include the following:

- Interpretation services must be available to all non English speaking patients/clients seeking Public Health services. While responsive services should include provision of interpretation services, at issue is how those services are paid for as a mandate in competition with other worthy services.

- Other federal regulations dictate that patients cannot be turned away because of an inability to pay for services. The ability of a public health organization to manage its budget with strict interpretation of this mandate is problematic at best.
- HIPAA (The Health Insurance Portability and Accountability Act of 1996) has introduced new complexities for collecting mandated disease information and is challenging the ability of clinical programs to communicate with patients/clients.
- Federal regulations that require the delivery of health messages that contradict scientifically accurate messaging have increased the need for resources from other revenue streams to deliver both mandated messages and technically accurate information. For example, requirements for abstinence education have blossomed in the absence of good evidence of effectiveness, while restrictions have been placed on providing facts about family planning methods.

Federal grant programs aren't considered mandates, using the definition we've offered for this paper. Health departments can choose which to apply for. Once a grant is received or contract is established, however, service provision must follow the dictates of the federal agency. Too often, federal programs are promulgated in response to a specific disease or health condition. Such policy restricts flexibility to address broader interconnected health problems. When such policy emerges as federal grants, they become what are referred to as "categorical programs," creating in effect silos which restrict how or to whom the service may be provided. A less flattering term to describe this approach is the "disease of the month" approach. To be sure, each issue has its own set of advocates that work hard to retain and expand funding from Congress while striving to retain the "purity" of scope. It has been said that categorical approaches are the most effective models for appropriating funding and the least effective models for administering programs. Many of the programs run by PHSKC and the CMHD are categorical, including WIC, HIV/AIDS, and Bioterrorism Preparedness.

Not only does the categorical approach limit flexibility at the state and local level, but sometimes the programs continue despite ignoring what may objectively be considered to be higher priorities from the local perspective. Such mandates and programs can become outdated because they do not take into consideration 1) improvements in the health issue resulting from the attention, 2) new scientific findings related to diseases and hazards or 3) new technological discoveries that change process for public health practice such as surveillance.

According to Erickson, Gostin, et al, [13] a public health law is essential in providing the legal authority for a public health agency to take action to

protect the public's health. One should expect to see governmental public health mandates that clarify the infrastructure and responsibilities of the public health system and that assure the provision of 1) modern surveillance techniques including reporting and monitoring of public health, 2) epidemiological investigations in response to outbreaks, 3) testing and screening for existing and emerging conditions, 4) vaccination of vulnerable populations, and 5) responsible and respectful use of quarantine and isolation in cases of communicable diseases[14].

State Mandates and Policies:

In the state of Washington, the legislature passes laws (RCW), and regulations authorized by law are written by the state Department of Health and the State Board of Health. The Department has a wide range of authority, including

- environmental health regulation
- health workforce licensure and regulation
- facilities licensure and regulation
- public health emergency preparedness
- health planning

The State Board of Health has more specific authority in certain areas, including:

- safe and reliable drinking water;
- prevention, control, and abatement of health hazards and nuisances related to the disposal of wastes;
- environmental conditions that threaten public health;
- prevention and control of infectious and noninfectious disease
- health data, including vital statistics.

In most states, legislative mandates are defined by a set of required categorical programs such as maternal and infant health and communicable disease control. Such was the case in Washington State until the late 1990s, when many of the mandates contained in WAC Chapter 246 were replaced by public health standards. Earlier, the core public health functions were included in the Health Services Act of 1993 (E2SSB 5304) as the "essential elements in achieving the objectives of health reform in Washington State"[16]. Based on that legislation, the Washington State Department of Health, local health departments, the State Board of Health, and many stakeholders in the public and private sectors collaborated to create The Public Health Improvement Plan[17] (PHIP) in 1994. The PHIP has served as a strategic plan for public health in the state and has guided the establishment of performance standards.

Moreover, the PHIP defined the minimum standards and core functions for public health protection and recommended strategies and a schedule for improving public health programs throughout the state. The PHIP continues to be published on a biennial basis and its guidance on public health practice and performance can be seen reflected in the structure and programs of PHSKC. A cross-walk of the PHIP standards to the 10 essential services is in Attachment D. The standards address the following key aspects of public heath:

- Understanding health issues
- Protecting people from disease
- Assuring a safe and healthy environment for people
- Promoting healthy living
- Helping people get the services they need.

As stated on the standards' website, "the standards focus on the capacity of our public health agencies to perform certain functions, and not on specific health issues." In this sense the PHIP focuses in a progressive fashion on the official governmental public health agencies and its critical infrastructure. It a is well organized expectation based upon a common set of basic standards and best practices which will help bring about improvements in health. While technically the standards are not yet required to be met by local health departments in the state, it is expected they will be when resources are made available.

The categorical "service formula" approach for mandating public health programs in most other states allows very limited flexibility for local and state response to emerging public health problems, particularly when compared to the "functions and essential services" approach used in Washington. For example, when emerging infections such as SARS and West Nile Virus occur, state and local public health agencies must be able to quickly respond in order to protect the public's health. The categorical service funding model creates problems in that funding would need to be reallocated from existing programs to new activities specifically addressing these emergent diseases. On the other hand, Washington's "functions and essential services" model for defining mandates facilitates responsiveness because the focus is on broad activities such as surveillance which can be marshaled to address any disease outbreak.

The issue of legislated public health mandates has drawn national attention in recent years. The Turning Point Initiative[11], funded by The Robert Wood Johnson Foundation and housed at the University of Washington School of Public Health and Community Medicine, was developed in part because of concern about adequacy of legislative public health statutes. In 2002, Turning Point published a model state public health act[12] to serve as a tool to

assess and revamp public health laws. The model law was intended to be used as a tool that states could adopt or adapt to transform and strengthen the legal framework for public health by comparing their own laws to those in the model. From January 1, 2003 to January 1, 2006, language from the model law has been introduced in part through 90 bills or resolutions in 32 states. Of these bills, 36 have passed. Although the Washington State legislature considered the model act and actually held hearings on one bill, it has not passed any bills based on the model law.

In addition to legislated mandates that derive from the Washington State legislature, agencies such as the Department of Health, the Department of Social and Health Services, and the Department of Ecology, and the governor-appointed State Board of Health all have authority to promulgate regulations. Typically, the Washington State Association of Local Public Health Officials (WSALPHO, the professional organization of local public health directors) plays a fairly significant role in reviewing and reacting to proposed agency rule promulgation as well as legislative bills that are pending.

Participation of the largest local health department in the state in WSALPHO's policy review and comment processes is very important. However, information from stakeholder interviews suggested that PHSKC does not always play an active role in those efforts. Since a significant portion of the mandates that affect PHSKC are generated within the state, the health department's level of participation in state level policy planning, development and review is important.

PHSKC Mandates

The policy environment within which Public Health Seattle King County currently functions includes a service area that ranks as the 12th largest county in the United States with one third of Washington State's population and a budget of over $235 million[15]. With a workforce of approximately 1700 employees covering the full range of skills required to provide quality public health services, the PHSKC is well positioned with capacity to fulfill its system responsibilities in assuring the ten essential services of public health.

In addition to the federal mandates discussed earlier, the legal basis for PHSKC's public health authority is extensive and includes more than 100 references in Washington State RCW and over 20 references in the Washington Administrative Code. However, some of that language is phrased "permissively," calling into question which are actual mandates. The WAC referenced earlier that was replaced by the Washington State Public Health Standards was widely interpreted as constituting mandates for local

health departments and is the basis for the King County responsibility for "core services" in its agreement with Seattle (Joint Executive Committee Agreement). However, the operative word in that regulation was "should" and not "shall." In other words, the services referenced (and sometimes taken as mandates) were never truly required to be provided.

PHSKC is one of 35 local public health agencies serving the state of Washington. In addition to the 35 local health agencies, the State's public health system includes a freestanding Department of Health and a State Board of Health with rule making authority. Washington State's local public health agencies are organized by one of three primary structures: county, city-county, and district agencies. PHSKC is a city-county agency with contractual relationships with the city of Seattle and multiple suburban cities. Washington State is a 'Home Rule' State, which means that local jurisdictions, including municipalities, have powers to set policies. The local policy environment is highly complex and includes a number of policy making bodies: the King County Board of Health, the King County Council, City of Seattle, and 37 Suburban City Councils, and 19 school boards.

The King County Board of Health, whose mandated role is to oversee "all matters pertaining to the preservation of the life and health" of the population, has policy influence over PHSKC because it represents the King County Council, Seattle City Council and suburban cities. (RCW 70.05.060) Other county departments that create and influence public health policy include the Department of Natural Resources and Parks, the Department of Transportation, the Department of Adult and Juvenile Detention, the Department of Community and Human Services. In addition, regional entities, such as the Puget Sound Regional Council operate in the local jurisdiction.

An agreement between King County government and the City of Seattle places the policy and statutory authority for the PHSKC with King County. The City of Seattle's responsibility rests within its own voluntary financial contribution to the Department and "influence" over policies that impact services in the city. The agreement includes language that directs the Board of Health to enact and enforce local public health regulations. At the time that this agreement was developed in 1996, a Joint Executive Committee was established (Mayor, County Executive, Director of the Department) whose role was to implement and monitor Board of Health directives and policy and serve as a forum for conflict resolution. According to information received through stakeholder interviews, the Joint Executive Committee is not currently active. The City of Seattle's interest in influencing PHSKC's approach to services can be seen in the City of Seattle Healthy Communities

Initiative, Attachment E. It is also of interest to note here that the service responsibilities outlined in the agreement were based on the previously mentioned WAC which was replaced by the public health standards. The language of the WAC defined services that "counties should provide" through health departments.

Lack of activity by the Joint Executive Committee might be problematic, particularly given the need for clarity regarding state mandates and to assure that the City-County agreement remains current with changing law.

PHSKC is the recipient of a number of grants administered by the State Department of Health (DOH). In several cases, grants received by PHSKC are also received by other health departments in the state. Allocation methods by DOH often are designed to assure core capabilities across the state rather than allocating resources on a basis of risk, vulnerability and levels of complexity. For example, state funding policies distribute resources evenly by county population, so King County gets 40% of the funding yet it has 60% of the statewide tuberculosis cases. With half the statewide total of hospital beds located in this one metro county, resources are still allocated on a per capita basis. This distribution of funds has an impact on the ability of PHSKC to coordinate preparedness efforts across the entire health care system.

In addition, PHSKC is the recipient of many program and research grants, all of which have their own set of required deliverables which may limit flexibility. For example:

- Assessment activities are considered an essential, basic function of local health departments; funding for these activities have traditionally been from local and state resources. An increasing proportion of assessment activities performed by PHSKC are funded as a component of grants. This necessary shift results from the inability of limited local and state governmental funds to keep pace with inflation.
- Many times, grant opportunities are not available for or do not allow for implementation and evaluation of promising programs. Thus, expansion of the evidence-based body of work in public health progresses slower than other health areas.

Milne & Associates asked department staff how the policy environment affects their ability to fulfill PHSKC's role as a major metropolitan health department. Staff responded using the framework of the 10 essential services, providing an analysis of the policy environment for each area. This analysis is in Attachment F.

CMHD Mandates

Similar to PHSKC, stakeholder and local elected official expectations are important but not the sole determinant of services for the CMHD examined. Legislative mandates vary across the CMHD, but since they determine a large portion of services (in one case 95% of services are mandated) they may comprise the most important determinant of the health department's services. Grant "mandates" are restrictive but the health departments were selective about which grants they pursued, usually based on need. In most cases need was determined by community assessments and/or a strategic planning process. Bioterrorism preparedness grants were seen as mixed blessings; while they are providing additional resources for public health, they come with specific requirements that require greater attention from leadership and management, diverting focus from other programs.

All but one CMHD manage mandates through negotiation with policymakers and through integrating the requirements into other programs, or using CMHD size to provide flexibility that may not be available to smaller health departments. Community expectations are an important driver for policy in most CMHD, and these expectations are generally discovered through formal strategic planning processes.

Section 2: Public Health Governance, Functions and Services

Overview

Because public health agencies at the state level are created under different sets of social and political circumstances to meet the needs of individuals living in communities where health status and circumstances vary, state and local public health departments are quite different across the United States. Over half of state health departments are "freestanding," consisting of a single agency whose primary mission is public health. Most of these freestanding agencies, including Washington's, have a relationship with a state board of health and over 40% have a district or regional structure that serves as an intermediary with local public health jurisdictions. Those state health departments not freestanding are located within a "super agency" whose mission is broader than public health; often including human services

and Medicaid functions. The vast majority of state public health agencies maintain the authority to propose budget and substantive legislation to policymakers. Less than half of the state health departments have a centralized form of local public health, giving the state agency the oversight of local agencies. One of the comparable CMHD is from such a state (Florida). In most cases (97.9%) the state agency acts as the state's public health authority. [18]

In Washington State, public health governance uses the decentralized model. The Washington State Department of Health is a freestanding "cabinet-level" agency whose Secretary is appointed by and accountable to the Governor. Washington's 35 local health departments are independent from the state in terms of governance but are closely associated through contracts, organizational affiliations (Association of Washington Counties) and through numerous joint planning initiatives (Public Health Improvement Partnership).

Local public health jurisdictions have developed in response to local needs and priorities, and vary widely. According to NACCHO's Chartbook[19] (1999, 2001) on local public health infrastructure, the highest priority services for metropolitan public health agencies are communicable disease control, environment health, child health, and regulatory inspections. Table 3, on the next page, shows the percent of metropolitan health departments that provide different types of public health services. The direct provision of services means that the agency provides it themselves as opposed to contracting the service out to another organization.

In 2001, an updated version of the Chartbook continued to show that no two local health departments are identical in structure or programs provided. For example, of the 3,000 local health departments in the US, 4% serve populations of 500 thousand or more; 50% serve populations of less than 25 thousand. It was reported that 60% of all local health departments, regardless of size, are county based, while 10% are city based, and 7% are a combined city-county health department. Lastly, 15% are township health departments, and 8% are multi-county. Most local health departments, regardless of type, report to a local board of health (56% of total; 66% of City-County) while only 9% directly governed by a city council or county council.

Table 3
% of Metropolitan Health Departments Direct Provision of Services (NACCHO Chartbook)

Food Safety	89%
Communicable Disease Control	77%
Epidemiology & Surveillance	72%
Sewage Disposal	71%
Tuberculosis Testing	67%
Childhood Immunizations	64%
Private Drinking Water	63%
Community Outreach & Education	62%
Vector Control	61%
Lead Screening & Abatement	58%
High Blood Pressure Screening	55%
Community Assessment	54%
STD Testing & Counseling	48%
HIV/Aids Testing & Counseling	47%
Emergency Response	46%
Tuberculosis Treatment	46%
Indoor air Quality	44%
WIC	43%
Maternal Health	40%
EPSDT	35%
Diabetes Screening	35%
Surface Water Pollution	31%
Cardiovascular Screening	31%
Family Planning	31%
Cancer Screening	28%
Dental Health	22%
Prenatal Care	22%
HIV/AIDS Treatment	15%

Financing local public health agencies may be the greatest challenge faced by policymakers and public health leaders. The factors associated with financing public health are related to accurate assessments of the capacity required for adequate infrastructure and public health programs. For example, programs created to protect the public's health from hazards now include a major focus on preparedness for bioterrorism and emerging infections such as avian influenza. The enormity of the shortfall for adequate funds to address these types of issues has taken policymakers by surprise.

Large metropolitan health departments face the major responsibility for preparedness activities since they serve the majority of the US population and have the necessary skills within the workforce to provide the types of

sophisticated assessment, surveillance, and response technology required[20]. One thing learned from the development of the CDC preparedness plans was that in terms of protecting the public from threats such as terrorism, the public health workforce must coordinate and work with partners in such departments as police and fire as well as private health providers.

The challenge of developing new programs and structures to respond to issues such as bioterrorism is often related to financing and may be hampered by the mechanisms used to fund local health departments-- Federal funds typically go to state health departments and then get "passed through" to local health departments by the state. This approach assumes that the state will be strategic in developing a formula that parses out the funds in a manner that will meet the needs of the state's population. This is not always the case, leaving some major metropolitan health departments to seek funds directly from the Federal government or from alternate funding sources such as foundations.[21]

PHSKC Functions and Services

The mission of the PHSKC as stated on its website is to achieve and sustain healthy people and healthy communities throughout King County by providing public health services which promote health and prevent disease. This mission is carried out through eight goals: 1) Provide needed or mandated health services & prevention programs to address individual and community health concerns. 2) Assess and monitor the health status of our communities. 3) Prevent disease, injury, disability and premature deaths. 4) Promote healthy living conditions and healthy behaviors. 5) Control and reduce the exposure of individuals & communities to environmental or personal hazards. 6) Employ and retain a skilled workforce that reflects the diversity of the community. 7) Provide for timely, consistent and clear two way communication tailored to the individual communities Public Health serves. 8) Anticipate and respond to the public health consequences of local emergencies.

The mission and goals are realized through five primary focused services lines depicted Table 4, below.

Table 4
PHSKC Programs and Services
(Source: 2006 Department Business Plan, July 2005)

Population and Environmental Health:
- Health Education Services
- Chemical and Physical Hazard Special Projects
- Prevention
- Public health preparedness
- Public Health Laboratory
- Food Protection
- Drinking Water Protection
- Waste Water Disposal

Emergency Medical Services
- EMS Basic Life Support Training
- Pre-hospital emergency care

Targeted Community Health Services
- Public Health Preparedness
- Family Planning
- Refugee Health Access Program
- Interpretation Services
- HIV/AIDS Program
- Family Support Services
- Occupational Health
- Tuberculosis Control
- Woman, Infants and Children

Clinical and Primary Care Services
- Health Care for the Homeless
- Primary Care
- Immunizations
- Child Profile
- Oral Health
- Jail Health Services

Management and Business Practice
- Accounting Services
- Budget and Financial Planning
- Compliance Office
- King County board of Health
- Professional Practice Support
- Management and Business Practice

The organization of services by functions reflects PHSKC's approach to service delivery. Clinical health services account for 30% of PHSKC revenue streams, including significant patient generated revenues. While a number

of local health departments around the country have moved away from the provision of direct clinical services, PHSKC continues to provide substantial safety net services to under and uninsured individuals and families. Also, unlike many local health departments and the CMHD, PHSKC receives significant funding from direct grants from the federal government and from foundations; the two comprise over 15% of the budget.[22]

Clinical services have been developed in response to community needs, as well as to priorities expressed by funding sources and policy-makers at various levels of government. For example, because of continued limited access to care for individuals and families as evidenced by waiting lists for the State's Basic Health Plan and concern over the widening disparities in health care for minority and immigrant children, PHSKC provides primary care through direct access and through coordination with community partners including community clinics. However, PHSKC seems to play a rather limited role in convening, facilitating, coordinating, and/or contracting to improve access to the broader healthcare system. Further, some stakeholders suggested that PHSKC has a conflict of interest in both providing and contracting for primary care services.

The decision of whether to provide clinical personal health services is an important policy issue for local health departments around the country. Many local health departments provide some clinical services, but fewer provide full primary care such as that provided in several of PHSKC clinics. During the early 1990s when there was legislative action around health reform in Washington State and the promise of universal access to health care was a reality (albeit short-lived), local public health departments began to examine their role in providing clinical services to individuals who were either under-insured or un-insured. At that time, a report was developed by the Health Policy Analysis Program at the University of Washington School of Public Health and Community Medicine (Clinical Personal Health Services Technical Assistance Project) [23] that examined the decision making about continuing clinical services within the changing health care environment anticipated from the Health Services Act. While the report is dated, these recommendations from that study still seem relevant today and have been acted on by several health departments in the state:

1. The local health department should actively involve the community in decision-making about whether to transition clinical services to other providers.
2. The local health department should examine the capacity of local providers, health plans, etc. to meet the needs of under-insured and un-insured individuals.

3. The health department should explore the potential for partnerships through which clinical services could be delivered.
4. The health department should set a priority on "population-based" services such as those provided by public health nurses (those that serve the entire population or subpopulation in order to assure health promotion, health protection, and disease prevention).
5. The health department should evaluate its effectiveness and efficiency in providing clinical services in comparison with alternative providers.
6. The health department should critically examine their preferred role and weigh that preference against current capacity, infrastructure, workforce, organizational structure, and community and stakeholder support.

Using these recommendations to examine the provision of clinical services would be a useful component of the master plan and of the next iteration of the PHSKC strategic planning process.

It must also be pointed out that within King County, PHSKC is working in coordination with community partners and local government to promote increased access to health insurance coverage or funding for services directed at un- or under-insured populations. In addition, through the Health Care Coalition on Emergency Preparedness, PHSKC works with community providers and health systems to better coordinate the health care system to respond in the event of an emergency to the care needs of the entire population, with a special emphasis on vulnerable populations.

An examination of the department's policy analysis (Attachment F) demonstrates that PHSKC places its statutory obligations from local government within the context of such national policy statements as the Ten Essential Services. Thus the array of services provided take advantage of investment opportunities by assuring consistency with local mandates and public health practice and priorities at the national level.

Functions and Services – Comparison

All of the CMHD have a similarly large set of services and activities, although it appears that the CMHD contract with external organizations for more of the services than is the case with PHSKC. The most prominent example is primary care. Among the five CMHD, comprehensive primary care is performed directly only by PHSKC. The other CMHD contract for these services. (Note: While Alameda County Health Department, one of the CMHD, does not provide primary care services, another department of county government does. Also, PHSKC

staff pointed out that 11 of the 25 largest health departments in the country, including PHSKC, provide comprehensive primary care).

While most of the CMHD have a history of primary care service delivery as part of their past service array, all have moved away from the direct delivery of primary care service to an indirect assurance or funding role, largely due to financial considerations, and the belief by the parent governmental body that other arrangements outside of the health department would be more cost effective. Some also expressed the belief that they were more effective in assuring access by serving in convening, organizing, and catalyst roles than in providing services. The original decision to offer primary care services by CMHD was based more on stakeholder expectations that became formalized within the health department operations and authorized through the local government appropriations, than through a specific legislative mandate. Likewise, the governmental appropriations process seemed to be the mechanism through which these CMHD stopped directly providing primary care clinic services.

Additional examples of areas where PHSKC has a larger direct role in providing these programs than the CMHD include inspection and licensing of solid waste haulers, development and enforcement of smoke-free ordinances, regulation of private drinking water wells, and regulation and inspection of health-related facilities. PHSKC was the only health department within our comparison group that provides school-based clinics, emergency medical services, or environmental work with the built environment. On the other hand, there are several areas where the opposite is true. For example, PHSKC does not provide behavioral/mental health services.

