

# Regionalization Update and Assessment Findings

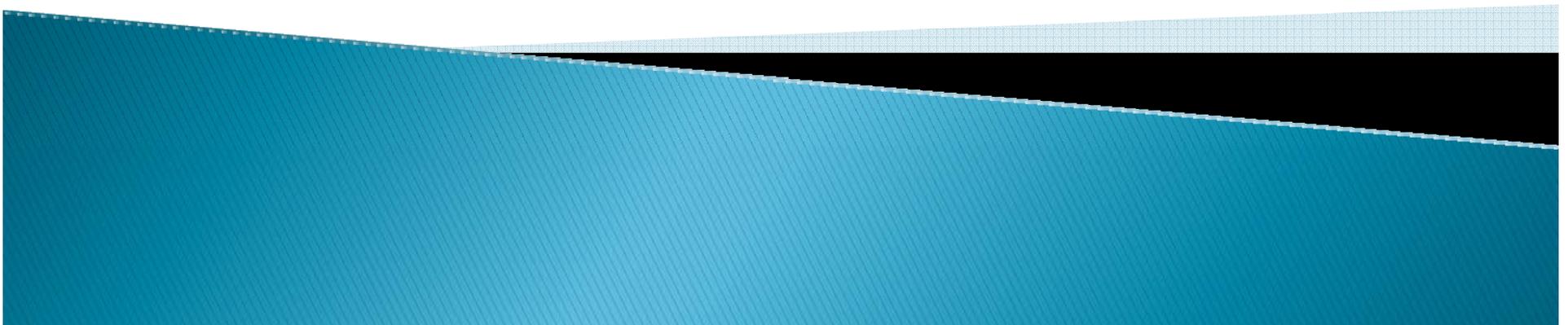
September 1, 2011

*This work was funded through the generosity of  
The New Hampshire Endowment for Health, and  
The Robert Wood Johnson Foundation*



# Welcome

José T. Montero, MD, Director  
NH Division of Public Health Services



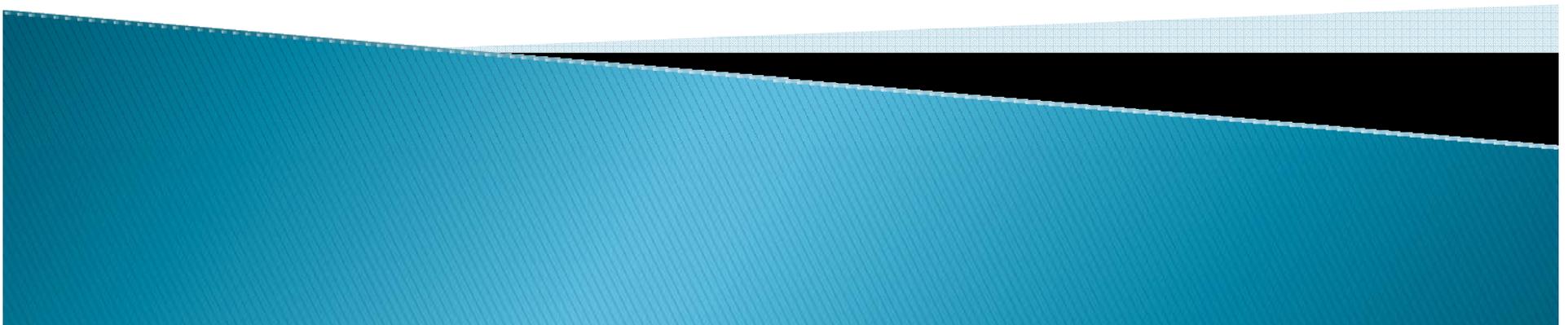
# NH Regionalization Background

Joan H. Ascheim, MSN  
Chief, Bureau of Public Health Systems,  
Policy and Performance, DPHS



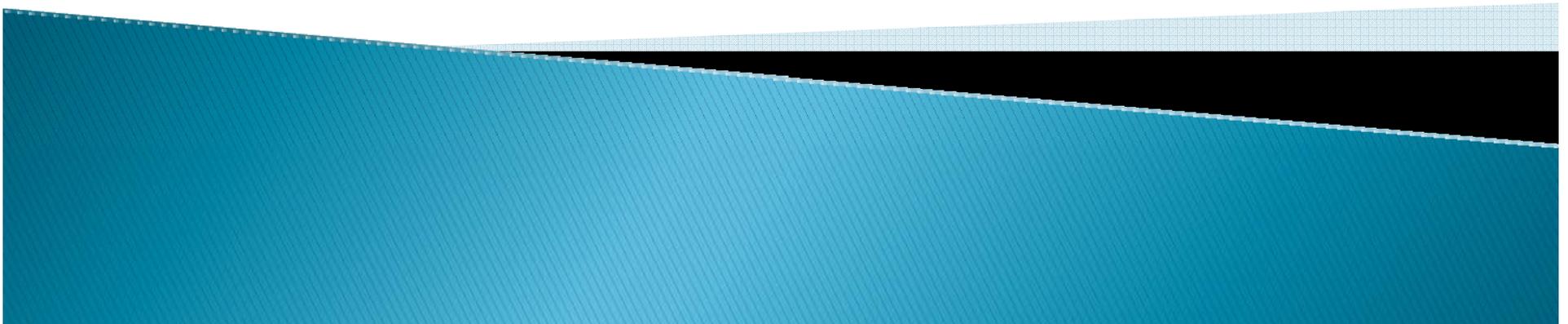
# Regionalization Background

- ▶ Building local public health began in 1997 with RWJF and Kellogg funds
- ▶ 2001 – 2005: Grew from 4 to 14 PHNs
- ▶ 2005– 2010: 19 All Health Hazard Regions for pandemic flu planning
- ▶ July 2010: 15 Public Health Regions



# Regionalization Background

- ▶ 2007 – PH Regionalization Initiative launched with convening of Task Force
- ▶ Consensus to develop infrastructure model to address all 10 Essential Svcs, with some remaining centralized at the DPHS (i.e lab, disease control)
- ▶ System based on national accreditation standards
- ▶ Linked to government through regional governing councils comprised of municipal/county officials and key PH partners with a designated “lead public health entity”
- ▶ Identified key regional staff positions





New Hampshire Department of Health and Human Services  
Division of Public Health Services



# Creating a Regional Public Health System in New Hampshire

**Goal – To develop a performance-based public health delivery system, which provides all 10 essential services throughout New Hampshire**

## What We Know Today

- There will be a new map of public health regions derived with stakeholder input.
- There will be a tiered system of public health including primary and comprehensive entities.
- These public health entities will deliver or assure the essential services based on national standards.
- Their capacity to do so will grow over time
- Public health entities will be linked to local/regional government
- Laws will be changed to provide proper statutory authority
- The state will continue to provide some local/regional services such as disease investigation

## How We Will Get There

**Finalize Regional Map**  
February 2010



**Assessments**  
June 2008– February 2010

- Financial analysis of all public health funding with consideration of efficiencies of regionalization
- Assessment of local/regional public health entities' capacity to deliver the 10 