Section 3: Policies and Tools for Planning, Operations, and Accountability

Overview

The call for greater accountability and performance by agencies at the federal, state and local levels is a theme that has pervaded the public sector over the past two decades. Nationally this has been championed in such books as Osborn and Gabler's Reinventing Government. Vice President Al Gore emphasized government performance initiatives and this initiative was formalized at the federal level by the 1993 Government Performance and Results Act (GPRA), which requires federal agencies to be more accountable for the public funds they administer. As a result, national public health

leadership organizations including the two major federal public health agencies (Centers for Disease Control and Prevention, and Health Resources Services Agency), the Institute of Medicine, along with the national professional associations NACCHO, ASTHO and APHA - have embraced this movement and have taken the lead in developing performance management conceptual frameworks and tools for use by state and local public health agencies.

This "movement" to greater accountability has encouraged the development of frameworks and tools for performance enhancing approaches such as strategic planning, performance measurement, standard setting, strategic partnership building, community engagement, program planning and quality management including:

1. The Robert Wood Johnson/Kellogg Foundation's Turning Point Initiative for developing community public health systems.
2. NACCHO's community public health strategic planning tool, Mobilizing Action though Planning and Partnerships (MAPP)
3. NACCHO's agency and community planning tool, Assessment Protocol for Excellence in Public Health (APEX-PH)
4. The federal government's Healthy People 2010 national objectives, and implementation tool, Model Standards
5. CDC's National Public Health Performance Standards (NPHPS)
6. CDC's Planned Approach to Community Health (PATCH)
7. NACCHO's Operational Definition and Standards for Public Health

While the adoption of these frameworks and tools has progressed slowly, the literature reports many cases of successful implementation of several of these initiatives. All of the CMHD in this study have, for example, used MAPP to at least inform strategic direction setting. Such inclusion is good in that it assures more extensive involvement of stakeholders.

PHSKC

At PHSKC, strategic planning for improving community health is a complex process that goes on at many levels in King County: within the department, within the multiple coalitions in which PHSKC participates, with city and regional planning groups. There is no single planning model that is suitable to these diverse planning processes. Many of the processes include elements similar to those included in the MAPP process, such as assessment of community health, assessment of systems capacities, and assessment of community assets.

The public health priorities and funding policies for PHSKC are described in the 2003 King County budget proviso. Developed by PHSKC and approved by the King County Council, this document outlines the mechanism that PHSKC uses to strategically manage toward service priorities and make decisions about service provision given their need to serve the whole of King County. The "Public Health Priorities and Funding Policies"[24] outlines a six step process that aligns resources to priority public health needs. The six steps include:

1. Identify legal mandates and public health standard requirements.
2. Describe the target population served using public health data resources.
3. Define program intervention and required resources for desired outcomes.
4. Assess the greatest needs within the program population.
5. Align resources to programmatic interventions to attain best outcomes with the least harm.
6. Continuous monitoring of health and financial performance outcomes and impacts.

It is unclear whether this "Public Health Priorities and Funding Policies" document is employed in making choices between competing demands and in considering new program opportunities.

In 1999, PHSKC developed a strategic plan that clearly stated the organization emphasizes the core functions of public health (assessment, assurance and policy development) with a focus on population health and community-wide health promotion and health education. In 2004 the strategic planning effort was renewed by PHSKC's leadership group. The leadership group selected three priority areas (Obesity and Overweight, Public Health Preparedness, and Land Use Planning and Health). They also selected three areas for infrastructure improvement (Grants Support Mechanisms, Human Resources, and Public Health Standards).

The assurance of accountability and quality are evident in several documents created by PHSKC -- the Conceptual Framework for Quality Management, the Quality Improvement Committee responsibilities, and the matrix defining the performance measures for PHSKC programs.

In addition, Washington State law mandates that the state Department of Health "Enter into with each local health jurisdiction performance-based

contracts that establish clear measures of the degree to which the local health jurisdiction is attaining the capacity necessary to improve health" (RCW 70.190.130). PHSKC has been audited twice under statute (RCW 43.70.580) Audit findings in both instances showed the department to be in compliance with the majority of measures, and many exemplary practices were noted and are shared on the Department of Health website as examples of best practices[25].

Comparison with CMHD

All five CMHD sites use or have used the 10 Essential Service framework at one time to organize their strategic plans, focus their services, and communicate about the purpose and role of public health internally and to outside stakeholders. Two sites have moved away from a strict essential services framework, adapting it to their own needs. One now uses the CDC "Healthy People in Healthy Communities" framework.

Four of five do formal strategic planning, following a process that has been internally tailored to the health department or one prescribed by the parent governmental unit. All have used MAPP at least as a reference tool for strategic or community planning. Executive leadership is a very important element in four of the five CMHD in determining services and investments. Leadership seems to be most influential when legal or political mandates are less but also important for negotiating the requirements set forth in mandates with local and state policymakers either directly through information sharing and education or through public health organizations and advocates. Strategic planning is not used extensively by the CMHD that reported that legislative mandates determine services.

All CMHD apply methods of community assessment to understand community needs and determine health department programs. Several use sophisticated methods of community participation, putting a great deal of importance on the role of community input. A variety of needs assessment tools are used, including some national tools and some locally developed.

All of the CMHD have formal methods of performance management and reporting to track and report activities and outcomes. All are very aware of the importance of employing methods to measure and assure accountability for performance management. Two use the parent governmental unit's performance management process. At least one has adopted a private sector model for performance management (Baldridge Quality Award, a national award program to recognize high performance). All do some evaluation in different degrees of sophistication. Most see the value of evaluation and plan to increase efforts in this area.

Conclusions and implications for next steps

In comparison to the CMHD included in this analysis, PHSKC is more complex in its mandates, the mix of services provided, and its governance structure.

In general, PHSKC exists within a policy environment that mandates services from the Federal government (via state directives), state statutes (RCW) and regulations (WAC), and local ordinances via King County Government, the City of Seattle, the King County suburban cities, and the King County Board of Health.

Mandates provide considerable structure and direction for what programs and services are provided. Yet PHSKC retains a certain amount of flexibility within which they have created structures for setting programming and funding priorities. For example, the department has responded to mandates and requirements by:

- organizing and delivering services along the framework of the ten essential public health services;
- using a quality management framework;
- focusing leadership in specific areas through strategic planning;
- providing measurable targets within a performance management framework.

PHSKC provided us with an analysis of the impact of the policy environment on its ability to improve the health of King County. This analysis, organized by the 10 Essential Services and cross-walked with the Washington State Public Health Standards, is found in Attachment F.

Key observations from this report are summarized below and followed by our interpretation of their significance and meaning for a broad policy framework for public health in King County. First, the key observations:

- **This analysis of the policy environment for public health includes an examination of government mandates; governance structures; functions and services; and policies and tools for operations and accountability.** We examined these factors from the perspective of national norms and through a comparison of how they influence the policy environment for PHSKC and the CMHD selected for comparison.

- **Policy environments differ from community to community.** The policy environment of the comparable metropolitan health departments (CMHD) is influenced by a number of factors including the historical context, local capacity, and community dynamics. Therefore, as would be expected, there are some notable differences between PHSKC and the five CMHD. This is also due, in part, because these CMHD were not chosen for their service mix. Rather they were chosen for their potential value to the overall project by virtue of the make-up of their populations, evidence of best practices, innovation and policy issues they are facing.

- **Washington State has moved from a "service formula approach" to a "functions and essential services approach".** The categorical "service formula" approach for mandating public health programs in most other states allows very limited flexibility for local and state response to emerging public health problems, particularly when compared to the "functions and essential services" approach used in Washington. Washington's "functions and essential services" model for defining mandates facilitates responsiveness because the focus is on broad activities such as surveillance which can be marshaled to address any disease outbreak.

- **State allocation of Grant funding is usually based on population.** Allocation methods by DOH often are designed to assure core capabilities across the state rather than allocating resources on a basis of risk, vulnerability and levels of complexity. For example, state funding policies distribute resources evenly by county population, so King County gets 40% of the funding yet it has 60% of the statewide tuberculosis cases. With half the statewide total of hospital beds located in this one metro county, resources are still allocated on a per capita basis. This distribution of funds has an impact on the ability of PHSKC to coordinate preparedness efforts across the entire health care system.

- **Government mandates impacting all major metropolitan health departments (MMHD), are numerous.** Mandates impacting PHSKC include
    - federal statutes and regulations
    - state statutes and regulations
    - local ordinances from King County governments
    - local rules from the King County Board of Health
    - interlocal agreements with the City of Seattle
    - the state Public Health Improvement Plan which sets forth practice standards.

- **The Ten Essential Public Health Services guide policy about core functions and responsibilities of local public health agencies and their system partners.** Based on this framework, public/private entities and coalitions have promulgated frameworks for quality management, strategic planning, leadership development, and performance management using quantitative targets for measuring accountability. While not mandates, both the essential services and these tools have become accepted national norms for public health practice.

- **While PHSKC is similar to CMHD in many ways, there are notable differences.** PHSKC plays a larger role than the other CMHD in
    - Conducting inspection and licensing activities
    - Providing primary care services directly
    - Operating school-based clinics
    - Providing correctional health services
    - Providing emergency medical services
    - Doing work related to the built environment

  PHSKC does not provide behavioral/mental health services, but its comparison CMHD either provide them directly or contract for them.

- **The governance of PHSKC is perhaps more complex than in other CMHD.** PHSKC is considered a city-county health department, one of five types of health departments. The department is governed by King County and the Board of Health, each with different authorities. Further, the City of Seattle and the suburban cities in the county all play roles in governance. The result is a complex model of governance.

- **Financing public health presents significant policy challenges.** Among the factors associated with financing public health, many are related to the challenges in obtaining accurate assessments of what constitutes an adequate infrastructure to address public health responsibilities and core programs. This will be a topic of the background paper on funding.

Important implications for next steps based on this description of the policy environment include:

- **The concept of a local public health system is very important, but system effectiveness has not been measured in King County.** Policies regarding what roles should be performed by PHSKC might be more clearly determined if system capacity and effectiveness were measured. Consideration of the NACCHO Operational Definition will also help identify service gaps within the system and help policy makers assign specific roles to the health department.

- **Some mandates are vague and need clarification.** Some services and activities are provided by PHSKC because they are considered to be mandates. However, room for greater flexibility in service selection may exist with some "mandates" because of unclear legal language, use of outdated language (as in the Joint Executive Committee Agreement), and questionable interpretation of the language. Competing demands for limited resources suggest that mandates be clarified.

- **Services that are "core" to the health department's mission are undefined.** The Seattle agreement is based on the WAC in place in the late 1990's. The WAC was widely interpreted as constituting mandates for local health departments and is the basis for the King County responsibility for "core services" with Seattle. The WAC was replaced by the Washington State Public Health Standards. Perhaps owing to this set of circumstances, the staff, when asked by Milne & Associates, could not identify what services are core to their mission.

- **King County's and PHSKC's participation in state level policy planning, development and review is important.** A significant portion of the mandates that affect PHSKC are generated within the state, by the legislature, State Department of Health and State Board of Health. Information from stakeholder interviews suggested that PHSKC does not always play an active role in those efforts. Since a significant portion of the mandates that affect PHSKC are generated within the state, the health department's level of participation in state level policy planning, development and review is important.

- **Lack of activity by the Joint Executive Committee might be problematic.** The agreement between the City of Seattle and King County was based, at least in part, on state laws then in place. Given subsequent changes in law, there is a need for clarity regarding state mandates and to assure that the City-County agreement remains current with changing law.

- **Reexamination of policy options related to the PHSKC emphasis on providing direct services to individuals should be considered.** The rationale for PHSKC's placing emphasis on providing services directly to individuals is explained in part because of continued limited access to care for individuals and families in King County. There are waiting lists for the State's Basic Health Plan and concern over the widening disparities in health care for minority and immigrant children. For these and other reasons, PHSKC provides primary care through direct access and through coordination with community partners including community clinics. However, PHSKC seems to play a limited role in convening, facilitating, coordinating, and/or contracting to improve access to the broader healthcare system. It was noted that CMHD contract with external organizations for more services than is the case with PHSKC, particularly for primary care. These CMHD discontinued the direct delivery of primary care services, providing instead an indirect role of assuring funding and/or fulfilling the role of convening, organizing, and catalyzing action.

  Some stakeholders perceive a possible conflict of interest in PHSKC's "competing" for primary care services with clinics with which it contracts. That perception alone justifies a reexamination of the options but care should be taken not to dismantle existing capacity without a thorough analysis of the impact of policy change.

- **Application of the PHSKC "Public Health Priorities and Funding Policies" document is unclear.** The public health priorities and funding policies for PHSKC are described in the 2003 King County budget proviso. Developed by PHSKC and approved by the King County Council, this document outlines the mechanism that PHSKC uses to strategically manage toward service priorities and make decisions about service provision given their need to serve the whole of King County. It is not clear if the policy is employed in making choices between competing demands or in considering new program opportunities.

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Attachment A
Glossary

- **Categorical funding:** governmental funding, usually from the federal level, which is designed to be used in support of specific public health programs and activities. It typically is accompanied with tight limitations on how the funds can be used, even within programs.
- **Clinical services** are provided to individual clients/patients by any of a variety of health professionals, including physicians, nurses, dentists and others, to address specific health issues, including treatment of illness or injury or prevention of health problems.
- **Comparable metropolitan health department (CMHD)** is a term used specifically for this project and describes one of the five CMHD to which PHSKC was compared. They include the health departments serving Alameda County (CA), City of Columbus (OH), Miami-Dade County (FL), Nashville-Davidson County (TN), and Nassau County (NY).
- **EPSDT:** A federally funded program for the "Early and Periodic Screening, Diagnosis and Treatment of children.
- **Essential Public Health Services:** established under the aegis of the federal Department of Health and Human Services in 1994, this list of ten sets of services comprises service categories that must be in place in all communities to assure an adequate local public health system.
- **Evidence-based practices:** public health activities which are designed based upon authenticated studies of efficacy and/or upon established practices.
- **Health Status**: The current state of health for a given group or population, using a variety of indices including illness, injury and death rates, and subjective assessments by members of the population.
- **Local public health agency (LPHA)** is a single governmental organization, regardless of size, providing public health services to the residents of a political jurisdiction; also known as a "local health department."
- **Local Public Health System:** in any community, the local governmental public health agency and all organizations, agencies and individuals who, through their collective work, improve or have the potential to improve the conditions in which the community population can be healthy.
- **Major metropolitan health department (MMHD)** is a local public health agency which is one of the 25 largest metropolitan health departments in the U.S.; while the size of the population served by MMHDs is widely variable, most provide services of close to a million or more people.
- **Metropolitan health department (MHD)** is a local public health agency that provides services to a political jurisdiction with a population of 350,000 or more.

- **Personal health care**: encompasses the services provided to individual patients by health care providers for the direct benefit of the individual patient. Examples include physical examinations, treatment of infections, family planning services, etc.
- **Population-based public health services** are interventions aimed at promoting health and preventing disease or injury affecting an entire population, including the targeting of risk factors such as environmental factors, tobacco use, poor diet and sedentary lifestyles, and drug/alcohol use.
- **Primary care** constitutes clinical preventive services, first-contact treatment services, and ongoing care for medical conditions commonly encountered by individuals. Primary care is considered "comprehensive" when the primary care health provider assumes responsibility for the overall provision and coordination of medical, behavioral and/or social services addressing a patient's health problems.

Attachment B
Ten Essential Services

- *Monitor health status to identify and solve community health problems*: This service includes accurate diagnosis of the community's health status; identification of threats to health and assessment of health service needs; timely collection, analysis, and publication of information on access, utilization, costs, and outcomes of personal health services; attention to the vital statistics and health status of specific-groups that are at higher risk than the total population; and collaboration to manage integrated information systems with private providers and health benefit plans.

- *Diagnose and investigate health problems and health hazards in the community*: This service includes epidemiologic identification of emerging health threats; public health laboratory capability using modern technology to conduct rapid screening and high volume testing; active infectious disease epidemiology programs; and technical capacity for epidemiologic investigation of disease outbreaks and patterns of chronic disease and injury.

- *Inform, educate, and empower people about health issues*: This service involves social marketing and targeted media public communication; providing accessible health information resources at community levels; active collaboration with personal health care providers to reinforce health promotion messages and programs; and joint health education programs with schools, churches, and worksites.

- *Mobilize community partnerships and action to identify and solve health problems*: This service involves convening and facilitating community groups and associations, including those not typically considered to be health-related, in undertaking defined preventive, screening, rehabilitation, and support programs; and skilled coalition-building ability in order to draw upon the full range of potential human and material resources in the cause of community health.

- *Develop policies and plans that support individual and community health efforts*: This service requires leadership development at all levels of public health; systematic community-level and state-level planning for health improvement in all jurisdictions; development and tracking of measurable health objectives as a part of continuous quality improvement strategies; joint evaluation with the medical health care system to define consistent policy regarding prevention and treatment services; and development of codes, regulations and legislation to guide the practice of public health.

- *Enforce laws and regulations that protect health and ensure safety*: This service involves full enforcement of sanitary codes, especially in the food industry; full protection of drinking water supplies; enforcement of clean air standards; timely follow-up of hazards, preventable injuries, and exposure-related diseases identified in occupational and community settings; monitoring quality of medical services (e.g. laboratory, nursing homes, and home health care); and timely review of new drug, biologic, and medical device applications.

- *Link people to needed personal health services and assure the provision of health care when otherwise unavailable*: This service (often referred to as "outreach" or "enabling" services) includes assuring effective entry for socially disadvantaged people into a coordinated system of clinical care; culturally and linguistically appropriate materials and staff to assure linkage to services for special population groups; ongoing "care management"; transportation services; targeted health information to high risk population groups; and technical assistance for effective worksite health promotion/disease prevention programs.

- *Assure a competent public and personal health care workforce*: This service includes education and training for personnel to meet the needs for public and personal health service; efficient processes for licensure of professionals and certification of facilities with regular verification and inspection follow-up; adoption of continuous quality improvement and life-long learning within all licensure and certification programs; active partnerships with professional training programs to assure community-relevant learning experiences for all students; and continuing education in management and leadership development programs for those charged with administrative/executive roles.

- *Evaluate effectiveness, accessibility, and quality of personal and population-based health services*: This service calls for ongoing evaluation of health programs, based on analysis of health status and service utilization data, to assess program effectiveness and to provide information necessary for allocating resources and reshaping programs.

- *Research for new insights and innovative solutions to health problems*: This service includes continuous linkage with appropriate institutions of higher learning and research and an internal capacity to mount timely epidemiologic and economic analyses and conduct needed health services research.[7]

Attachment C:
Essential Public Health Services
The "Lay Version"
Milne & Associates, LLC
2004

Essential Service Number	Non-Public Health Version
1	What's going on in my community? How healthy are we?
2	Are we ready to respond to health problems or threats in my county? How quickly do we find out about problems? How effective is our response?
3	How well do we keep all segments of our community informed about health issues?
4	How well do we really get people engaged in local health issues?
5	What local policies in both government and the private sector promote health in my community? How effective are we in setting healthy local policies?
6	When we enforce health regulations, are we technically competent, fair, and effective?
7	Are people in my community receiving the medical care they need?
8	Do we have a competent public health staff? How can we be sure that our staff stays current?
9	Are we doing any good? Are we doing things right? Are we doing the right things?
10	Are we discovering and using new ways to get the job done?

Attachment D
Crosswalk of Core Functions and 10 Essential Services to Washington State Public Health Standards

The following information compares the federal framework of 10 Essential Services of Public Health with the Standards for Public Health in Washington State. Local and state health officials drafted the standards with frequent reference to the 10 Essential Services, but they did not use the federal framework to organize their work. Instead, they chose to develop standards in five topic areas. For each area, they sought to assure that the 10 Essential Services were addressed. Please note that the standards, as referenced here, are abbreviated. An entire standard and its measures must be read to understand its scope.

The 10 Essential Services are:

Assessment
- Monitor health status of the community.
- Diagnose and investigate health problems and hazards.
- Inform and educate people about health issues.

Policy Development
- Mobilize partnerships to solve community problems.
- Support policies and plans to achieve health goals.

Assurance
- Enforce laws and regulations to achieve health goals.
- Link people to needed personal health services.
- Ensure a skilled public health workforce.
- Evaluate effectiveness, accessibility, and quality of health services.
- Research and apply innovative solutions.

Each Standard is linked to the relevant 10 Essential Services placed in parentheses

Assessment
1. Assessment skills and tools in place (Monitor, Investigate, Workforce)
2. Information collected, analyzed, and disseminated (Monitor, Investigate, Workforce)
3. Effectiveness of programs is evaluated (Monitor, Workforce, Evaluate)
4. Health policy reflects assessment information (Inform, Mobilize, Policies)
5. Confidentiality and security of data protected (Workforce)

Communicable disease

1. Surveillance and reporting system maintained (Monitor, Investigate, Inform, Enforce, Workforce, Research)
2. Response plans delineate roles (Inform, Mobilize, Workforce)
3. Documented investigation and control procedures (Investigate, Policies, Enforce, Services, Workforce, Evaluate)
4. Urgent messages communicated quickly (Inform, Mobilize, Services, Workforce)
5. Response plans routinely evaluated (Inform, Workforce, Evaluate, Research)

Environmental health

1. Environmental health education planned (Investigate, Inform, Mobilize, Workforce)
2. Response prepared for environmental threats (Monitor, Investigate, Mobilize, Services, Workforce, Research)
3. Risks and events tracked and reported (Monitor, Inform, Mobilize, Evaluate, Research)
4. Enforcement actions taken for compliance (Enforce, Workforce)

Prevention/health promotion

1. Policies support prevention priorities (Monitor, Investigate, Inform, Policies, Workforce, Research)
2. Community involvement in setting priorities (Inform, Mobilize, Policies)
3. Access to prevention services (Inform, Mobilize, Services, Workforce, Evaluate, Research)
5. Prevention, early intervention provided (Mobilize, Policies, Services, Workforce)
6. Health promotion activities provided (Inform, Mobilize, Policies, Workforce, Evaluate, Research)

Access to critical services

1. Information on service availability (Monitor, Inform, Services)
2. Information shared on trends, over time (Investigate, Inform, Evaluate, Research)
3. Plans developed to reduce specific gaps (Inform, Mobilize, Policies, Services, Evaluate)
4. Quality and capacity monitored and reported (Inform, Enforce, Workforce, Evaluate, Research)

Attachment E
City of Seattle Public Health Goals[26]

Attachment 1 to RESOLUTION
The City of Seattle Healthy Communities Initiative
Policy Guide for the City's Public Health Efforts and Investments
February 7, 2006

Public health and community health services have a great impact on the health and well being of Seattle's residents and neighborhoods. One of the ways the City improves its residents' health is by investing in what are called enhanced public health services. King County, through Public Health—Seattle & King County (Public Health), is responsible for providing regional core public health services to residents throughout the county. Public Health's regional core services can be considered a "platform" or base of public health services that must be in place, and upon which the City of Seattle may choose to fund enhanced services. The City's investments are voluntary and are to be used for enhanced public health services benefiting Seattle residents.[12]

The City of Seattle's vision for the health of the community

This vision applies to all of the City's efforts to improve health conditions for Seattle's residents, as well as the City's specific investments in enhanced public health services.

The people of Seattle will be the healthiest of any major city in the nation.

There are many socioeconomic factors affecting the health of the community. This policy document focuses on the role of public and community health services in achieving this vision as well as on the City's more comprehensive work and investments that contribute to the public's health. The term health includes mental as well as physical health.

How successful we are in reaching this vision will be assessed in four ways. First, the City will compare Seattle's health indicators with the goals set by Healthy People 2010[13], which is a set of national health objectives developed

[12] The City has no obligation to fund any enhanced public health service, with the exception, as delineated in RCW 70.96A.087, that a minimum of 2% of the City's share of state liquor taxes and profits must support alcohol and drug programs approved by the King County Alcoholism & Substance Abuse Board.

[13] When it is adopted, the City will use the nationally-recognized health objectives that will be promulgated to reach 2020 health goals, the successor to Healthy People 2010.

by the Centers for Disease Control and Prevention, the U.S. Surgeon General, and the U.S. Department of Health and Human Services, and endorsed by most states, including Washington. The overarching goals of Healthy People 2010 are to increase the quality and years of healthy life, and eliminate health disparities. Second, the City, in partnership with Public Health, will monitor health disparities. Our success in reaching the vision will be judged by how well we are meeting/exceeding Healthy People 2010 objectives and whether disparities in health outcomes are being eliminated.

Thirdly, the Human Services Department (HSD) contracts with agencies to deliver health services and programs. All HSD contracts include measurable outcomes to be achieved and HSD evaluates compliance with all contract requirements.

Finally, HSD will assure there are mechanisms by which clients of city-funded services can provide feedback and information on how well city-funded health services are addressing their needs. This information will inform HSD's program performance assessments.

Goals for the City's public health efforts and investments

These goals are applicable to all of the City's efforts to improve health conditions for Seattle's residents, as well as the City's specific investments in enhanced public health services. The City of Seattle recognizes that a continuum of public and community health services is necessary. This continuum must address health needs identified by public health data across the lifespan. Recognition will be given to the differing health needs of Seattle residents, including very young children, adolescents, pregnant women and older adults. The City's efforts and investments are focused on promoting the health of the public and, particularly, of groups who experience disparities in health outcomes.

1. **Eliminate health disparities** based on race, income, ethnicity, immigrant/refugee status, gender, sexual orientation, gender identity, health insurance status, neighborhood, or level of education.

   Public health data analysis reveals that there are significant disparities in health outcomes based on race, ethnicity, income, immigrant/refugee status, health insurance status and neighborhood. These disparities are consistent across most health indicators. There are also major disparities based on gender affecting both women and men. Although little local population-based data on sexual minorities exist, national research indicates that there are significant disparities

in health outcomes and risk factors based on sexual orientation. In addition, disparities tend to be interrelated; for example, there is a correlation between race and income level. People who are part of more than one disadvantaged group that experiences health disparities may experience greater health problems.

The City intends to increase the understanding of the causes of these health disparities and obtain additional local population-based data. The City will work with Public Health, Washington State and community and mainstream health providers to improve data collection.

Although the trends of most health indicators are improving overall, disparities persist. A primary focus of the City's efforts and funding is to increase understanding of and eliminate these disparities.

2. **Promote access** to clinical and preventive health services.

   The City encourages and supports evidence-based strategies to:
   - promote the early detection of disease;
   - increase access to primary care, dental care and specialty care for the uninsured, underinsured, and Medicaid eligible;
   - improve access to preventive health services, such as education and clinical services that promote healthy sexual behaviors; and
   - provide access to culturally-appropriate clinical and preventive health services in order to address health needs identified by public health data and to reach groups experiencing disparities in health outcomes including immigrants and refugees.[14]

3. **Protect and foster the health and well being of communities** through:
   - health promotion and disease and injury prevention activities;
   - preparedness for emerging public health threats; and
   - promotion of safe environments and protection from environmental hazards.

   The City promotes strong communities by fostering healthy and safe physical environments that encourage active living and social cohesion and by engaging in community-based strategies that promote public health, including evidence-based strategies for improved nutrition,

[14] The City will work with its contractors, community and mainstream health providers, Public Health and others to adopt and implement guidelines and standards for culturally-appropriate clinical and preventive health services such as the Culturally and Linguistically Appropriate Services (CLAS) standards.

increased physical activity and decreased risky behaviors. The City prepares for public health emergencies, such as pandemic influenza and bioterrorism, through integration and coordination among the regional public health delivery systems and City emergency services and infrastructure.

4. **Support other City goals** such as ending homelessness, closing the academic achievement gap, ending domestic violence, and healthy aging.

   Augment health services for the homeless to improve and stabilize their health as they improve other aspects of their lives such as housing and employment. Promote access to health services that have the potential to help children succeed in school. Support strategies that prevent domestic violence. Promote good nutrition and physical activity for all.

The City's overall strategies to advance the vision and goals

For all of the following strategies the City uses data to inform all of its public health efforts and investments.

1. **Investments –** Invest in enhanced public health services for the purpose of improving health outcomes for Seattle residents and communities, outcomes that could not be expected from providing core public health services alone.
   The City encourages, promotes and invests in promising, innovative, community-based and collaborative strategies that address disparities in health outcomes.

   City investments in public health services fund:

   a. enhanced services for Seattle residents that Public Health does not provide as part of its regional core responsibilities; (e.g., Enhanced tuberculosis services for the Seattle homeless population are not regional core services provided by Public Health); or
   b. greater service levels to increase the number of people in Seattle who are served. (e.g., Seattle investments ensure that more Seattle at-risk second and third graders receive dental sealants through the community-based oral health program.)

2. **Partnerships –** Work in partnership with Public Health, the University of Washington and other public, community-based and private health-related organizations to improve the health of the community and to prevent and address public health problems. Maximize resources through public/private partnerships.

   The City works in partnership with Public Health because a strong regional health department is critical to the health and well being of Seattle's people and communities. Public Health provides a rich array of regional core services and programs. It is the City's intention to help shape Public Health's services and activities in Seattle. The value of these services to Seattle is nearly $100 million. Through the inter-local agreement between King County and the City of Seattle and through its membership on the King County Board of Health, the City works with Public Health to identify and address the public health needs of Seattle's residents and neighborhoods. The City has a strong working relationship with the University of Washington and facilitates connections between Public Health and the University in order to strategically advance the region's health and vitality. The City supports the continued connection between University research and public health practice, which historically has led to innovation and development of state-of-the art best practices.

   In addition, the City works with other public, community-based, and private health-related organizations, including the King County Department of Community and Human Services, hospitals, community health centers, and organizations focused on promoting the health of groups experiencing health disparities. The City's aim is to proactively address the health needs of Seattle's residents.

3. **City services and policies affecting the public's health –** Identify and adopt policies and provide services that contribute to improving the health, safety and well being of residents, families and neighborhoods. These include human services, prevention of domestic violence and sexual assault, aging and disabilities services, access to public benefits, food assistance, child care, housing, emergency preparedness, sidewalks, walking and bike trails, parks, jobs, transportation, land use policy, indoor air quality regulations and enforcement, and emergency medical services. Just as the City's investments and efforts in public health help to advance other City goals, these other City services contribute to the health of the community.

4. **Innovation.** Look for opportunities and promising community-based and collaborative strategies to achieve the City's vision and goals. The City welcomes new ideas, new voices, and new strategies in its approaches to addressing disparities in health outcomes and in all of the City's public health efforts and investments.

Policy framework and criteria to guide the City's investments in enhanced public health services

The following criteria specifically applies to the City's investments in enhanced public health services. Prior to funding an enhanced service, the City will review the level of regional core public health services being provided to Seattle residents and the proportional distribution of resources to geographic areas and populations with the greatest unmet needs.[15]

Once that review is completed, the following policy framework and criteria will be used by the City to determine whether a service is an enhanced public health service that might be *considered* for City funding. Enhanced public health services funded by the City must meet all of the criteria listed in 1 through 5 below, including all of the sub-points under 4 and 5.

1. The enhanced service advances one or more of the City's four public health goals.

2. The enhanced service addresses an identified health need that is documented with public health data and is not being addressed adequately through existing public health or community efforts.

3. The enhanced service includes a coherent strategy to address disparities in health outcomes and to effectively reach the target population.

4. The enhanced service will likely result in measurable outcomes for either the community as a whole or for specific groups experiencing health disparities.[16]

[15] The City will review the level of regional core services being provided by Public Health for each program area in which the City is considering funding enhanced services. In the absence of standards for service levels that are to be developed under the King County Operational Master Plan for Public Health, HSD, in consultation with public health experts, will make its best assessment of whether the County is fulfilling its responsibility to adequately provide regional core services. If necessary, HSD will work with Public Health to increase the provision of core services to target populations.

[16] Since many health problems, including narrowing disparities, are complex and require significant resources and time to address, measuring some outcomes will be a long-term endeavor.

a) The enhanced service improves health outcomes that would not likely result from the provision of regional core public health services alone.
b) The expected outcomes are justified by the investment.

5. The enhanced service must be based on sound public health, service delivery and administrative practices.
   a) The service reflects evidence-based practices or promising innovative, community-based or collaborative strategies.
   b) The service delivery system is culturally competent and is likely to serve the target population effectively.
   c) City funding is critical to addressing the need—no other resources are available, or City funding leverages other funds.
   d) The investment is cost-effective. Provider costs are reasonable and justifiable.
   e) The investment is significant enough to be administratively efficient and to yield measurable results.
   f) There is a contracted commitment on the part of the provider to document use of City funds and to track, achieve and report outcomes and milestones.

Attachment F
Policy Environment Impacts of Standards on PHSKC Organized by the 10 Essential services
Compiled by King County

1. Assessment Standards: Monitor health status and understand health issues facing the community

Relevant Washington State Standards: AS1, AS2, AS5, EH3

PHSKC Policy Environment Impacts

- Mandated by RCW and WAC to collect reportable diseases information, and analyze and report on these data.
- Mandated by federal HIPAA law to maintain confidentiality of health data.
- Required to track status of major health indicators and identify emerging trends for Board of Health, local government and PHSKC. Need to respond to data requests from these customers in timely fashion. This entails presentations, preparation of special reports, etc.
- Obligated to fulfill deliverables on assessment activities funded by external funders such as private foundations. An increasing proportion of assessment activities are funded in this way due to limited local and state governmental funds that are not keeping pace with inflation. Assessment activities in response to these demands include primary data collection (obtaining raw data through surveys and qualitative methods), acquisition of secondary data (large data sets from state, census, health care organizations, etc.), development of analytic methods and software, analysis of data, reporting of findings, collaboration with stakeholders in report development. The department has a minimum set of deliverables each year for its assessment activities, including one major report, two Data Watches (shorter, more narrowly focused topical reports), and timely response to data requests.
- Obligated to carry out assessment linked to policy and program development in order to be consistent with the department's value of evidence-based planning and policy development. This requires assessment staff participation in planning and policy development activities department- (and community-) wide (e.g. custom data analysis to support development of a particular policy, review of evidence for best practices in addressing a specific health issue).

- Obliged to use a collaborative process to determine priorities and scope of assessment activities. The process includes both internal and external stakeholder in identifying priorities for assessment, generating questions to be addressed by assessment, discussing best ways of obtaining data, reviewing analysis and participation in interpretation and dissemination of findings.
- Interested in finding some sustainable assessment activities that support a community health model.
- Lack of funding and reliance on temporary grant sources.

2. Protection: Protect people from health problems and health hazards.

Relevant State Standards: AS5, CD1, CD2, CD3, CD4, CD5, EH1, EH2, EH3, EH4, PP1, PP3, PP4, PP5

Policy Environment Impacts

- The health department enjoys a high level of support from elected and appointed policy makers including the Board of Health
- Washington law now prohibits smoking in all public places and places of employment, so the focus of the health department's efforts can shift from policy to enforcement and prevention.
- HIPAA requirements and restrictions limit the ability of clinical programs in the department to communicate with patients/clients in ways that could enhance services and access of services to those who need them.
- The State Department of Health approaches public health preparedness by establishing core capabilities across the state rather than allocating resources to appropriately address risk, vulnerability and complexity of response regions. For example, state funding policies spread resources evenly by county, so King County gets 40% of the funding yet has 60% of the statewide TB cases.
- A dominant focus at the federal and state level on hospital preparedness has created vulnerability in other areas for metropolitan areas. With half the statewide total of hospital beds located in this one metro county, resources are still spread evenly statewide. This distribution of funds significantly hampers the ability of PHSKC and other CMHD to coordinate preparedness efforts across the entire health care system. Federal agencies prioritizing equipment purchases for hospitals, rather than enabling them to identify their critical needs

based on a set of measurable objectives has created inefficiency and duplication of effort across funding sources.

- Direct CDC funding for public health preparedness to MMHDs up to this point has only been made available to New York City, Chicago, Washington DC and Los Angeles. This fails to acknowledge the special needs of other large cities' health departments, which are arguably as great in some respects as those facing these three cities.
- CDC funding for Public Health Preparedness has thus far excluded a focus on chemical and radiological threats.
- "Healthy Planning" is a primary prevention environmental health approach that takes into account health consequences related to water, air, noise, injuries, physical activity, food security, access and social cohesion. With resources, this effective approach could be more widely adopted by the department.
- Efforts such as healthy planning are good for the economic healthy of the region.
- Social cohesion is an important emergency preparedness strategy, especially for vulnerable populations.
- County policies and procedures governing travel can make it difficult for the Department to ensure its employees have ready access to training and conferences that are needed to maintain skills at the level required to ensure optimal protection of the health of the public.

3. Health Information: Give people information they need to make healthy choices.

Relevant Washington State Standards: CD4, PP3, EH2, AC1

Policy Environment Impacts

- Federal regulations that require the delivery of health messaging that contradict scientifically accurate messaging have increased the need for resources from other revenue streams to deliver both mandated messages and technically accurate information.
- PHSKC has a number of health educators working with a population based focus with school districts, community-based organizations (CBOs) and community gatekeepers to deliver effective health information. Much of the work is focused on training the trainers, i.e. teachers, CBO and community workers, to deliver this messaging to their constituents. The ability to do this consistently and effectively is limited by resources.

- PHSKC plans to encourage the adoption of policy that recommends or requires health care institutions be trained to CLAS standards to assure cultural competent health care delivery.
- The mandated use of county-defined graphic design and production facilities restricts the departments' ability to rapidly produce high quality materials in large volumes.

4. Community Engagement: Engage the community to identify and solve health problems.

Relevant Washington State Standards: AS4, PP1, PP2, PP3, EH1, AC3

Policy Environment Impacts

- The local policy environment is highly complex and includes a number of policy making bodies: the King County Board of Health, the King County Council, 39 city councils, and 19 school boards, a policy framework for the City of Seattle to guide public health efforts and investments.
- Washington State Public Health Standards require the following local measures that relate to community engagement:

  1) There is a planned systematic process that describes how health assessment data is used to guide health policy decisions.

  2) The PHSKC coordinates and works with a broad range of community partners in considering assessment information to set prevention priorities.
- PHSKC engages the local public health system to establish goals and solve problems through a multi-layered approach that includes public sector, health delivery system and community partnerships across the many levels. Community health assessment information and both categorical and broader partnerships are used to increase awareness of health concerns, inform priorities and develop policy and programmatic interventions.
- Community engagement activities across all regions of King County include:
  - Community-based partnerships and coalitions to address focused health promotion/ disease prevention activities, health access and to eliminate health disparities.

  - Dissemination and dialogue on community assessment information with policy makers, planners and community based organizations across the County.
  - Technical assistance with multiple jurisdictions to develop response plans for communicable disease outbreaks and other public health emergencies.
- By sponsoring and participating in the King County Health Action Plan, the Puget Sound Health Alliance and the Health Care Coalition, the department influences the policy decisions of private institutions throughout the county and elsewhere in ways that focus attention on prevention and preparedness.
- The department's connections to the business community have helped the region become prepared for a possible pandemic flu. The County also has implemented innovative worksite wellness practices, with assistance from the department.

5. Policy Development: Develop public health policies and plans.

Relevant Washington State Standards: PP1, PP4

Policy Environment Impacts

- The local policy environment is highly complex and includes a number of policy making bodies: the King County Board of Health, the King County Council, City of Seattle, 39 Suburban City Councils, and 19 school boards. Other county departments that create and influence public health policy include the Department of Natural Resources and Parks, the Department of Transportation, the Department of Adult and Juvenile Detention, the Department of Community and Human Services. In addition, regional entities, such as the Puget Sound Regional Council operate in the local jurisdiction.
- Federal, State, and local legislators set policy, mandate provision of Public Health services and, in some instances, dictate how services will be provided. These entities include the federal Department of Health and Human Services, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and state agencies, such as the Department of Health, the Department of Social and Health Services, and the Department of Ecology.
- For example, Federal regulations dictate that patients cannot be turned away because of inability to pay. Interpretation services must be available to all non English speaking patients/clients seeking Public Health services.

- At the State level, Public Health Standards have been adopted as policy and apply to the local governmental public health system in the following areas: understanding health issues, protecting people from disease, ensuring a safe and healthy environment, promoting healthy living and helping people get the services they need. The City of Seattle is establishing the "Healthy Communities Initiative" a policy framework to guide enhanced public funding and influence public health services in the City of Seattle.
- Washington State is a 'Home Rule' State, which means that local jurisdictions, including municipalities, have powers to set policies.
- Within the State, King County is viewed as atypical of counties in the "state" which can cause policy and funding friction with other jurisdictions.

6. Enforcement: Enforce public health laws and regulations.

Relevant Washington State Standards: EH 4

Policy Environment Impacts

- New information leads to updated and/or new codes which may or may not be welcomed by stakeholders.
- Stakeholders are generally opposed to fees and fee increases associated with these regulations.
- Stakeholders generally feel that these programs and services should be supported by general tax dollars at the same time that there is substantial public pressure to hold the line on such taxes.
- There a growing demand for stakeholder involvement in the design and execution of our regulatory programs which seems contradictory to the traditional enforcement approach.
- The ability to gather and analyze data relating to enforcement activities may serve as a factor in future policy decisions by the Board of Health.

7. Access: Help people receive health services.

Relevant Washington State Standards: PP3, PP4, PP5, AC1, AC2, AC3, AC4

Policy Environment Impacts

- The federal government is unwilling to lead the type of reform required to assure universal access to health care.

- The federal government can and does impose unfunded mandates for health services (requirements for access to interpretation services, HIPAA) that add to the costs of providing services and which has an unintended consequence of decreasing access to services and/or interest of some providers in serving vulnerable populations.
- The federal budget is targeting reductions to existing funding for Medicaid and Take Charge (family planning) funding, which will result in reductions in service levels for low income clients – with the risk of increasing health disparities.
- State agencies are limited in their ability to push back on changes required by the federal government in areas with partial federal funding.
- State government is supporting incremental efforts to ensure health insurance coverage for all children by 2010, but waiting lists for BHP and immigrant children cause disparities in access to widen.
- PHSKC leads in coordinating with community partners and government to promote increased access to health insurance coverage or funding for services directed at un- or under-insured populations.
- KC is a leader in the effort to improve health care quality while reducing costs in the activities of the Puget Sound Health Alliance.
- KC and PHSKC have created an appropriate infrastructure, through the new Health Care Coalition on emergency preparedness, to work with community providers and health systems to better coordinate the health care system to respond to the care needs of vulnerable populations while distributing the risks of providing this care more equitably. There is optimism that this preparedness practice will lead to greater coordination and burden sharing in the everyday health responsibilities of all partners
- A thorough assessment of the health of King County is performed every decade and serves as a roadmap for strategic health policy and program foci for the department.

8. Workforce Development Standards: Maintain a competent public health workforce.

Relevant Washington State Standards: All standards reference the need to have well trained and qualified staff.

Policy Environment Impacts

- PHSKC's workforce is >80% unionized. PHSKC has 12 Collective Bargaining agreements many of which have different provisions for basic personnel practices such as leave provisions, OT/Comp Time, seniority calculations and promotional rights.
- King County policy which provides an additional 12 weeks of Family Medical Leave (FMLA) to the federally required FML creates extended authorized absences which must be filled by temporary hires, rather than permanent hires
- The unfunded HIPAA policy requires a significant investment in a security and privacy infrastructure using funds that could otherwise be invested in other functions
- Need to engage public health academic programs to prepare public health workforce for changing practice environment.

9. Evaluation: Evaluate and improve programs and interventions

Relevant Washington State Standards: AS2, PP3, PP5, CD5

Policy Environment Impacts

- County contracting practices can compromise the flexibility and speed with which the department is able to respond, and limit options for evaluation activities.
- KC travel restrictions make it difficult for staff to attend professional meetings and to learn about current evidence and state of the art practice.
- Funders often require evaluations/research yet PHSKC has limited capacity to conduct research/evaluation in terms of sufficient availability of qualified staff
- Limited mechanisms exist to effectively connect academic researchers with research issues of importance to local public health.
- HIPAA policy interpretation within the department does not allow public health to collect evaluation information from or contact clients via the internet or email.

10. Evidence: Contribute to and apply the evidence base of public health.

Relevant Washington State Standards: N/A

Policy Environment Impacts

- Funders often require research activities yet PHSKC lacks widespread capacity to conduct research in terms of sufficient availability of qualified staff. This in turn limits PHSKC ability to compete for grants which contain both program and research components.
- Limited mechanisms to effectively connect academic researchers with research issues of importance to local public health.
- Many times grant opportunities do not allow for promising programs to be implemented and evaluated and thus expansion of the evidence-based body of work in public health progresses slower than other health areas.

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XII: Milne & Associates: Funding Environment Background Report

Funding Environment Background Report
Prepared by Milne & Associates, LLC
June 19, 2006

Please note: This background paper should be viewed as a dynamic product. It is likely that new information will continue to be provided during the life of this project. The reader should regard this paper together with the companion papers on Role Definition, Policy Environment and Health Environment as initial guidance for the production of a broad policy framework.

Executive Summary and Implications for Next Steps

In this executive summary we provide our interpretation of the significance and meaning of the observations in this paper as they relate to a broad policy framework for public health in King County. First, the key observations:

- **Funding approaches for PHSKC are fairly typical of CMHD.** While PHSKC has significantly higher per capita funding overall than CMHD, the department is funded in a similar fashion with many of the same sources of funding as the CMHD interviewed.

- **Local funding for PHSKC is low.** Local general fund support is higher among four of the five CMHD, both as a percent of budget and on a per capita basis. The level of local funding for PHSKC is significantly lower than that for comparable health departments. This lack limits flexibility in making decisions about what services to conduct, and limits the health department's ability to develop capacities for core responsibilities.

- **State support of local public health is low:** Total funding from the state to PHSKC in 2005 provided $16.33 per capita. When one considers all sources of funding for public health (more broadly defined and inclusive of all federal, state and local funding), a yearly survey by the United Health Foundation shows Washington State to be 44th in the nation with total per capita support of $81.

- **Adequate discretionary funding is essential.** Most of the funding streams, and particularly federal categorical programs, available to local health departments offer limited opportunity to build capacities for services that are core to the mission of public health. Flexible funding sources are of critical importance to assuring capacities to conduct community assessments, perform communicable disease control work, and conduct population-level work designed to improve overall health status.

- **Core capacities have been assembled creatively with categorical funding.** In the absence of adequate levels of discretionary funding, virtually all health departments assemble capacities for assessment, community participation, and other core activities from creative use of categorical program funds. Those capacities are continually at risk of funding shifts among the categorical programs.

- **Public Health Funding is not predictable.** All MMHDs in the country are facing the same challenges with regard to funding. It is not possible to predict with certainty the likelihood for expansion or contraction of existing public health funding streams in the current political environment.

- **Funding opportunities don't have equal merit.** Adding more categorical programs may not really strengthen health department core capacity and may be a distraction in some instances. It can also lead to a dilution of managerial resources needed to support the department's mission.

- **PHSKC has managed well through lean budget times.** However, it is very important to understand that the nearly flat budget over the past 5 or 6 years is taking its toll. Costs increase by perhaps 5% per year while revenues at the macro level have increased less than 3% per year. It will not be possible to maintain services at current levels without new resources.

Important implications for next steps in development of the policy framework based on this description of funding include:

- **Being clear on mission and core responsibilities is essential, particularly in times of uncertain funding.** There is no agreed upon definition of "core" and it is more a term of art subject to various interpretations. In order for the funding challenges of today and tomorrow to be addressed adequately, the core responsibilities need to

be defined on a basis of the Departments mission and vision, and should be the basis for programmatic decisions in the future.

- **PHSKC needs higher levels of discretionary funding.** With the relatively large dependence of PHSKC on external funding sources, it should not be a surprise that activities and services are heavily influenced by the Federal and State politics and policy. In order to assure a well functioning and effective local public health system, adequate levels of flexible funding, including in particular adequate local funding, is critically important to creating a public health infrastructure able to protect and improve the health of the community.

- **Stability of external funding for the years ahead is dependent on numerous issues.** While federal and state funding is dependent to a significant degree on the changing make-up and political perspectives of members of the respective legislative bodies, some generalities can be stated and might be considered as implications for future choices and for the policy framework:

    - Federal categorical programs with well-established successes and large, supportive interest groups have fared reasonably well in the past during economic downturns. Examples include Immunizations, WIC, and probably HIV/AIDS programs (although the latter is currently experiencing budget challenges).

    - Programs with less well-established successes and/or with political "liabilities" are challenged in Congress each year. Examples include health workforce programs, family planning, community block grant funds.

    - Funding associated with building critical basic infrastructure to assure minimal levels of essential services, for example epidemiology and surveillance, have been tied to categorical programs like Bioterrorism and Pandemic Flu preparedness. The CDC made early attempts to promote "dual use" strategies; however this emphasis has disappeared in recent grant cycles.

    - Large programs that have appeared "over night" in recent years are probably at risk of disappearing or going through significant down-sizing. An example is the bioterrorism preparedness program.

  - Most stable and subject to the most growth potential at present are funds generated by dedicated tax assessments (e.g. Alameda County; as growth continues, the revenues will continue to grow).

- **Primary care needs are not declining.** Unless a major health access initiative occurs at the state or federal level, health departments providing primary care will continue to see increases in the numbers of un- and under-insured people. Costs will continue to rise, while Medicaid and Medicare reimbursements are declining, at least at present.

- **Innovative approaches should be considered.** Some of the answer to longer term stability may lie in completely reassessing the costs and benefits of the funding streams currently in play for public health, and considering an approach similar to that being attempted in Alameda County, CA. There, the director believes the only hope for making significant gains in health status and decreases in health inequities is through full engagement of the community, addressing the social determinants of health.

Introduction

Purpose of this paper

In this paper we provide a high level overview of the funding for public health in King County. The paper is meant to complement three other related papers dealing with the role of public health, the health environment and the policy environment. The focus of this paper is on public health funding sources, funding stability, and how PHSKC compares with comparable metropolitan health departments (CMHD) regarding funding and budgets. Because of the overarching nature of each of the four themes, some of the issues addressed in the other three papers will be touched on in this paper as well.

This White Paper is written as a part of Deliverable A, Phase I Framework Development for the Public Health Operational Master Plan for Public Health Seattle-King County. The paper is intended to address funding issues for public health. The specific language of the project RFP requested the following content:

> What is the forecasted funding under the current funding streams? Include:
>
> a. Most common funding approaches for MMHDs and how they provide short, mid and long term stability compared and contrasted to

those for PHSKC. *(include a description of the federal to state funding ratios as well as how funding breaks down along the lines of core discretionary and categorical)*

b. Forecast the risk for PHSKC's various funding streams, separating by discretionary source vs. categorical source for the next 10 years, establishing risk levels for stability and corresponding expenditure/programming that is most vulnerable as well as providing assessment of funding sources for the future. (Due to the conclusion that public health funding is not predictable, (see executive summary page 4), Milne & Associates was not able to detail forecast the revenue streams for the next 10 years. Milne & Associates did provide a risk assessment of the revenue streams and drivers that may impact their continuation.)

The RFP was issued subsequent to the County Council budget proviso adopted as part of the County's 2003 budget. This background paper goes beyond the specific information requested, giving consideration to budget issues identified from stakeholder interviews and review of PHSKC budget documents and related information.

Terminology:

Several terms have been used in this paper to describe programs or services in order to covey the degree of external influence, particularly financial, on a program. In order to address funding issues, we would recommend using the following definitions with this paper and throughout development of the Operational Master Plan. The terms are also included in the Glossary, Attachment 1.

- Discretionary — Programs, activities or funding for which authority rests solely with the department or local policy makers to address public health issues or problems. Discretionary funds are the most flexible category of resource.

- Mandatory – Explicitly required by state or local laws or regulations.

- Enhanced Mandatory – Programs and activities associated with mandatory programs, but providing services beyond basic program requirements.

- Match – Funds or other resources, usually local, which must be applied to a specific program or activity under rules associated with the granting authority for the program or activity. While these funds begin

as discretionary, once a grant requiring matching funds is accepted, the match dollars are no longer discretionary but are bound by the grant contract.

- Non-discretionary —Programs, activities or funding for which authority rests with the granting organization, usually federal or state. While such programs and activities are contractual in nature, specific contract requirements may be subject to some negotiation between the Department and granting authority. All categorical funds are, by their very nature, non-discretionary.

- Recommended – Programs or activities implied or directed by State or National Standards, or commonly understood to be good public health practice. At this point in time both National and State Standards are not mandatory.

- Core – Responsibilities, programs or activities critical to the mission of public health and embodied in the intent of Essential Services, NACCHO Operational Definitions and/or State Standards.

Background:

Public health funding sources: Local health departments of all sizes rely almost exclusively on public funding and service reimbursement (including fee revenue) to support operations. The most recent national data available (NACCHO, 2001[17]) indicates that for health departments serving populations of 500,000 or more, budget sources include local tax support (36%), state funding (35%), federal funding (8%), service reimbursement (16%), and other sources (4%). Each of those funding streams is described below.

- Local Funding: The percentage of budgets from local general fund support (county and city) for local health departments varies widely, but typically is in the range of 25% to 50%. Compared with all funding streams, local funding has the greatest potential for flexible use, potentially supporting what most view as core mission activities which other available funding streams don't fund. Community assessment, community organization, system development, and convening activities rely mainly on the availability of flexible funding. To the degree that local funding is lacking (PHSKC had the lowest amount of the four county or city CMHD; the fifth is part of a state-

[17] Local Public Health Agency Infrastructure: A Chartbook. National Association of County and City Health Officials. (October 2001)

centric system), flexibility decreases and the potential to support these core activities is less. Moreover, health departments with relatively small local support typically seek resources from a wider range of funding sources, such as direct federal or private foundation grants, as strategies to support core activities. Many of these grants are time-limited, placing additional pressure on the organization to continue the program after grant funding expires.

- State Funding: State funding decisions regarding public health vary widely in both amount and purposes supported. Most states allocate resources for local health departments, although there is very little consistency in per capita approaches and amounts. In most cases, state support is earmarked to support state public health priorities; often funding augments federal priorities (e.g. preparedness). But support for specific local community needs is typically not considered in defining state funding priorities. Funding may be transmitted to local health departments by states as program funding (i.e. supporting specific programs) or as formula funding (e.g. based on population).

  Well under half of the states include responsibility for local public health as a state function. In such states, local health department employees are employees of the state, most policy is generated centrally, and the state serves as a principal source of funding. Typically, very little local funding is included in health department budgets in these states. One of the CMHD (Miami-Dade County) is located in one such state.

  It is nearly impossible to compare state investments in public health because of widely differing budgeting systems and differing definitions of what is included as "public health." The NACCHO database is not complete, so does not account for all state funding for public health. Efforts have been conducted to determine levels of funding for local public health in the US.[18] In each case, however, it was determined that a great deal of effort would be required to collect comparable data from all 50 states regarding public health expenditures, and comprehensive efforts were not undertaken. In an effort to compare CMHD, this report uses the National Association of County and City Health Officials (NACCHO) 2006 unpublished and self-reported profile forms, summarizing 2004 and 2005 data, submitted by the respective health departments.

[18] Including "Measuring Expenditures for Personal Health Care Services Rendered by Public Health Departments" - April 1997, and Where Do the Dollars Go? Measuring Local Public Health Expenditures - March 1998 by the Public Health Foundation, Washington, D.C.

The United Health Foundation provides an annual ranking of states titled "America's Health Ratings: A call to Action for People and Their Communities."[19] One of the rankings used is "Per Capita Public Health Funding." That rating differs from what is included in the NACCHO data; it includes "direct public health care," "community based services health expenditures," and "population health expenditures." The funds included in this measure are inclusive of all federal, state and local revenue sources. The 2005 data show that the average per capita public health funding was $162. Table 1, below, summarizes per capita support in Washington and in the 5 states from which the CMHD were drawn, along with their respective national rankings in that category.

Table 1
Comparison of Per Capita Public Health Funding – 6 States

State	Per Capita	Ranking
New York	$ 316	4
Florida	143	27
California	132	29
Ohio	127	32
Tennessee	91	43
Washington	81	44

The lower level of state funding in Washington certainly reflects changes that have happened over that past ten years or so. Prior to the mid-1990s, basic local public health services were supported through local governmental general funds and little state money. While the amount of local funds provided were guided by formulas published in the WAC, the formulas were non-binding and per capita support varied widely from county to county. That approach was replaced by legislative action, substituting local tax revenues with a state-wide motor vehicle excise tax. A subsequent voter decision resulted in elimination of the MVET tax as a funding source for public health. A funding crisis in the state resulted. While the state legislature took action to mitigate 90% of the lost public health revenue from state general funds, a gap was left that has not been fixed. Turnover of legislators and legislative staffers during and since that period may well signal the loss of opportunity to repair the damage.

[19] http://www.unitedhealthfoundation.org/shr2005/Findings.html

At present, the State of Washington contracts with local health departments to provide two streams of revenue. One, termed "state public health support", is formula based for basic public health support and the other, called "state public health direct," includes a combination of funding for specific services local health departments contract with the state to provide and replacement funding for MVET tax. Combined for King County, those two revenue streams from the state provided about $29,202,185 in 2005, or $16.33 per capita.

- Federal Funding: Federal funding decisions for public health are not made, in general, on a basis of a federal strategic health plan or clear priorities, or even on leading causes of health problems. Rather, federal allocations to public health are made principally to continue established programs, address emerging issues that are receiving attention in the media, and in response to interest group advocacy.

  Many if not most federal programs are promulgated in response to a specific disease or health condition. Federal grants directed at relatively narrow health issues are referred to as "categorical programs." Such programs include funding restrictions about client eligibility, service definition, and expenditure of grant funds. It is not uncommon for such restrictions to seriously hinder flexibility to address broader interconnected health problems. For example, bioterrorism funding requirements limit use of the grant funds for preparedness for other public health emergencies such as avian influenza. The net effect is that many federal grants are, in effect, silos which limit health department flexibility. It has been said that categorical approaches are the most effective approaches for appropriating funding and the least effective strategies for administering programs. Many of the programs run by PHSKC and the CMHD considered in this work are categorical, including WIC, HIV/AIDS, and Bioterrorism Preparedness. Local funding and management may be able to weave/bridge these categorical programs into a more systematic and integrated strategy to overcome the seemingly "categorical" nature of these programs to meet local priorities.

  Federal agencies that provide grants to local public health (usually through the states) include the Centers for Disease Control (e.g. sexually transmitted diseases, HIV/AIDS, tobacco control, local public health emergency preparedness), the Health Resources and Services Administration (e.g. community health centers grants, family planning, maternal and child health), and the US Department of Agriculture (WIC). All of the categorical programs funded by federal agencies are

authorized in statute; each is controlled by a unique set of program requirements regarding client eligibility, authorized activities, reporting requirements, etc. In most instances, funding for such federal grants is administered by the states which, in turn, contract with local health departments for performance**,** sometimes applying additional requirements or restrictions. Some grants (e.g. community health center grants, some preparedness funding) are funded directly by a federal agency to local health departments or community organizations, bypassing the state departments of health. Local health departments receiving direct federal grants are typically large, metropolitan health departments. Directly funded grants from the federal government to PHSKC are summarized in Attachment 5.

- Service Reimbursement: This funding category includes fees collected from patients/clients of public health services, fees for permits and licenses (usually restricted to environmental health services), and reimbursements from insurance plans, Medicare and Medicaid. In this latter category, Medicaid is far and away the most significant revenue source for most local health departments.

    - Medicaid: Medicaid is a significant source of funding for many local health departments, and particularly for those providing primary care or extensive clinical services. Medicaid principally provides payment for healthcare services, and can also be used for a designated set of administrative services. The federal Centers for Medicare and Medicaid Services (CMS), housed in the US Department of Health and Human Services, administers Medicaid through agreements with the states. Prior to the late 1980s, the federal agency defined which health services were reimbursable, and provided funding on a match basis with the states. State legislatures were given some flexibility in defining eligibility requirements and were required to match federal payments at a slightly lower percentage than the federal percentage. Provider organizations (private physicians, medical centers, health departments) submit billings for client services to the state Medicaid agency (the Department of Health and Human Services in Washington State); the agency reviews billing information and authorizes reimbursement.

      The federal Medicaid agency began allowing limited experimental approaches at the state level beginning three decades ago to test completely new strategies for health care delivery and financing. Section 1115 waivers were used extensively by states interested in pursuing welfare reform in the late 1980s and early

1990s and have contributed to significant state innovation. Experiments have resulted in new managed care service delivery and financing mechanisms, and have enabled federal Medicaid funds to be used to cover expanded populations of low-income individuals who would otherwise be uninsured.

The current administration has been fairly aggressive in encouraging waivers. The administration has signaled that it will permit states to offer reduced benefit packages to certain populations and to require them to pay higher levels of cost sharing than were previously permitted under the Medicaid statute. Some analysts have raised concerns that some of the waivered approaches are not appropriate for low-income and medically fragile populations and may have negative effects on access to medical care.

Medicaid is also the source of funding for Federally Qualified Health Centers (FQHCs). FQHCs include Community Health Centers, Migrant Health Centers, Health Care for the Homeless programs, Public Housing Primary Care programs, and Urban Indian and Tribal Health Centers. Once an organization meets requirements for designation as an FQHC (e.g. non-profit organization, community governance board, sliding fee scale), its reimbursement rate is calculated prospectively at or near actual cost of providing service. PHSKC has FQHC designation, awarded for fulfilling federal requirements in providing both primary care services and its Health Care for the Homeless program. In 2005, PHSKC received about $17.5 million through its FQHC designation.

- Other User Fees: Most local health departments, including PHSKC and the CMHD, collect fees from users of services. Some fees are for clinical services provided to patients/clients of the health department, while others are for licenses and permits granted by the health department for such activities as septic systems, food service licensure and inspection, and licensure of public swimming pools and spas. Fees are typically set by boards of health or other governing bodies on a basis of service cost. In some states, many of the environmental health fees are set by state regulation. In most states including Washington, user fees are restricted for use only within the service or activity in which they were generated.[20]

[20] Interview, Washington State Association of Local Public Health Officials, April, 2006.

Budget Support for the Essential Services: Most MMHD agree that assuring that the Ten Essential Public Health Services are fulfilled within a local public health system is of critical importance. (The essential services have been discussed in previous background papers, and are included in two versions in Appendices 2 and 3.) Because of limitations in how revenues in the various funding streams may be used, however, health departments struggle with funding general activities that are core to the public health mission and are directly related to one or more of the essential services. While some activities (e.g. restaurant inspection) line up well with an essential service (No. 6, enforce laws and regulations), most do not. Table 2 on the next page is an attempt to illustrate comparative flexibility of funding sources, comparing the potential for various resource streams to support individual essential services. (It should be emphasized that the table was developed by Milne & Associates based on the collective experience of the project team. It is used principally for illustrative purposes.)

For health departments receiving sufficient funding from flexible revenue streams (especially local support), fulfilling the governmental public health role to assure the ten essential services is not too great a challenge. Unfortunately, many health departments do not have sufficient local or other flexible funding, and as a result gaps appear in fulfilling the essential services. Such health departments typically try to "piece together" capacities for community assessment, community organization and other core mission activities from categorical grants, leveraging some of the grant resources for "related" activities. PHSKC, for example, has found it necessary to be very creative to assemble the resources needed to conduct community assessments and to provide data to partner organizations. It is clear that flexible local funding is important to connect the categorical programs, reducing their silo effect, and to assure that the essential services are performed.

Table 2
Flexibility of Funding Sources in Supporting Essential Services
(For Illustrative Purposes Only)

Essential Service	Federal Funds	State Funding	Local Funding	Licenses & Permits	Medicaid & Medicare	Client Fees
1. Monitor health status	Medium	Low-Medium	High	Low	Low	Medium
2. Diagnose & investigate health problems	Medium	Medium	High	Medium	Low	Low
3. Inform & educate	Medium - High	Medium – High	High	Medium	Low - Medium	Medium
4. Mobilize partnerships	Low	Medium	High	Low	Low	Low
5. Develop policies & plans	Low	Low	High	Medium	Low	Low
6. Enforce laws & regulations	Low	Low – Medium	High	High	Low	Low
7. Link people to services	High	Medium	High	Low	High	High
8. Assure competent workforce	Low	Medium	High	Low	Low	Low
9. Evaluate effectiveness & quality	Low - Medium	Low – Medium	High	Low	Low	Low
10. Research for innovation	Low	Low	High	Low	Low	Low

Source: Milne & Associates, LLC

By way of example from the chart above, the potential to support health department capacity to monitor health status (Essential Service #1) is estimated to be of medium potential using federal funds, high potential with local funding, and low potential using Medicaid.

The question of how much resource is needed by health departments has never been answered satisfactorily. Washington state is perhaps in as good a position as any state to address this question, since it has in place a set of

performance standards specifically designed for the well-defined system of 35 local health departments and the state department of health. This challenge was considered by the Public Health Finance Committee for the Public Health Improvement Plan. The Committee concluded: "System-wide planning for stable funding is not possible within this current framework [of financing]." The PHIP-sponsored Public Health Standards were designed to identify an expected level of performance from the state's public health system. It was estimated that an additional $400 million is needed to meet the state standards at a 95 percent level. Research to refine that figure continues and should be published in the summer of 2006.

One limitation to use of Essential Services or the State Standards is the lack of specificity with respect to performance measures, performance expectations or outcomes. There are numerous national efforts underway to better define performance and capacity (as described in the policy paper).

Approach:

To compile the information contained in this report, Milne & Associates (M&A) reviewed a large number of documents provided by PHSKC regarding the funding of the health department, including budget information for the years 2000-2005 and the approved budget for 2006. In addition, M&A had a number of discussions with King County and PHSKC budget staff, with the Washington State Department of Health, Washington State Association of Local Public Health Officials, and others. M&A reviewed information from numerous externally produced documents, including the Public Health Improvement Plan. Questions related to the funding of public health were included in stakeholder interviews and with interviews conducted with directors and senior staff of five major metropolitan health departments (MMHDs). A draft of this paper was shared with PHOMP and PHSKC staff for their review and comment as an additional check for accuracy of information contained in the paper.

Findings:

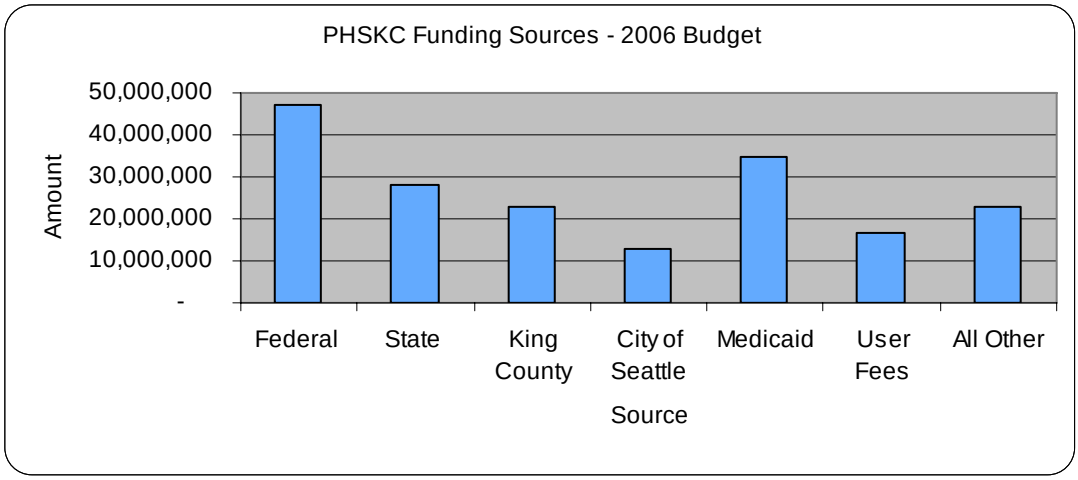
PHSKC Funding:

PHSKC has one the most complex budget structures and mix of funding sources that M&A has experienced. For purpose of this background paper we have collapsed and categorized revenues to provide a macro level view of issues and trends affecting revenues in the Public Health Pooling Fund. As discussed in later sections, this will introduce assumptions or conclusions that may not be fully accurate in reflecting impact at the program or project level. Conversely, the project level accounting which creates the complexity

affords the opportunity to "fine tune" and isolate management, policy and geographic impacts more precisely.
There are 251 distinct revenue line items and 123 projects (down from 151 in 2005) in the 2006 adopted budget. In addition, revenue line items in many instances support more than one project. Since 2000, there have been 289 projects and 581 revenue line items. Some of these changes may represent changes in name only; however, it was not possible for us to provide a totally accurate trend analysis beyond one or two years.

The total budget for 2006 is $185.7 million, up 0.8% from 2005. Chart 1 compares the budget estimate of revenues by major funding source for the 2006 budget. (It should be noted that this figure does not include the Jail Health or Emergency Medical Services programs or their associated revenues. Table 4 on page 19 does include those programs, reflected in the $243.8 million budget amount.)

Chart 1
Source: PHSKC Financial Data



Federal funds make up about 25% of the budget, state funds account for 15% and local funds (King County and Seattle combined) make up 19% of revenues. Overall, the PHSKC budget has remained fairly static since 2002, with some decrease since 2003. Table 3 displays changes in funding levels by source since 2003. (Note: all figures for 2003-2005 are actual revenues.)

Table 3
Changes in Revenue from Prior Year

	2003 Actual		2004 Actual		2005 Actual		2006 Budget	
Federal	53,561,274	17.4%	57,664,291	7.7%	53,060,031	-8.0%	47,187,998	-11.1%
State	30,145,684	10.0%	28,239,213	-6.3%	29,202,185	3.4%	28,199,192	-3.4%
King County	17,135,788	-1.6%	23,062,191	34.6%	20,456,653	-11.3%	23,000,080	12.4%
City of Seattle	16,608,638	-7.4%	14,697,117	-11.5%	13,055,283	-11.2%	12,790,875	-2.0%
Medicaid/FQHC	30,744,140	5.9%	31,048,152	1.0%	36,138,458	16.4%	34,914,327	-3.4%
Other User Fees	13,434,634	16.3%	14,484,020	7.8%	15,146,360	4.6%	16,765,874	10.7%
Other	35,139,816	-4.8%	15,887,167	-54.8%	17,122,169	7.8%	22,800,173	33.2%
Total	196,769,974	5.9%	185,082,151	-5.9%	184,181,139	-0.5%	185,658,519	0.8%

Wide swings in funding levels from year to year, as can be seen from the percentage changes in the table, can create significant management challenges. The growth in Medicaid and user fees has been strong in most years, however, increasing since 2003 by 13.6% and 24.8% respectively. But overall, the total budget for 2006 is almost 6% less than it was in 2003, with funding from the following sources declining since 2003: Federal (-11.9%), State (-6.5%), All other (-35.1%), and City of Seattle (-11.9%). It is also important to note that support from the City of Seattle declined by nearly $5 million between 2001 and 2005, while support from King County has increased by about 26%.

County general fund dollars have been somewhat unsteady since 2000, decreasing in 2001, 2002, 2003, and 2005. County general funds budgeted for 2006 increased about12% over 2005 levels and are supporting 42 projects compared with 40 last year. This revenue source has increased by 23% since 2000, or 3.8% per year. It is also interesting to note that county general funds have been moved around between projects from year to year, demonstrating that PHSKC has reasonable flexibility with this revenue source. For example, for the 15 projects budgeted in 2006 for more than $250,000 in county general funds (excluding King County Overhead), 7 were increased by 20% or more over the 2005 allocation level, 2 were newly funded with county general funds (Family Health and Clinical Dental Services), and 1 was decreased by slightly over 20%. Overall, 19 of the 41 projects received allocation changes (increases and decreases combined) of 20% or more, and six programs that did not receive county general funds in 2005 are budgeted in 2006.

Two programs in particular have received significant increases in county general fund allocations since 2000, and especially over the past 2 or 3 years: the family planning project has increased its general fund allocation by 1095% since 2004 and Tuberculosis Control has seen a 224% increase. As a side note, it appears that the family planning project was supported not only by significant increases in county general funds, but also through spend-down of the fund balance. Staff indicated that a significant portion of this increase reflected need in 2006 to distribute pharmacy costs, affecting the family planning, family health and dental programs. Attachment 6 shows changes in allocation of county general funds to projects from 2000 to the 2006 budget.

County general funds comprise the most flexible revenue category that PHSKC has if viewed from the perspective of the County. As with most local governments, the funds are authorized by the legislative branch for purposes recommended by the executive branch. With the exception of general funds to be used as match for a grant, there is a high degree of

potential discretion as to how these funds may be budgeted and what activities they supports. Program support from county general funds has as much to do with historical patterns, control, politics and advocacy as it does stating the county's public health policy.

The 2006 business plan for PHSKC identifies five business lines: Population & Environmental Health; Emergency Medical Services; Targeted Community Health Services; Clinical & Primary Care Services; and Management & Business Practice. Table 4 shows the distribution of the budget into these categories.

Table 4

LINE OF BUSINESS	2006 ADOPTED	Pct.
CLINICAL HEALTH SERVICES/PRIMARY CARE ASSURANCE	41,022,430	22.1%
EMERGENCY MEDICAL SERVICES	766,596	0.4%
MANAGEMENT & BUSINESS PRACTICE	11,466,650	6.2%
POPULATION & ENVIRON HEALTH SERVICES	60,299,652	32.5%
TARGETED COMMUNITY HEALTH SERVICES	72,103,191	38.8%
TOTAL	**185,658,519**	

The issue of budget clarity came up on several occasions during the interviews, including member of the Council and the Board of Health, and was experienced by M&A in attempting to gather information for this background paper. The accounting structure, as complex as it may seem, is an excellent cost accounting structure that can be employed to analyze policy and performance. The ability to match revenues and expenditures by location, program and cost center is a valuable management and policy analysis tool if understood and utilized for that purpose. One could easily ask "why is Current Expense (or any revenue for that matter) supporting this program or activity, for this population and in this location" to get an idea of the management and policy implications. It is at this level and not the Fund level that reveals what PHSKC is doing, and what may be affected by revenue changes. However, that level of analysis has not been completed.

Most common funding approaches:

The financing of local public health departments of all sizes around the country is complex and difficult to characterize. Complicating factors include:

- wide variations in local and state general fund support
- complexity imposed by programmatic silos of categorical funding

- numerous, often convoluted formula-based allocation methods, particularly at the state level
- variations in the services provided
- the effect of multiple years of incremental decision-making

Both the Role Definition and Policy Environment background papers discussed at some length factors considered by health departments, including the CMHD, in making decisions about what programs to operate. The implications for this paper are that the budgets for health departments will vary widely as a result. Attachment 4 summarizes factors affecting CMHD strategic decisions.

Sources of funding:

Actual revenue streams available to local health departments (and the CMHD) are consistent. What varies widely are the use of the streams and the amount of revenue provided by each. Table 5, on the next page, compares funding by revenue stream between PHSKC and the five CMHD.

It should be noted that the sources of data in Table 5 and Chart 2 on the following page, are unpublished, self-reported profile forms, summarizing 2005 data, submitted by the respective health departments to the National Association of County and City Health Officials (NACCHO) for inclusion in the 2006 Chartbook.[21]

It is not clear whether the data from each of the health departments accurately reflect audited revenue reports. It has been suggested to us, for example, that the form submitted by PHSKC was not reviewed centrally prior to its submission. At least two of the CMHD submitted the forms without keeping a copy or tracking reliability of their data. The data from Alameda County Health Department don't appear to differentiate between federal indirect support (administered by the states) and state support. Nevertheless, the data should be reasonably adequate for comparative purposes.

The comparisons in the chart reflect percentages of each funding source and are somewhat misleading since the dollar amounts vary significantly, ranging from $37.8M for Columbus to $243.7M for PHSKC. Additionally, services provided by the respective health departments vary fairly significantly as discussed in prior background papers. Furthermore, some of the funding categories are amalgamations of smaller funding streams (some of which may be unique to the state or CMHD), showing additional differences. Nevertheless, the chart helps identify a few interesting differences:

[21] NACCHO, "Local Public Health Agency Infrastructure, A Chartbook." Scheduled for release in 2006.

- Local Support: PHSKC receives a much smaller portion of its budget from city and county sources (15% vs. an average 40%) than do the CMHD. In fact, if Miami-Dade County Health Department were excluded from the calculation, with only 3% of its resources coming from city/county sources (because it is in a state-centric system), the other four CMHD realize 49% of their revenue locally from their cities and counties.

Table 5
Comparative Funding Streams and Total Expenditures
Source: NACCHO Profile Sheets, 2006 (Unpublished)

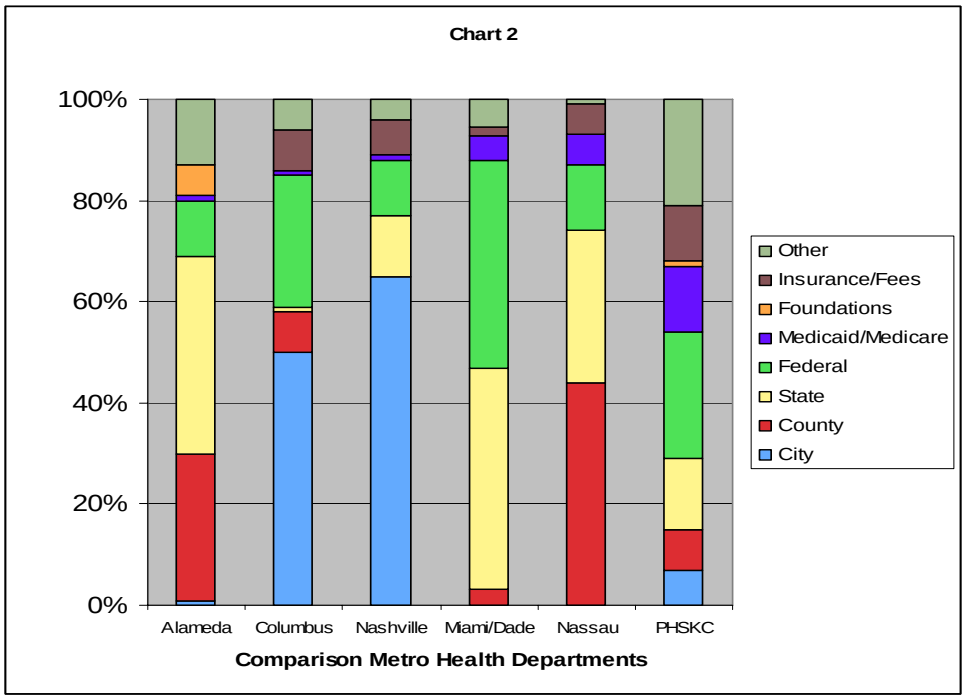
FUNDING SOURCE	PHSKC	Alameda County, CA	City of Columbus, OH	Miami-Dade County, FL	Nashville-Davidson County, TN	Nassau County, NY
Expenditures (thousands)	$243,794[22]	$99,867	$37,850	$66,090	$42,339	$88,600
Population (thousands)	1,737	1,444	1,069	2,253	570	1,350
Percentage of funding streams						
City sources	7 %	1 %	50 %	0 %	65 %	0%
County sources	8 %[23]	29 %	8 %	3 %	0 %	44%
State sources	14 %	39 %	1 %	44 %	12 %	30%
Fed sources (via State pass-thru)	18 %	0 %	23 %	41 %	6 %	6%
Fed sources (direct)	7 %	11 %	3 %	0 %	5 %	7%
Medicaid/Medicare	13 %	1 %	1 %	5 %	1 %	6%
Private foundations	1 %	6 %	0 %	0 %	0 %	0%
Health insurance/ patient fees	1 %	0 %	2 %	0 %	2 %	2%
Regulatory fees	10 %	0 %	6 %	1 %	5 %	4%
Other	21 %[24]	13 %	6 %	6 %	4 %	1%

- Medicaid/Medicare: PHSKC receives a significant portion of its budget from patient charges to Medicare and Medicaid, with 13% of its revenues budgeted from those sources. As noted earlier, PHSKC also

[22] From 2004 Actual Expenditures, all counties. For King County, includes jail health, emergency medical services, and the Public Health Fund actual expenditures.
[23] For PHSKC, county sources does not include Jail Health, CX contribution, even though the 2004 Actual Expenditures do include Jail Health.
[24] PHSKC Other includes: the EMS Voter Approved Levy ($35M or 17%), and miscellaneous revenues.

enjoys FQHC status, receiving Medicaid reimbursements for service provided under that designation at rates much closer to actual cost than is the case with other services provided to Medicaid-eligible patients. None of the other CMHD was close to this level of revenue support, demonstrating lower levels of primary care and clinical services. None of the other CMHD have FQHC-designated clinics.

The same data is included in Chart 2, which also provides more revenue source detail than Table 4[25].



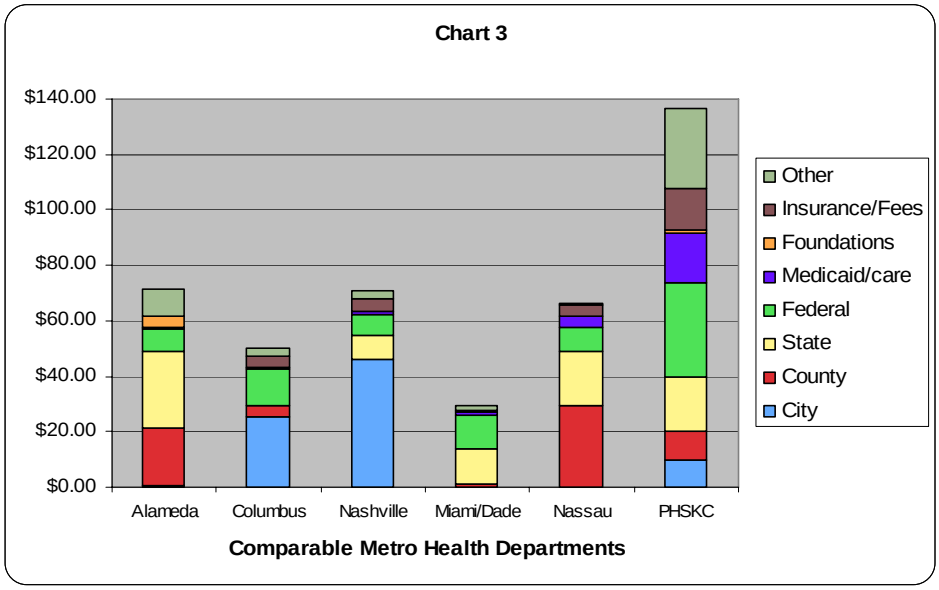
Per Capita Support:

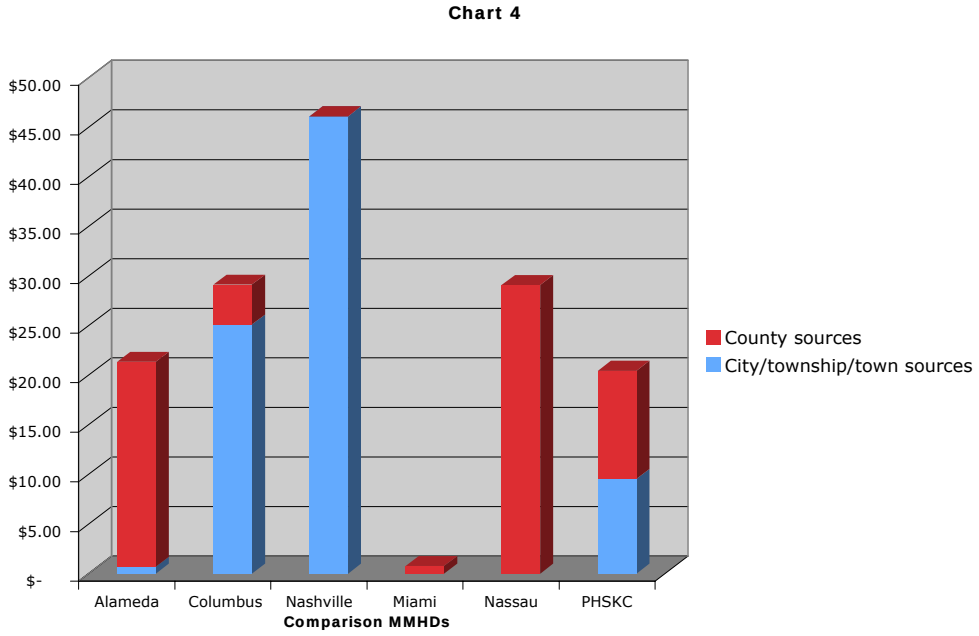
Given the variation in budget size and size of population served among the CMHD and PHSKC, another way to view funding support is by considering per capita support from the various funding streams. PHSKC has been very successful in seeking funding from a wide range of funding sources. As noted earlier, PHSKC receives funding from 251 different sources to support its services and activities. Total per capita support for PHSKC is well above the level for all of the CMHD. PHSKC total per capita funding budgeted for 2006 is over $130, while the average for the five CMHD is $56. Chart 3 on the next page displays per capita support levels by funding source for PHSKC and the 5 CMHD.

[25] PHSKC Other includes: the EMS Voter Approved Levy ($35M or 17%), and miscellaneous revenues.

An examination of the chart shows significantly higher levels of per capita funding received by PHSKC from regulatory fees, Medicaid, & federal funding.

On the other hand, as can be seen in Chart 4, local per capita funding for public health in King County is significantly below three of the CMHD. PHSKC received $20.45 per capita from its county and cities governments, while the average for the four CMHD was $31.42. (Note: Miami-Dade is not included in this calculation as it is in a state-centric system and therefore receives nearly no local money.)





Emerging Funding Options

Emerging infectious diseases (e.g. avian flu) and public health issues (e.g. bioterrorism preparedness) have brought with them new revenues. Such has nearly always been the case with the emergence of new issues of public health concern, and there has long been a pattern of "Disease of the Month" funding by Congress. However, new disease- or issue-specific funding by federal agencies do not solve the local health department challenge of finding sources of discretionary funding. Each comes with its own set of requirements and restrictions. In many instances the funding for new issues is not new money but rather is reprogrammed from existing funds which may impact other current programs.

While the environment is far from replete with new funding streams, there are a few options that might be considered:

- Tax initiatives and special levies: Several health departments, including at least one CMHD interviewed, have benefited from local tax initiatives earmarked for public health. For example, Alameda County residents passed a 0.5% sales tax on all items, with revenues earmarked for a "Health Fund." While 75% of proceeds support indigent medical care, approximately 5% - about $3 million per year – of the revenues are dedicated to the health department as discretionary support.

- Bond issues: Some communities (e.g. DeKalb County, GA) have passed bond issues to support replacement of buildings used by their health departments.

- Modification of existing funding streams: Increased flexibility in permissible uses of funding can be achieved through negotiation with federal and state agencies. In some instances, state health departments add requirements regarding use of federal categorical funds that they pass through to local health departments, well beyond requirements from the federal agencies. The potential exists for negotiation on these added requirements, particularly if multiple health departments collaborate. In California, Assembly Bill 1259 was passed some time ago to increase flexibility in use of public health funding. We understand that the State Department of Health has delayed implementation for reasons that are unknown to locals.

- Collaboration with other organizations: While none of the CMHD had examples where significant new resources had been brought to the table yet, a few felt that there is potential for creating community approaches to address local priorities. One mentioned the need to "make a business case" to local businesses, demonstrating how investment in local health improvement strategies could have a positive effect on the bottom line.

Support for "Core Programs"

While a widely accepted definition of "core public health programs" doesn't exist, the phrase is generally used to reflect programs that are central and critical to the mission of the health department. Nearly all health department directors would likely agree that communicable disease control is a core public health program, for example. Most others that might be suggested would reflect population level public health programs. In discussions with PHSKC, staff viewed all of their activities with the exception of specifically contracted services to be "core" services, principally because services are defined as core or basic in the joint agreement between King County and the City of Seattle.

Unfortunately, we did not ask the CMHD directors what they consider to be core programs in their respective health departments. From the interviews with directors, however, a number of services, activities and issues were repeatedly emphasized as being of core importance. Those included:

- Social justice
- Health inequities

- Social determinants of health
- Community connections/involvement
- Strategic Planning
- Assessment of communities
- Public health infrastructure
- Health promotion
- Environmental health

Each of the CMHD directors also lamented the scarcity of flexible funding to address these issues. Like PHSKC, many have pursued a number of categorical grants as a strategy to build capacity for assessment and other important population services. Obviously, those with the most local support were able to address issues of core importance more fully than were those with limited local support.

Relative Stability of Funding

All CMHD directors interviewed agreed that it is impossible to project future funding or to rate funding streams with any degree of certainty as to relative stability. Reasons shared include

- Federal funding for public health categorical programs is, with few exceptions, reexamined on a yearly basis. While support levels area relatively stable overall, they vary significantly on a program by program basis each year. In some years, a new initiative of size (e.g. Bioterrorism Preparedness) can result in cost shifting among other categorical programs. Further reductions can be expected in categorical programs over the next few years.

- Revenues from Medicaid are expected to decline in 2006 and beyond because of Congressional budget decisions made in the 2006 session of Congress. While the specific reductions may have limited impact for PHSKC, at least initially, since it appears to impact family planning but not primary care, immunizations, dental or maternal health. However, PHSKC still has the underlying problem of reimbursement rates not keeping up with costs of providing service, and it is expected that the numbers of uninsured will continue to grow in King County.

- While states have experienced difficult budget challenges in recent years, even the expected economic recovery may not benefit public health because of backlogged needs in other areas.

Table 6 summarizes responses from CMHD directors who were asked to rate stability of funding sources. Some offered multiple ratings, noting that

several of the general funding streams support a variety of programs that are funded independently of one another and include different levels of risk.

Table 6
Funding Stability Estimates

Funding Stream	Risk of Major Decrease	Risk of Minor Decrease	Stable	Chance-Minor Increase	Chance-Major Increase
Local General Funds	ND	SK,C	A,N	SK,M	
Local licenses and Permits			C	SK,M,N,ND	
Local user fees, insurance and other			A	SK,C,M	
State general fund support	ND	N	SK,A,M		
State categorical grants	ND	SK,C,N	A,M		
Federal grants thru state	SK,C,N	SK	A,M		
Federal direct grants	SK,N	SK,A	C		
Federal/State: Medicaid		SK,C	A,M,N		
Federal: Medicaid Match		SK	A,M,N		
Other:		SK		A	

Key: SK = Seattle-King A= Alameda C = Columbus M = Miami-Dade N = Nassau ND = Nashville-Davidson

It is interesting to note that the respective directors were most pessimistic about federal and state grants for categorical programs. To the degree that the prognostications are accurate, CMHD that rely most heavily on such grants for general support are likely to experience more significant funding challenges. This is particularly the case for PHSKC, where local funding comprises a relatively small portion of the overall budget. Staff has indicated that increasingly they are finding it necessary to construct capacities for mission-critical activities such as community assessment

through creative use of federal categorical dollars. It is feasible that reduction in that funding stream could threaten basic capacities in the years ahead.

The most optimism was reserved for increasing revenues from licenses, permits and user fees. While potentially helpful, those revenue sources are not very flexible and are not likely to contribute to general capacities that are threatened by other reductions.

The challenges of seeking financial security result in an endless pursuit of resources among all health departments, and particularly for the MMHD around the country. All of the CMHD interviewed acknowledged that finding resources to continues services is a continuing challenge; in the words of one, "there simply is no magic bullet" for funding health departments. Each is facing similar challenges. The director in Alameda County Health Department expressed a unique perspective that real improvement in health status will ultimately require a very different approach than "continuing to scrap for little siloed grants, many of which are of questionable value." He is convinced that the only hope for making significant gains in health status and decreases in health inequities is through full engagement of the community, addressing the social determinants of health. His health department has begun a pilot program in two areas of Alameda County, placing nurses, educators, environmental health specialists and community organizers in the community to help residents address very local issues and to advocate for their needs and interests before elected bodies. Evaluation of the effort is planned, although it is too early to gage results now.

<u>Stability of PHSKC funding:</u>

Overall, fund resource levels have been relatively stable for the past 7 years. Percentage shifts have been minimal and would be viewed as within normal management discretion to make appropriate adjustments. However, there have been significant shifts at the project level, indicating that a great deal of flux has taken place. Funding must be analyzed at a project/program level to make determinations of relative stability or policy implications that have occurred over the years. Given the very large number of programs at PHSKC, we have not analyzed all to consider funding stability of each. However, the following comparison of selected projects illustrates the wide differences that have occurred in the growth rate of funding for specific projects during the 7 year period. Some of the changes reflect organizational change and not necessarily growth or decline.

Deeper analysis would be required to determine the cause of such disparities. Factors might include the level of funding from the funding

source, changing prioritization of critical needs, and/or management decisions to direct discretionary funding in different directions. It is also important to note that these changes are based on 2000 dollars; the positive percentages would have increased and negative percentages decreased by approximately 13.8% to adjust for inflation or population size changes("Adjusted" column) .

	2000 $	**Adjusted**
STD Clinical	-54.9%	-62.5%
PCH Community Programs	-53.0%	-60.3%
STD Prevention	-0.2%	-0.2%
Total Public Health funding	16.1%	18.3%
Epidemiology	27.3%	31.1%
Food Protection	35.6%	40.5%
PH Community Based PCH	41.8%	47.6%
Family Health	46.0%	52.3%
Immunizations	48.5%	55.2%
Family Planning	59.1%	67.3%
PH Interpretation	92.9%	105.7%
Child Care Health	208.4%	237.2%
Access & Outreach	290.3%	330.4%

General Risks to Funding Streams:

There are several very real risks to public health funding streams at the national, state and local levels, both in the intermediate and longer terms. While all may not agree with this listing, it is important to think outside of public health and healthcare to anticipate and prepare for such risks. Most of the areas listed below were mentioned by leaders from the CMHD as having some likelihood of risk.

National level risks:

- Reduction in "federal discretionary[26]" funding due to
    - Continued or expanded military actions
    - Additional or continued tax reductions
    - Significant inflation and/or economic downturns
    - Continued obligation for debt burden with a large budget deficit

[26] Federal discretionary funding refers to funding for all programs that are not mandated. Mandated programs are items such as Medicare, Social Security, debt service, and perhaps the military. Virtually all other programs are considered discretionary in the federal budget, including public health.

  - Medical care inflation, dumping more people out of coverage
  - Concerns regarding social security and Medicare funding
  - Inflation costs not matching revenue increases
  - Medicaid Administrative Match discontinues

- Changes in Congressional make-up and/or the Administration, resulting in new priorities replacing old ones that support public health
  - National health insurance (which could affect public health positively or negatively)

- New federal laws that impact public health services
  - Immigration laws
  - Medicaid changes
  - Additional federal mandates
  - Elimination of federal mandates
  - New service mandates pertaining to emerging diseases and issues

Examples of public health programs and services that could be affected by such reductions or changes could include any of the grant programs (e.g. WIC, Family Planning), emergency preparedness, HIV/AIDS, primary care clinics and general administrative capacity.

<u>State level risks:</u>

- Legislature
  - Continued failure to address core public health funding
  - Initiative for improved access to healthcare (could affect public health positively or negatively)
  - Change in leadership
  - Tax revolt
  - The Basic Health Plan fails or has funding reduced significantly

- Governor
  - Change in leadership
  - Refocus of priorities
  - Replacement of current DOH leadership with ineffectual leader

Examples of services that could be affected by any of the changes at the state level include immunizations, HIV/AIDS prevention, youth tobacco prevention, and foster care.

<u>Local level risks:</u>

- Worsening relationships among units of government
- Economic crisis

- Growth in current budget obligations that exceeds funding growth
- Significant health risks from new or emerging infectious disease, resulting in widespread illness and death
- Annexations and incorporations. Municipal level or type of services with a shrinking regional funding base.

Reductions in city or county support for PHSKC could affect any of the programs supported by county general fund allocations (Attachment 6), the clinics supported by funds from the City of Seattle. Further, reductions in county general fund support could jeopardize federal grants where match is required and provided by such funds.

One can add to or delete from this list, but the point is that there are a number of potential risks to public health funding, and any can occur in the future. Potential outcomes could have a significant impact on public health in general, and on PHSKC in particular. The Department already has a process in place for making programmatic decisions in times of significant budget reductions through the "Proviso Report – Public Health Priorities and Funding Policies 2003." Other CMHD directors have indicated that the best preparation for funding catastrophes include

- having a well organized and operating health department with solid leadership
- having a clear understanding of and dedication to core programs and activities
- keeping the board of health and elected officials fully informed
- being deeply connected with the community
- having collaborative relationship with partners
- maximizing flexible funding streams

One general risk of relying on funding streams that do not support core programs and activities is that of diluting focus and attention on mission and increasing the cost of administration. For example, all the CMHD interviewed no longer provide primary care[27], saying that it both detracted from population services and distracted their vision away from trying to find solutions to the access problems. An additional consideration is that the policy intent with respect to provision of primary care is never clearly articulated. Resolving health coverage issues is not generally considered to fall within the scope of resources available to local government, and the policy changes required to fully assure access are not within the purview of local government. On the other hand, at the very least the health

[27] Alameda County public health does not provide primary care, but another department within the County structure does.

department must have the capacity and expertise to assess access issues and health consequences, and to develop policies which can impact them.

Conclusions

In this concluding section, we provide a summary of our interpretation of the significance and meaning of the observations and findings in this background paper, and their implications for a broad policy framework for decision making about public health in King County. First, the key observations:

- **Funding approaches for PHSKC are fairly typical of CMHD.** While PHSKC has significantly higher per capita funding overall than CMHD, the department is funded in a similar fashion with many of the same sources of funding as the CMHD interviewed.

- **Local funding for PHSKC is low.** Variations in funding of MMHDs are principally related to differences in community and state dynamics. Local general fund support is higher among four of the five CMHD, both as a percent of budget and on a per capita basis.

- **Adequate discretionary funding is essential.** Most of the funding streams, and particularly federal categorical programs, available to local health departments offer limited opportunity to build capacities for services that are core to the mission of public health. Flexible funding sources are of critical importance to assuring capacities to conduct community assessments, perform communicable disease control work, and conduct population-level work designed to improve overall health status.

- **Core capacities have been cobbled together.** In the absence of adequate levels of discretionary funding, virtually all health departments assemble capacities for assessment, community participation, and other core activities from creative use of categorical program funds. Those capacities are continually at risk of funding shifts among the categorical programs.

- **Public health funding is not predictable.** All MMHDs in the country are facing the same challenges with regard to funding. It is not possible to predict with certainty the likelihood for expansion or contraction of existing public health funding streams in the current political environment.

- **Funding opportunities don't have equal merit.** Adding more categorical programs as a capacity building strategy may not really strengthen health department core capacity and may in many instances be a distraction. It can also lead to a dilution of managerial resources needed to support the department's mission.

- **PHSKC has managed well through lean budget times.** However, it is very important to understand that the nearly flat budget over the past 5 or 6 years is taking its toll. Costs increase by perhaps 5% per year while revenues at the macro level have increased less than 3% per year. It will not be possible to maintain services at current levels without new resources.

Important implications for next steps in development of the policy framework based on this description of funding include:

- **Being clear on mission and core responsibilities is essential, particularly in times of uncertain funding.** There is no agreed upon definition of "core" and it is more a term of art subject to various interpretations. In order for the funding challenges of today and tomorrow to be addressed adequately, the core responsibilities need to be defined on a basis of the Departments mission and vision, and should be the basis for programmatic decisions in the future.

- **PHSKC needs higher levels of discretionary funding.** With the relatively large dependence of PHSKC on external funding sources, it should not be a surprise that activities and services are heavily influenced by the Federal and State politics and policy. In order to assure a well functioning and effective local public health system, adequate levels of flexible funding, including in particular adequate local funding, is critically important to creating a public health infrastructure able to protect and improve the health of the community.

- **Stability of external funding for the years ahead are dependent on numerous issues.** While federal and state funding is dependent to a significant degree on the changing make-up and political perspectives of members of the respective legislative bodies, some generalities can be stated and might be considered as implications for future choices and for the policy framework:
    - Federal categorical programs with well-established successes and large, supportive interest groups have fared reasonably well in the past during economic downturns. Examples include Immunizations, WIC, and probably HIV/AIDS

- Programs with less well-established successes and/or with political "liabilities" are challenged in Congress each year. Examples include health workforce programs, family planning.

- Funding associated with building critical basic infrastructure to assure minimal levels of essential services, for example epidemiology and surveillance, have been tied to categorical programs like Bioterrorism and Pandemic Flu preparedness. The CDC made early attempts to promote "dual use" strategies; however this emphasis has disappeared in recent grant cycles.

- Large programs that have appeared "over night" in recent years are probably at risk of disappearing or going through significant down-sizing. An example is the bioterrorism preparedness program.

- Most stable and subject to the most growth potential at present are funds generated by dedicated tax assessments (e.g. Alameda County; as growth continues, the revenues will continue to grow).

- **Primary care needs are not declining.** Unless a major health access initiative occurs at the state or federal level, health departments providing primary care will continue to see increases in the numbers of un- and under-insured people. Costs will continue to rise, while Medicaid and Medicare reimbursements are declining, at least at present.

- **Innovative approaches should be considered.** Some of the answer to longer term stability may lie in completely reassessing the costs and benefits of the funding streams currently in play for public health. Creating and resourcing innovative ideas such as the approach in Alameda County, CA, should be considered. There, the director believes the only hope for making significant gains in health status and decreases in health inequities is through full engagement of the community, addressing the social determinants of health.

ATTACHMENT 1
Glossary

- **Categorical funding:** governmental funding, usually from the federal level, which is designed to be used in support of specific public health programs and activities. It typically is accompanied with tight limitations on how the funds can be used, even within programs.
- **Clinical services** are provided to individual clients/patients by any of a variety of health professionals, including physicians, nurses, dentists and others, to address specific health issues, including treatment of illness or injury or prevention of health problems.
- **Comparable metropolitan health department (CMHD)** is a term used specifically for this project and describes one of the five CMHD to which PHSKC was compared. They include the health departments serving Alameda County (CA), City of Columbus (OH), Miami-Dade County (FL), Nashville-Davidson County (TN), and Nassau County (NY).
- **Core Public Health Program:** A public health program or service that is crucial to the central mission of the health department. Such programs include assessment, communicable disease response, and others that contribute to population level prevention, health protection, and health promotion.
- **EPSDT:** A federally funded program for the "Early and Periodic Screening, Diagnosis and Treatment of children.
- **Essential Public Health Services:** established under the aegis of the federal Department of Health and Human Services in 1994, this list of ten sets of services comprises service categories that must be in place in all communities to assure an adequate local public health system.
- **Evidence-based practices:** public health activities which are designed based upon authenticated studies of efficacy and/or upon established practices.
- **Health Status**: The current state of health for a given group or population, using a variety of indices including illness, injury and death rates, and subjective assessments by members of the population.
- **Local public health agency (LPHA)** is a single governmental organization, regardless of size, providing public health services to the residents of a political jurisdiction; also known as a "local health department."

- **Local Public Health System:** in any community, the local governmental public health agency and all organizations, agencies and individuals who, through their collective work, improve or have the potential to improve the conditions in which the community population can be healthy.
- **Major metropolitan health department (MMHD)** is a local public health agency which is one of the 25 largest metropolitan health departments in the U.S.; while the size of the population served by MMHDs is widely variable, most provide services of close to a million or more people.
- **Mandatory:** Programs or activities which are explicitly required by state or local laws or regulations.
- **Match** – Funds or other resources, usually local, which must be applied to a specific program or activity under rules associated with the granting authority for the program or activity. Such resources are not discretionary.
- **Metropolitan health department (MHD)** is a local public health agency that provides services to a political jurisdiction with a population of 350,000 or more.
- **Personal health care**: encompasses the services provided to individual patients by health care providers for the direct benefit of the individual patient. Examples include physical examinations, treatment of infections, family planning services, etc.
- **Population-based public health services** are interventions aimed at promoting health and preventing disease or injury affecting an entire population, including the targeting of risk factors such as environmental factors, tobacco use, poor diet and sedentary lifestyles, and drug/alcohol use.
- **Primary care** constitutes clinical preventive services, first-contact treatment services, and ongoing care for medical conditions commonly encountered by individuals. Primary care is considered "comprehensive" when the primary care health provider assumes responsibility for the overall provision and coordination of medical, behavioral and/or social services addressing a patient's health problems.
- **Recommended –** Programs or activities implied or directed by state or national standards, or commonly understood to be good public health practice. At this point in time both national and state standards are not mandatory and are subject to interpretation.

- **Required** — Programs and particularly program activities related to implied or explicit contractual or grant requirements. Services in "categorical" programs that are not mandatory fall into this category.
- **Social Determinants of Health** – Major factors which are significantly associated with health status, including poverty, employment, education, housing, and racism.

Attachment 2
Ten Essential Services of Public Health

1. *Monitor health status to identify and solve community health problems*: This service includes accurate diagnosis of the community's health status; identification of threats to health and assessment of health service needs; timely collection, analysis, and publication of information on access, utilization, costs, and outcomes of personal health services; attention to the vital statistics and health status of specific-groups that are at higher risk than the total population; and collaboration to manage integrated information systems with private providers and health benefit plans.

2. *Diagnose and investigate health problems and health hazards in the community*: This service includes epidemiologic identification of emerging health threats; public health laboratory capability using modern technology to conduct rapid screening and high volume testing; active infectious disease epidemiology programs; and technical capacity for epidemiologic investigation of disease outbreaks and patterns of chronic disease and injury.

3. *Inform, educate, and empower people about health issues*: This service involves social marketing and targeted media public communication; providing accessible health information resources at community levels; active collaboration with personal health care providers to reinforce health promotion messages and programs; and joint health education programs with schools, churches, and worksites.

4. *Mobilize community partnerships and action to identify and solve health problems*: This service involves convening and facilitating community groups and associations, including those not typically considered to be health-related, in undertaking defined preventive, screening, rehabilitation, and support programs; and skilled coalition-building ability in order to draw upon the full range of potential human and material resources in the cause of community health.

5. *Develop policies and plans that support individual and community health efforts*: This service requires leadership development at all levels of public health; systematic community-level and state-level planning for health improvement in all jurisdictions; development and tracking of measurable health objectives as a part of continuous quality improvement strategies; joint evaluation with the medical health care system to define consistent policy regarding prevention and treatment services; and development of codes, regulations and legislation to guide the practice of public health.

6. *Enforce laws and regulations that protect health and ensure safety*: This service involves full enforcement of sanitary codes, especially in the food industry; full protection of drinking water supplies; enforcement of clean air standards; timely follow-up of hazards, preventable injuries, and exposure-related diseases identified in occupational and community settings; monitoring quality of medical services (e.g. laboratory, nursing homes, and home health care); and timely review of new drug, biologic, and medical device applications.

7. *Link people to needed personal health services and assure the provision of health care when otherwise unavailable*: This service (often referred to as "outreach" or "enabling" services) includes assuring effective entry for socially disadvantaged people into a coordinated system of clinical care; culturally and linguistically appropriate materials and staff to assure linkage to services for special population groups; ongoing "care management"; transportation services; targeted health information to high risk population groups; and technical assistance for effective worksite health promotion/disease prevention programs.

8. *Assure a competent public and personal health care workforce*: This service includes education and training for personnel to meet the needs for public and personal health service; efficient processes for licensure of professionals and certification of facilities with regular verification and inspection follow-up; adoption of continuous quality improvement and life-long learning within all licensure and certification programs; active partnerships with professional training programs to assure community-relevant learning experiences for all students; and continuing education in management and leadership development programs for those charged with administrative/executive roles.

9. *Evaluate effectiveness, accessibility, and quality of personal and population-based health services*: This service calls for ongoing evaluation of health programs, based on analysis of health status and service utilization data, to assess program effectiveness and to provide information necessary for allocating resources and reshaping programs.

10. *Research for new insights and innovative solutions to health problems*: This service includes continuous linkage with appropriate institutions of higher learning and research and an internal capacity to mount timely epidemiologic and economic analyses and conduct needed health services research.[7]

Attachment 3
"The 10 Essential Services in English"

Essential Service Number	Non-Public Health Version
1	What's going on in my community? How healthy are we?
2	Are we ready to respond to health problems or threats in my county? How quickly do we find out about problems? How effective is our response?
3	How well do we keep all segments of our community informed about health issues?
4	How well do we really get people engaged in local health issues?
5	What local policies in both government and the private sector promote health in my community? How effective are we in setting healthy local policies?
6	When we enforce health regulations, are we technically competent, fair, and effective?
7	Are people in my community receiving the medical care they need?
8	Do we have a competent public health staff? How can we be sure that our staff stays current?
9	Are we doing any good? Are we doing things right? Are we doing the right things?
10	Are we discovering and using new ways to get the job done?

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Attachment 4
Factors Affecting Strategic Direction of CMHD

Factor / MMHD	PHSKC	Alameda	Columbus	Miami	Nashville	Nassau	Average
Community Needs	5	5	5	5	5	3	4.7
Beliefs re MMHD Role	3	2	5	5	5	3	3.8
Tradition & History	3.5	2	5	5	2.5	3	3.5
Mandates & Contracts	5	2	4	5	4	5	4.2
Incremental Decisions	3	4	4	2	4	4	3.5
Threats & Crises	5	4	5	4	4	4	4.3
New Funding Opportunities	5	4	4	4	4	5	4.3
Politics & Advocacy	4	3	4	4	4	3	3.7
MMHD Leadership	4	5	4	5	5	3	4.3
State vs. Local Responsibility	3	3	3	2	2	5	3.0
Statutory Authority	5	3	2	5	5	5	4.2

Note: The factors were rated by directors of the 6 MMHDs, using a subjective scale of significance, ranging from 1 (low) to 5 (high).

Attachment 5
Federal Direct funds –PHSKC 2006

Grant	Amount (2006)
AIDS Care Contracts	4,813,027
Health Care For Homeless	1,788,442
Perinatal HIV Consortium	1,032,091
Trends In Drug Resistant	255,950
Health Resources Services Admin.	237,830
Women Infants & Children (WIC)	212,428
Access & Outreach	200,000
HRSA – Quality Assurance	187,431
HIV Access	186,425
Clinical Dental Services	150,000
WIC Contracts	124,000
Parent & Child Health Community	89,010
Methamphetamine Labs	75,000
Laboratory	51,828
Education-HIV/Aids	23,203
Clinic-HIV/Aids	10,474
CDC-TB Epidemiology Studies	1,900

Attachment 6
Change in County General Fund Support by Project
2000-2006

Project	2000 Funding	2006 Budget	% Chg
KING COUNTY OVERHEAD	1,756,463	1,913,132	0.0891957
INVESTIGATIONS	1,379,764	1,737,803	25.9%
AUTOPSY EXAMINATIONS	920,740	1,687,703	83.3%
PH COMM BASED PCH SVCS	11,962	1,446,677	11993.9%
PH INTERPRETATION PROGRAM	292,518	1,363,931	366.3%
IMMUNIZATIONS	453,375	1,331,916	193.8%
FAMILY PLANNING	975,436	1,312,410	34.5%
TUBERCULOSIS CONTROL	533,454	1,146,056	114.8%
EPIDEMIOLOGY	601,018	976,115	62.4%
TB OUTREACH-OVERFLOW		853,335	
LABORATORY	660,023	764,758	15.9%
FAMILY HEALTH	338,933	524,908	54.9%
CLINICAL DENTAL SERVICES	-55,709	398,285	-814.9%
HEALTHY AGING	184,854	314,547	70.2%
ACQ IMMUN DEF SYNDROME	128,474	279,871	117.8%
VECTOR/NUISANCE CONTROL	268,740	251,238	-6.5%
CORE COMMUNITY ASSESSMENT	311,409	248,778	-20.1%
EDUCATION-HIV/AIDS	37,886	226,954	499.0%
CHILD CARE HEALTH	161,269	215,632	33.7%
FOOD PROTECTION	536,848	212,196	-60.5%
NEEDLE EXCHANGE		201,483	
INDIGENT REMAINS	158,967	143,233	-9.9%
WASTE WATER DISPOSAL	242,707	140,678	-42.0%
STD-CLINICAL	804,306	139,957	-82.6%
STD-CLINICAL OUTREACH		134,401	
DRINKING WATER PROTECTION	94,106	132,719	41.0%
COMMUNITY CLINICS	1,292,866	101,265	-92.2%
HIV ACCESS	174,758	96,688	-44.7%
STD-PREVENTION		96,498	
AIDS PREV/ED CONTRACTS	109,659	93,418	-14.8%

CLINIC-HIV/AIDS	67,301	83,407	23.9%
ACCESS & OUTREACH	86,974	81,356	-6.5%
PCH COMMUNITY PROGRAMS	-9,691	73,775	-861.3%
CHEMICAL/PHYSICAL HAZARDS	235,917	66,959	-71.6%
AIDS CARE CONTRACTS	218,572	64,376	-70.5%
HIV OUTREACH/INTERVENTION	145,243	44,422	-69.4%
CHILD & FAMILY COMMISSION		37,287	
HEALTH RESOURCES SVC ADM	12,221	29,535	141.7%
HRSA – QA		27,605	
PLANNING COUNCIL-PREVENT	-203	10,935	-5486.7%
WOMEN INFANTS & CHILDREN	341,165	6,517	-98.1%
INJURY PREVENTION	32,121	6,274	-80.5%
CEDAR HILLS-MEDICAL	718,968	0	
FAMILY PLANNING HLTH EDUC	329,280	0	
TEEN HEALTH CENTERS	233,815	0	
HLTH CRE FOR HOMELESS NET	200,253	0	
COMM BASED ORAL HLTH SVCS	129,317	0	
BOARD OF HEALTH	118,162	0	
CHLD PROFILE-HLTH PROMOTE	112,743	0	
HLTH EDUCATION/PROMOTION	97,191	0	
TACOMA SMELTER PLUME	71,134	0	
MATERNAL CARE-OTHER	63,725	0	
LIVING ENVIRONMENT	59,529	0	
BREAST&CERVICAL HLTH PROG	51,892	0	
GERIATRICS	29,561	0	
COMM CLINIC PHARM/PROG SU	26,040	0	
MCH/AIDS CENTER	25,804	0	
SKIL ACTIVITY REGS/DIVS	23,344	0	
SEATTLE ACCESS&OUTREACH	19,327	0	

PFP COUNTY	17,248	0	
ADMIN-REVENUE SUPPORTED	10,471	0	
MOMS PLUS	8,287	0	
FAMILY PLANNING-CSO	7,300	0	
UNDISTRIBUTED ENCUMBR	7,205	0	
HCFA MATCH OVERSIGHT	6,681	0	
KC HEALTH ACTION PLAN	5,140	0	
COORD FAMILY SERVICES	2,815	0	
COMMUNITY CLINICS-SEATTLE	2,794	0	
PLUMBING/GAS PIPING	2,417	0	
SEA-DAY CARE SCREENING	1,572	0	
EH PROGRAM SUPPORT	1,305	0	
PEDIATRICS & TEEN HEALTH	1,095	0	
YOUTH TOBACCO PREVENTION	886	0	
SITE HAZARD-ASSESSMENTS	564	0	
OSS WORKSHOPS	529	0	
TOTAL	15,890,840	19,019,033	19.7%

Best Practices Interviews
Prepared by Milne & Associates, LLC

***Provision*:**

1. Memphis, TN
2. Portland/Multnomah County (overlap with Protection)
3. San Francisco, CA
4. Alameda County, CA (overlap with Promotion)
5. Lake County, IL

Promotion

1. Alameda County, CA (Overlaps with Provision)
2. Louisville, KY
3. Miami-Dade County
4. Nashville, TN
5. New York City

Protection:

1. Portland, Multnomah: (Overlaps with Provision)
2. Santa Clara, CA
3. Montgomery, AL (No response from health department)
4. Boston PH Commission
5. Chicago, IL

Note: Data from the interviews above were used to inform best practices for both Organizational Attributes and Funding.

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XIII: Milne & Associates: National Best Practices – Themes

National Best Practices - Themes
Prepared by Milne & Associates, LLC

HEALTH PROTECTION POLICY FINDINGS

Milne & Associates Findings: Milne & Associates interviewed four health departments for best practices on provision (a fifth declined an interview). The five health departments were selected through input with the health department as well as based on Milne's experience and history. The four interviewed were:

- Multnomah County, OR
- Chicago, IL
- Santa Clara, CA
- Boston, MA

Finding 1: Adequate epidemiologic capacity and expertise is essential to highly effective health protection capacity

Chicago:
The expertise of the health department is due at least in part to the fact that they run highly competent clinical operations for the control of infectious diseases, and they have highly qualified medical professionals in charge. They have built significant epidemiology capacity, and out of that, they are helping hospitals to solve some of their problems (e.g. drug resistant organisms). They have a monthly meeting for review of infectious disease issues with hospital staff and physicians. The hospitals now call them for advice because they are experts.

Finding 2: Use of GIS mapping helps guide targeted responses to environmental health risks

Boston:
They have used GIS strategies and aerial maps to track lead problems, waste transfer and recycling stations, soil-based hazards, etc, to track high risk areas and target resources at the census tract level. They have mapped all the public schools and high risk sites within a certain distance of those schools. This can be particularly valuable for smart growth and development in the city, to avoid building in potentially high risk areas. This also helps with targeting inspections and educational interventions. They've added the use of aerial photo overlays to GIS maps to document

changes over time, using digitized Sandborn Industrial Maps, and receiving assistance from a Polytechnic Institute.

Chicago:
The health department uses GIS approaches a lot to target interventions in lead tracking and to support planning in immunization work.

Portland/Multnomah County:
They are working with GIS to display demographics and disease incidence, among other data sets, by geographic area. They put this information in front of the community to support decision making. They are also using web-based partner identification in their HIV work.

Finding 3: Innovation can create new approaches to health protection.

Boston:
The health department has begun a program to encourage taxi companies to use hybrid vehicles which get better mileage and pollute less. The program was begun with some foundation money, and has demonstrated to the taxi companies that this can save them money for a "win-win." The health department convinced Logan Airport to allow hybrid cabs to go to the front of the line, and the highway authority to allow their use of the HOV even when empty.

Portland/Multnomah County:
The health department utilizes a food handler online training tool in seven languages, available from any computer with connectivity on a 24/7 basis, for education and testing. In the first few months they had: 66,000 hits. Over 6,000 people took the certification test on-line and had higher pass rates for the test than those taking the test at a health department site, and a 99% satisfaction rate with the approach. The tool uses lots of visual graphics for people with low literacy, and is recognized for its cultural competence.

Santa Clara:
The health department has been working at the elimination of silos among their services for several years, and focusing on organizational culture change. Their involvement of all staff in training for and response to infectious diseases and public health emergencies is one example.

Finding 4: Collaboration with other agencies that have authority to inspect and regulate enhances capacity and effectiveness of health department work in health protection.

Boston:
The health department has formed a multi-agency "Strike Team," comprising agencies that have jurisdiction solid waste and recycling sites, and in particular, abandoned buildings that are filled with trash. Each agency retains its independent authority, but participates in coordinated inspections when problems have been reported. Strike team members typically are seasoned experts who have influence in their organizations and/or with the City.

Chicago:
The Mayor put together a task force to address West Nile Virus, with the health department in the lead, and lots of city departments involved. Much of the work involves larviciding and standing water control – public works does the work with catch basins and other standing water sources, so the health department doesn't have to have a large workforce. There has been much leveraging of effort through collaborative work with other city department. They also have focused on building coalitions around TB prevention and control – involving the Lung Association, city government, jail services, etc – to coordinate activity for TB control beyond the health department.

Santa Clara:
The health department worked with the city and all of its relevant departments to deal with infection control in water parks and city fountains. An outbreak involving a waterborne bacterium occurring in the fountains and water features in the city resulted in the health department's convening a meeting of representatives of water system organizations, local government, and others. Improvements in filtration and greater interdepartmental and public awareness of contamination risks resulted.

Santa Clara:
They are working on development of influenza care centers. The centers would be used in instances when hospital capacity is unavailable. They brought together appropriate elected officials and other representatives from all the 15 municipalities in the county, including emergency management staff, elected officials, and various departmental staff, to help them understand the potential impact of an outbreak of influenza and the need for their staff involvement in the event of a public health emergency. They will be having regular meetings to update this process.

Finding 5: Involvement of community is an essential strategy for effective health protection

Portland/Multnomah County
There has been an increasing focus on including the community in decisions about the environment to help guide decision-making and health department activities. A concrete example is the HUD Health Homes Grant. The department brought scientific information and demographics to community groups to help with decisions. The community has contributed to identifying the area of the county on which to focus and the subjects to address, in addition to lead poisoning – asthma, indoor air quality, trash collection, and low income properties.

Finding 6: Health department participation in state level health policy development is essential to assure adequate statutory provisions for health protection.

Chicago:
The health department provides technical leadership in state conversations on infectious diseases and immunization policies where legislators tend to develop legislation without a lot of public health and other technical input.

Finding 7: Broadening scope of responsibility of staff for health protection enhances response and increases surge capacity

Chicago:
A best practice is integration of TB and clinical services with field service. They are trying to provide services through vertical integration within the health department, linking the program experts with field staff for a seamless response. This approach connects outreach, case management, and tracking, and the field staff that perform those functions, with clinical activities and staff. The TB program owns all the tactical decisions related to TB control; field staff, however, are not a part of the TB program. STD services also involve integration of clinical and field services.

Santa Clara:
All staff of the health department are trained for and expected to participate in response to infectious diseases. Professional staff in other programs respond to reported infectious diseases on a rotational basis. The health department regards staff's primary responsibility as "health protection." A full time employee is charged with conducting health

protection/infectious disease training in all of the health department's facilities for all staff.

Finding 8: Health protection work must include education and case management of people affected by environmental risks.

Boston:
Part of the health protection program of the health department includes a comprehensive case management program, including education, home assessments, referrals to social workers and other agencies. In lead poisoning work, the health department is currently shifting focus to risk reduction and health promotion and education, rather than starting with blood levels alone. They are using their pediatric clinic to integrate services for affected children, and to help parents understand the need for full follow up and thorough inspection of the home.

Finding 9: Health Protection activities include opportunities to address health disparities.

Portland/Multnomah County
The health department expends a considerable amount of resource to addressing communications across cultural boundaries, in particular because certain community groups are at higher risk and the health department is dedicated to addressing health disparities. They have been struggling with a chronic disparity – e.g., STD rates are much higher among African-Americans. By engaging African-American employees, some of which don't work with STDs at all, they have had some success – e.g. the formation of a group, which focuses on risk reduction in African-American youth (12-15 and up) through such media as MySpace pages on healthy and safe sexual practices, having creative and health outlets, etc. Without a culturally competent approach, this probably wouldn't have worked.

Alameda County

They have engaged in a strategic planning process (MAPP) for a number of years, which has led to engaging in community partnerships with a budget of about $4 million/year. They are employing community organizers, do baseline surveys, and develop community leadership around identified issues, including both the physical and social environments, with the overall goal of improving health status. They call this process Community Capacity Building and it targets the social determinants of health to address health inequities. Details of their approach can be found in the recent NACCHO publication, Tackling Health Inequities through Public Health Practice: A Handbook for Action, Chapter

7, Tackling the Root Causes of Health Disparities through Community Capacity Building, written by Anthony Iton, M.D.

HEALTH PROMOTION POLICY FINDINGS

Milne & Associates Findings: Milne & Associates interviewed five health departments for best practices on promotion. The five health departments were selected through input with the health department as well as based on Milne's experience and history. The five interviewed were:

- Louisville, Kentucky
- Miami-Dade, Florida
- Nashville, Tennessee
- Alameda, California
- New York, New York

Finding 1: Data driven, high impact health policy fostering a healthier environment and healthier personal choices is essential to addressing population health improvement.

New York:

NYC'S Smoking and Trans Fat ban regulations were adopted principally based on the scientific data researched and presented by the health department.

Alameda:

The health department has adopted a neighborhood by neighborhood community engagement strategy. Referencing a community capacity building philosophy, the health department focuses on data based policy and programming at the neighborhood level targeting concentrations of high risk via mapping indicators.

Nashville:

The health department publishes a comprehensive health status report, compiling and comparing local health care and population based data, displaying trends and standard measurements The assessment supports community health planning to develop programs, including MAPP, a community based public health strategic planning process, and a process called Healthy Nashville 2010 (mayor's initiative).

Finding 2: Conducting a "place-based" approach to assessment and planning at the neighborhood level strengthens community involvement and buy-in.

Alameda:

The health department has developed a handbook for community based assessments. The process involves identifying who is in the neighborhoods, surveying and conducting focus groups to help identify issues and assets, engaging city representatives and other county agencies to help identify key leaders, and focusing on solutions. A key effort is to identify and build leadership.

New York City:

NYC has established three high need area field offices to support community capacity building and engagement. NYC collects and reports health status data at the neighborhood level. Data are analyzed and disseminated in order to influence health program decisions, to increase the understanding of the relationship between health behavior and health status, and to support health policy positions.

Finding 3: Partnerships with Academia foster practice training and applied research.

Miami-Dade:

Miami-Dade health department has established a strong relationship with academic institutions. Planning is underway in the health department to develop an academic health department in partnership with Florida International University in Miami-Dade County The arrangement include opportunities for teaching within the health department. High value is placed on innovation in partnership with the university. The academic health department should be fully functional in two years.

Louisville:

Louisville health department has initiated a specialized university/community partnership facilitated by the University of Louisville that focuses on education strategies and opportunities addressing human equity, economics, and health.

Finding 4: County level health stakeholder advisory forums can support policy development and collaboration.

Metro Louisville:

Mayor's Healthy Hometown Movement, which puts into action the mayor's commitment to developing a long-term, multi-phase program that builds on social marketing and public/private partnerships. The intent is to "create a community wide culture that encourages and supports healthy lifestyles by promoting increased physical activity, better nutrition, healthy public policy and access to needed resources." The effort is led by the Louisville Metro Department of Public Health and Wellness (LMPHW),

and unites diverse community partners from business, schools, government, academia, neighborhood groups and non-profit organizations to coordinate activities that will increase physical activity and healthy eating to improve the health status of Louisville Metro residents.

Miami-Dade County

Consortium for a Healthy Miami-Dade, the purpose of which is to coalesce efforts to improve population health by pooling the resources of multiple community partners and to facilitate engagement in joint ventures to more successfully target priorities and affect outcomes. As a broad coalition-based organization, the *Consortium for a Healthier Miami-Dade* aims to catalyze change, streamlining and increasing the efficiency of Miami-Dade County's development as a healthy community. Ultimately, it will serve as a focal point and beacon, leading community health work in Miami-Dade County

Nashville

Healthy Nashville 2010 is a process to continually improve health status and quality of life for Nashville as a community. Healthy Nashville 2010 uses an approach called "Mobilizing for Action through Planning and Partnerships" or MAPP. The Healthy Nashville 2010 (MAPP) process will build upon previous experiences and current collaborations. Healthy Nashville 2010 is guided by Healthy Nashville Leadership Council. The Mayor makes appointments to the Council through Executive Order. The Council convened in February 2003.

Finding 5: An integral part of public health work at the local level involves taking action to reduce disparities and promoting social justice

Metro Louisville:

The health department established the Center for Health Equity within the health department, focused on health disparities. Their disparities initiatives include activities in upstream data analysis (determinants of health), community organizing, community capacity building, policy development and training, anti-racism workshops, and the reeducation of the public health workforce around social justice issues.

Alameda:

The health department uses mapping technology to map health inequity to neighborhoods linking poverty to health outcomes. Policies established by the health department give priority to addressing health inequities.

Finding 6: School health promotion through assessment, policy/program development and evaluation support is a priority.

Miami-Dade:

Miami-Dade initiated the School Connect Program to address health problems associated with children who have limited access to health care. Through the State's Children's Trust State Charter supported by state and local taxes (based on one cent of every dollar of state sales taxes for children's health)., the health department invests in children issues as a priority. They have created a new model for school health. A public health professional is assigned to every school to support health promotion initiatives at all levels of policy and programs.

Finding 7: Worksite health promotion through assessment, policy/program development and evaluation support is a priority.

Miami-Dade:

Miami-Dade has prioritized worksite wellness, building on established partnerships with businesses. As part of the Consortium for a Healthy Miami-Dade process. The health department works with employers and non-profits, using a subcommittee devoted to worksite wellness. Team includes law firms, insurance brokers, Burger King, Home Depot, etc. Efforts are directed to impact worksite policy, employee health benefits/services and education. The focus is to create the culture within organizations elevating the importance of employee health and safety.

HEALTH PROVISION POLICY FINDINGS

Milne & Associates Findings: Milne & Associates interviewed five health departments for best practices on provision. The five health departments were selected through input with the health department as well as based on Milne's experience and history. The five interviewed were:

- Memphis-Shelby County, Tennessee
- Alameda County, California
- San Francisco, California
- Lake County, Illinois
- Portland/Multnomah County, Oregon

Finding 1: Public health's role in leadership includes convening and supporting a formal strategy-driven access to health care coalition/consortium of all stakeholders, public and private – including public health, community health centers, hospitals, physicians, business, labor, community-based organizations.

Memphis
Memphis has established a Regional Health Council (RHC) in the county, which serves as the planning arm for health care in the community. Its participants are consumers, providers, institutions, managed care organizations, federally funded community health centers (CHCs), city/county government representation and private hospitals. It is convened and led by the Memphis Health Department. The process to form the RHC was collaborative in the sense that the health department worked with the Regional Medical Center (RMC) to develop the Health Loop clinics – six from the HD, four from the RMC. The RMC is responsible for the management of the Health Loop clinics. There is no information suggesting that there has been any formal assessment of either health system or health status outcomes. The continued oversight by the HD is through the medium of the contract with the RMC, a contract through which the HD provides over $4 million annually to support primary care services in the Health Loop clinics. Members of the RHC are convened regularly and staffed by the health department; the RHC has good support from its constituent members.

On the subject of access, the subcommittee and the Regional Health Council have worked with the CHCs and other providers to assure a medical home for the patients who have lost their Medicaid insurance. But even with this structure in place, it still is not adequate to meet the needs in the area.

Portland:
The Portland/Multnomah County Health Department initiated the Tri-County Safety Net Enterprise, which brings hospitals and health departments together to develop regional approaches which include public health preparedness and access to medical care. Outcomes of the community convening facilitated by the Health Department include: New primary care resources; A Medicaid managed care plan that eventually became an independent 501(c)(3), The Tri-County Safety Net Enterprise; The developing regional arrangement for specialty referrals. All of this is still deemed insufficient to meet the needs. Excellent linkages have resulted, however, for preparedness planning, exercises, and coordination of epidemiology.

San Francisco:
San Francisco HD convened a steering committee which meets weekly, currently includes consortium hospitals, foundations, and community representatives, and is shaping the roll out of the Health Access Program (universal access to care) for the county; In 2006, the San Francisco DPH

Website says they are insuring 99.2% of all children in San Francisco and that the HD health plan is managing 1 in 4 children. Levels of satisfaction with HD primary care services are very high. The HAP is in itself a positive outcome; assessment of the results of the HAP on health status will occur at some point in the future. See the HAP Website for more details.

Alameda:
Alameda County has taken a lead in the Access to Care Collaborative. The health department provides leadership for the Access to Care Collaborative and is its main information source. Other participants in the collaborative include the Alameda County Medical Center, community clinic consortium, Kaiser Permanente (which also helps to fund these efforts). There is a lot of additional information on the Website, under Alameda County Communities in Charge. The Access to Care Collaborative is a formalized process involving public providers, for studying, planning and organizing the system to provide better access to care.

Finding 2: Establishing a role of system advocate helps build system resources to improve health care access

Portland/Multnomah County:
The health department has helped several community groups acquire funds to develop new primary care resources (FQHCs) for the county. The soon to be reviewed paper on funding will provide more detail.

San Francisco:
A monthly meeting of the Department of Public Health with hospitals, listening to one another, has led to an increase in care for the uninsured, dollars donated to community clinics, the setting of priorities for identified populations with needs (e.g., a pediatric clinic, an asthma clinic, a health campus for an underserved community, etc.)

Finding 3: A defined process is required to determine and periodically evaluate the community vision for the provision of health care services

Memphis:
The Memphis-Shelby County HD made a decision to not to be a direct service provider due to increasing cost and complexity of the enterprise. They maintain a funding and system oversight role. (See Finding #1) Regular meetings of the RHC include discussions of progress and evaluation findings.

San Francisco, Alameda:
San Francisco and Alameda health departments are continuing to make a strong commitment to primary care by incorporating revenue generating initiatives. Alameda is providing services in a different unit of local government using a voter approved sales tax. San Francisco legislated a contribution by business as one component of a funding scheme.

Finding 4: Assuring access to health care is critically important.

San Francisco:
The Health Access Program in San Francisco is one model for assuring access to all. In February 2006, San Francisco Mayor Gavin Newsom created a Universal Healthcare Council (UHC) to develop a plan to provide access to healthcare for San Francisco's 82,000 uninsured adults. This collaborative effort, comprised of representatives from the health, business, labor, philanthropy, and research communities, met for four months. The Council reviewed demographic and actuarial data, and heard from community advocates and employers to identify and quantify the needs of the uninsured. The San Francisco Health Plan is the vehicle of the Health Access Program. The Plan is composed of Medi-Cal, Healthy Families-, Healthy Kids &Young Adults and Healthy Worker Plans. The various plans target individuals and families who are low income, residents of San Francisco, and not eligible for Medi-Cal or Medicare. The range of plans are designed to provide universal access to San Francisco residents. If all eligible adult residents of San Francisco enrolled in the program, the estimated annual cost (in 2006 dollars) is approximately $198 million, just over $200 per person, per month. Phase in of the program will start July 2007. The HAP website provides more information about the model, which is intended to lead to universal health care coverage for the population of San Francisco (http://www.sfhp.org/).

Finding 5: Health department credibility with health care providers is essential to work to increase access, and is built by developing expertise in categorical clinical services (e.g. TB, STD, HIV, and emergency preparedness.)

Memphis:
The health department has an active and effective internal quality assessment program, using a large range of quality indicators, both for categorical and for primary care services in the clinics supported by the health department.

San Francisco:

The Department of Public Health helped to band together nine public clinics together into a consortium system. Four of them are FQHC and all see a mix of patients similar to the DPH clinics.

Finding 6: Arranging for Specialty Care is a necessary part of primary care and can be accomplished through community partnerships: Both of the models below are similar to "Project Access" currently being initiated in King County.

Lake County, IL:
In Lake County, IL, they are close to rolling out a new public/private partnership to provide specialty care access, reimbursing private physicians at Medicaid rates.

Portland:
In Portland/Multnomah County, a group consisting of public health, hospitals, and insurers is dealing with the specialty referral issue and currently looking toward a network of private physicians, each one taking a defined number of referrals, and using a broker to assure equal distribution of responsibility.

Finding 7: **Case management for defined segments of the uninsured population is critical, in conjunction with consistent primary care access. There are several case management models to examine.** A common theme was attention being paid to "health determinants" issues (i.e. housing assistance, nutrition education). The "case management "role ,to efficiently and appropriately coordinate resources on behalf of the client,(patient) appears to be integral to successful outcomes among the complex cases and needs. This also may have implications for the possible ongoing role of health departments in the provision of care arrangements within the health care system.

ORGANIZATIONAL ATTRIBUTES POLICY FINDINGS

Milne & Associates Findings: Milne & Associates interviewed twelve health departments in fourteen separate interviews for best practices on provision, health promotion and protection. Each of those interviews revealed a variety of findings about Organizational Attributes, some of which may have relevance to the King County Operational Master Plan. The health departments were selected through input with the health department as well

as based on Milne's experience and history. Those interviewed were the health departments serving:

Alameda County, CA	Boston, MA
Chicago, IL	Lake County, IL
Memphis-Shelby County, TN	Metro Louisville, KY
Miami-Dade County, FL	Multnomah County, OR
Metro Nashville, TN	New York City, NY
San Francisco, CA	Santa Clara, CA

Finding 1: Leadership Development and management training is essential to assure high performance internally and effectiveness in working with the community.

Alameda County:
The health department has a leadership fellows program for 20 employees at a time, all of whom are considered to be up and coming leaders. The program enables employees to spend considerable time in building leadership skills, management development, exploring racism, and participating in organizational strategic planning. Each of the fellows receives mentoring. The health department also runs a Management Development Program for senior staff, which includes focus on leadership succession planning within the department. The health department believes that leadership is a core professional responsibility that is central to successful practice by all professional staff

Metro Louisville:
A strongly held value is that "staff must assume a leadership role to fulfill the mission of the department". An example of how they incorporate these attributes is through the health department leadership training program. Modeled after the public health leadership institutes, health department employees go through leadership training, develop proposals to projects that will enhance the work environment and present those to the director for support.

Chicago:
The health department provides leadership training, and regards leadership as of core importance to their organizational value of *creat[ing] a culture of performance excellence and employee engagement.* The health department believes it is important to have credible experts leading programs and being leaders in community coordinating and convening activities.

Santa Clara County:

They are developing broad-based excellence through the elimination of program silos and through leadership development with emphasis on communications in particular.

Finding 2: Collaboration, including the sharing of power and decision making, is of core importance to a health department's effectiveness.

Alameda County:
The health department gives high priority on building capacity of staff to work with communities and to work within teams. The health department provides a "public health 101" training series for all employees in the health department and has developed and uses a module on community capacity and undoing racism. Teams of staff work in the community, doing community organization to mobilize advocacy for neighborhood health priorities.

Boston:
The health department has operated under a "If it makes sense, just do it," driven by a corporate culture of protecting the health of the community. The principal focus is on the community and the underserved. They try to hire people from the community with appropriate language and cultural skills as well as education and experience.

Multnomah County:

Staff members do business where possible through collaboration with other organizations and across cultures. They work to understand the community's perceptions of its environmental risks and bring scientific information and demographics to community groups to participate in making decisions. The health department convened a PACE-EH (Protocol for Assessing Community Excellence in Environmental Health) coalition in 2004, which led to formation of a 501©(3) organization called OPAL (Organizing People-Activating Leaders, www.opalpdx.org) with a mission of supporting "ignored communities that fight against the oppression of pollution and social injustice." OPAL is funded by a variety of local and national foundations and has a strong and sustainable board. OPAL is convening, in partnership with the health department, a Healthy Homes Summit May 17, bringing together people in housing, environmental issues, health, academia, and communities to identify housing policy changes needed to connect health and housing.

Finding 3: Success at recruiting, training, and retaining strong staff is essential for attaining a high level of performance.

Miami-Dade County:
Work on creating an academic health department model is designed to foster partnership, applied research, practice orientation and recruitment. The health department received a Sterling Award for its emphasis on transformation of organizational culture to one of high performing staff.

Metro Louisville:
The health department is engaged in a "Signature Partnership" with the University of Louisville. This is a university/community partnership facilitated by the University that focuses on education of staff about human equity, economics, and health. A significant investment has been made in addressing the implications of health inequity through staff training.

Metro Nashville:
The health department partners with Lentz University in a broad training program designed to foster growth of employees. Training includes "Public Health 101," bioterrorism training, and management skills for supervisors.

New York City:
The health department takes pride in being a premier organization. They aspire to excellence, hiring and sustaining high quality staff. The department is committed to training and leadership.

Chicago:
The health department went through a core values process, identifying as core values for the organization integrity, excellence, innovation, and acquiring talented and dedicated staff. The health department is still regarded as the place to work in the city. One of the other core values is maintaining a "*Positive work environment.*" Two elements in their strategic plan include:

- *Ensure organizational effectiveness and accountability through the development, reporting and analysis of high-quality performance and results measurement information*
- *Create a culture of performance excellence and employee engagement*

Multnomah County:
The health department works hard on succession planning and actually has a low turnover rate.

San Francisco:
The Health Department puts "huge efforts" into recruitment and retention of staff. They have an Integration Steering Committee, which meets regularly to address future issues and to deal with interface issues within the health department. They have a variety of effective ways for communicating, internally and externally.

Lake County:
They put a lot of energy into both management team and staff development. They conduct regular meetings which focus on organizational values, and reinforce those values in many ways – through regular staff meetings, through orientation of new employees, and through performance reviews. "Adult interactions" are the theme.

Finding 4: Effectiveness in working with the community to eliminate health disparities requires internal emphasis on equity.

Metro Louisville:
The health department places great internal emphasis on the importance of human equity and its impact on health. Extensive training is done with staff on equity, health disparities and related issues, which is coordinated through their Center for Health Equity. The intent is to achieve a culture that regards health inequity as unacceptable.

Alameda County:
They define themselves as a social justice institution and intend to be the best in translating social justice into public health practice. They rely on strong organizational attributes to support this work. As part of their participatory approach to strategic planning, they emphasize a social justice approach using an internal view (i.e. Institutional racism), but also understanding of community needs, capacity, and assets. Involvement is sought from all employees in the strategic planning process.

Finding 5: Greater flexibility in the use of staff can achieve enhanced capacity and improved effectiveness in responsibility areas of high priority.

Santa Clara County:
Staff in two of the health department's divisions (Community Services Division and Health Protection Division), comprising a third of total health department staff, were merged into a new Division of Community Health Protection. All receive on-going training in the core areas of responsibility of the new division, including disease control, epidemiology, health communication and education, preparedness and needs of vulnerable populations. While many of the staff continue to work in categorical personal health service programs during routine times (e.g. WIC, family planning), their first responsibility is to health protection. Staff rotate through work in infectious disease case finding and follow-up; in the event of a major public health emergency such as an outbreak of avian flu, the health department is well prepared with full surge capacity through their 200 staff that have been trained and have rotated through infectious disease work.

Finding 6: Additional tools are absolutely essential to supporting well-trained staff in performing core public health services.

Boston:
The health department relies on extensive access to GIS and aerial maps to track lead problems, waste transfer and recycling stations, and soil-based hazards, as well as to track high risk areas and target resources at the census tract level. They have mapped all the public schools and high risk sites within a certain distance of those schools. This can be particularly valuable for informing policy related to smart growth and development in the city, and to avoid building in potentially high risk areas. GIS is also used in targeting inspections and educational interventions.

Chicago:
They use GIS approaches at a significant level to target interventions in lead and immunization work, and in doing department planning. There has been some good partnership development within and beyond city government to leverage limited resources and expenditures in GIS to get the job done.

Multnomah County:
This health department is demonstrating technologic excellence, working extensively with GIS to display demographics and disease incidence, among other data sets, by geographic area. They put this information in front of the community to support decision making.

They are also using web-based partner identification in their HIV work, and have implemented use of on-line food handler testing and licensure.

Multnomah County:
The PACE-EH tool for assessing and conducting community-based strategic planning on issues related to environmental health has been used recently to focus on the community environment, community empowerment, and to support use of socio-ecological approaches to health promotion. The results have helped guide decision-making and health department activities. A Department of Housing and Urban Development Healthy Homes Grant was a direct result of the PACE-EH process. In years past, the approach to lead poisoning involved health department staff focusing on individual houses – similar to primary care, one house at a time. However, the community wasn't aware of the risk and didn't own commitment to or understanding of the need to eradicate environmental lead. In an effort to identify what the community wanted and needed, the health department worked with Portland State University and included community partners in the PACE-EH process. The community identified the area of the county on which to focus and the subjects to address. In addition to lead poisoning, the health department has increased focus on asthma, indoor air quality, trash collection, and low income properties as a result.

Memphis-Shelby County

The Regional Health Council (RHC), which is convened and led by the health department and serves as the planning arm for health care in the community, has begun the MAPP process, a national public health assessment and strategic planning process for public health. A lot of data have been collected and analyzed, and the RHC has voted on five focus areas for the next two years, one of which is access to primary care. Each focus area has a subcommittee addressing it and reporting to the RHC. The RHC meets about every two months to consider the results.

Alameda County
The health department has done MAPP for a number of years, modifying it to accommodate to their communities. They use it to address community partnership capacity; about $4 million/year goes into this effort. They employ community organizers, do baseline surveys, and develop community leadership around identified issues,

including both the physical and social environments, with the overall goal of improving health status.

Metro Nashville
Healthy Nashville 2010, the mayor level health coalition is, is facilitated by the health department and is composed of high level multi-sector leaders. That group has gone through the MAPP process. The outcomes have resulted in health priorities for the community being placed on obesity, health disparities, and cardiovascular disease. Healthy Nashville 2010 members are appointed by the mayor of Nashville; the 2010 Council is somewhat separate from the health department but acts in an advisory capacity.

Finding 7: Accessing the full capacity of health department staff requires creation of an environment where personal growth and risk taking are supported and encouraged.

Santa Clara County:
The health department director helped design the environment and an internal approach that supports the creating and nurturing of a learning organization while valuing a collective intelligence—"especially during hard times so that that we can remain flexible in our thinking of what we do, and how we do it as an organization." Risk taking is encouraged.

Finding 8: The organizational attributes, as presented by the interviewer, were universally, and often enthusiastically, endorsed. The only caveat was that resource limitations do tend to constrain health departments' abilities to measure up to some of the expectations.

FUNDING & BUDGET POLICY FINDINGS

Milne & Associates Findings: Milne & Associates interviewed twelve health departments in fourteen separate interviews for best practices on provision, health promotion and protection. Each of those interviews revealed a variety of findings about the financing of health departments, some of which may have relevance to the King County Operational Master Plan. The health departments were selected through input with the health department as well as based on Milne's experience and history. Those interviewed were the health departments serving:

Alameda County, CA	Boston, MA
Chicago, IL	Lake County, IL

Memphis-Shelby County, TN Metro Louisville, KY
Miami-Dade County, FL Multnomah County, OR
Metro Nashville, TN New York City, NY
San Francisco, CA Santa Clara, CA

Finding 1: Many of the more successful metropolitan health departments receive significant local general funds.

Chicago:
They receive a very small amount of state funding, approximately $2 million. A lot of the rest of the funding comes from city general funds. Of the total budget of $198.6 million, general fund accounts for $45,883,695 or 23.1%.

San Francisco:
The SFDPH is well supported locally. Of the total annual budget of $1.2 billion, local general funds total $198.6 million, comprising 27.2% of the total budget. This appropriation includes part of the operational budget for the San Francisco General Hospital, a 1250 bed skilled nursing facility, as well as primary care and public health. General funds include $30.6 million for primary care services and $34 million for public health. The City of San Francisco, through the health department, has initiated an innovative program of finding and funding housing for the homeless, addressing a major health determinant. This program is supported entirely by general funds.

Memphis-Shelby County:
While the heath department has gotten out of providing primary care, the organization that picked those services up (The Regional Medical Center, a 501©(3) organization) and the health department are both supported by local tax dollars from the city. Some of the health department's budget is for pass through for primary care. On a $61 million budget, the City contributes $11.7 million (19.2% of budget) in general funds, the County contributes $12.3 million (20.2% of budget) in general funds; combined, general funds comprise 39.3% of the total health department budget.

Santa Clara County:
This is primarily a general fund agency. $41 Million of their $93 Million budget, or 44%, is from local general funds. However, the County is facing a deficit of $240 million in 2008, and the health department's budget is decreasing to $73.5 million, $21 million of which will be general funds (29% of total). They have very little in the way of fees

available to them. About 25% of the health department budget is in health protection. Environmental health is in another organization.

Multnomah County:
On a total budget of nearly $125 million, general funds total $49.2 million, or 39%. Approximately 60-70% of the health department's health protection budget comes from County general funds, reflecting the county's interest in vector and communicable disease control.

Metro Louisville:
Although its budget is relatively small by comparison ($24 million), it receives $9 million in local general funds, or 37.5%

Finding 2: Use of the Federally Qualified Health Center (FQHC) designation has increased primary care revenues for some health departments.

Lake County:
Fully one-third of the health department's revenues are generated through its FQHC; it provides care to over 60,000 residents and over 100,000 visits per year, by far the largest provider of care to un- and under-insured residents. The FQHC designation includes reimbursement for 67% of actual costs, which is substantially above most Medicaid and Medicare reimbursement rates where those apply. The health department is able to fold family planning and other personal health services into the FQHC to increase coverage. However, the FQHC designation applies only to the designee and cannot be used to build cost sharing alliances in the community. The health department depicted FQHC designation and related funding as very sustainable and well positioned for national health insurance at some point in the future.

Santa Clara County:
The County operates a hospital and system of clinics, all covered under FQHC and which include substantial general fund support as well. While general fund departments (public health, mental health, substance abuse) have been making budget reductions for the past 5 years, the hospital and clinics have been "increasing their scope of services and general fund subsidy to over $430 million." The construction of a new, state-of-the-art hospital, primary clinics, and a medical office building probably contributed to the voters defeating a measure for increased support for public health. This example may demonstrate a downside to FQHC support inside a health department.

Finding 3: Creative uses of taxing authorities, fees, and legislated contributions have contributed to health department operations.

Alameda County:
Residents of Alameda County passed an additional 0.25% sales tax in 2003, specifically earmarked for indigent care. The tax generates $100 Million per year. 75% of the funds go to the Medical Center, an FQHC to which primary care services formerly provided by the health department were transferred (the health department now provides no primary care services and only limited personal health services). The other 25% of funds is distributed to community health centers in the county, to behavioral health, the health department and to school services. The health department receives $4.5 million each year, of which $1.5 is distributed to cover unreimbursed physician visits in emergency rooms, as required by county policy. The remaining $3 million is used to improve population health status and address health inequities in two large neighborhoods in Oakland.

New York City:
The State has levied an excise tax on tobacco. $1.50 of the $3.00 per pack tax goes to the City. These dollars are not dedicated to the health promotion budget per se, but do support interventions for reducing tobacco use.

Boston:
The city is considering a 5% tax on paint, to accrue to a rehabilitation fund for lead poisoning control, to be used to remove environmental paint from low income residences primarily.

Miami-Dade County:
State and local taxes support are dedicated to children's issues. One cent of every dollar of state sales taxes are dedicated for children's health, supporting the School Connect Program and other activities.

Chicago:
Funds to support mosquito control to address West Nile Virus issues come in large part from the state's Used Tire Fund ($2-$3 goes into the fund for each change of vehicle tires).

San Francisco:
The new Health Access Program, due to be deployed in summer 2007, has as its main goal the provision of a medical home for every resident

of the city/county. The funding for this program is creative, and includes legislated contributions from businesses, with a possible reduction in the amount of tax money from businesses.

Finding 4: Community collaboration has resulted in significant leveraging of resources to address public health issues, although there have been some mixed results.

Alameda County:
The California Nutrition Network provides funding of school-based nutrition programs and the operation of "Healthy Living Councils." However, collaboration and leveraging of resources is often lacking, not because of poor intent but due to overwhelming demand and institutionally fragmented components of the health care system.

Metro Louisville:
The Mayor's health initiative brings in other partners to leverage funds to address a range of health and public health issues. The Passport Health System contributes $305,000/year from reserves to assist in prevention work targeted at Medicaid recipients. Finally, the health department participated as a partner in securing the RWJF funded program "Healthy Living by Design" for the community. The grantee is a 501©(3) organization, Louisville Living By Design. The goal of these programs is to "create a new culture where physical activity and healthy nutrition is a community norm."

Miami-Dade County:
The health department convened and participates in a collaborative approach called the Consortium for Healthy Miami-Dade. The consortium is lead by volunteers from various community agencies, and addresses a variety of health improvement agendas.

Metro Nashville:
The health department participates as one of several organizations in a Mayor's health initiative, leveraging internal resources with those from the Mayor's Office and community partners to address priority health improvement activities.

New York City:
The City level leadership initiative, Take Care New York, is supported by health department expertise. The initiative has identified and is promoting 10 City-wide public health goals and leverages resources from a variety of sources.

Chicago:
The health department participates in a Mayor's initiative on West Nile virus, which results in leveraged resources which are applied to reduce risks. There has been good partnership development within and beyond city government to leverage limited resources

Finding 5: Creating "spin-off" organizations to take on activities that may not fit in governmental public health departments has resulted in increased resources being directed to public health.

Multnomah County:
The health department participated in the formation of a 501©(3) organization called OPAL (Organizing People-Activating Leaders, www.opalpdx.org) with a mission of supporting "ignored communities that fight against the oppression of pollution and social injustice." OPAL is now funded by a variety of local and national foundations and has a strong and sustainable board. OPAL is convening, in partnership with the health department, a Healthy Homes Summit May 17, bringing together people in housing, environmental issues, health, academia, and communities to identify housing policy changes needed to connect health and housing. These new resources would not have been available to the health department.

New York City:
The Fund for Public Health NYC was incorporated as a 501©(3) organization in 2002 with a specific charter to serve and support the NYC Health Department. The specific purposes were

1. To address problems associated with grant procurement and administration, the use of grant funds, and subcontracting. The processes related to grants, contracts and procurement internal to NYC government are very bureaucratic, requiring up to 10 months to authorize grants for example, rendering one year grants not worth going after.
2. To address the potential for generating resources from private donors and funders (corporations, foundations, individuals, etc.) that otherwise wouldn't be available because of perceptions that government
    a. should already be responsible for funding public health
    b. is not very accountable
    c. is inefficient
    d. does not provide a tax benefit for giving

The Fund received its first large grant to administer (preparedness) in 2003, operated under an "incubation" foundation on the West Coast until 2004, when the Fund became independent. (The Tides

Foundation, located on the West Coast, helps not-for-profits get started and begin operations.) The Fund is completely separated from the health department, and receives no funding from the city. Its board consists of people from the private sector.

The total annual expenditure of The Fund in support of the health department is approximately $16 million. The Fund is supported by indirect funding from the grants it administers AND from unrestricted funds received from annual fund raising efforts to cover infrastructure needs not covered by indirects.

The Fund has been of benefit to the health department by

- procuring and administering one year grants
- receiving private donations
- supporting grants to do activities the health department otherwise couldn't have done
- supporting partnerships with outside agencies that the bureaucracy would not have been able to support in timely ways
- seek funding from competitive grant opportunities

Finding 6: Alternative organizational structures can support the retention of various revenue streams.

Boston:
Because the health department is recognized under statute as an "Authority," the Boston Health Commission can collect fees and keep them for their operations, not turning unexpended revenues back at the end of the fiscal year.

Finding 7: Achieving cost savings represents another strategy to maximize use of resources.

Multnomah County:
An on-line system to test and license food inspectors saves significant staff time and expense while increasing convenience to users. The system has resulted in significant improvements in test scores and passage rates as well.

Finding 8: Greater transparency in budgeting can result in increased community support and increased revenues.

Multnomah County:
Priority-based budgeting is being used for six priority areas in the county. The health department's budget is divided into segments, each

of which addresses one of the priority areas. The budgeting process includes the identification of both output and outcome measures for each budget segment and results in what is called "a performance offer" during the budgeting process. After adoption of the budget, each measure is assessed regularly. In this way, citizens can understand what is being done and how the money is being spent. This has actually been helpful in increasing some of their funding.

Finding 9: In spite of creative revenue generation and budgeting approaches, most if not all metropolitan health departments are experiencing significant financial strains.

Miami-Dade County:
The health department expressed concern about funding limitations.

New York City:
Resources are inadequate to meet the needs.

Multnomah County:
The health department is in its 7th year of budget cuts. In 2003, one primary care clinic was closed because it was in major deficit due to Medicaid disenrollments. In 2007, the health department purchased a mobile medical clinic to reach out to the homeless. The unit has been overwhelmed with a range of demands including uninsured adults. The program ran a $400,000 deficit in 2007.

Lake County:
They have no formal caps on primary care services, but must stay within their budget, leading to service constraints near the end of the fiscal year.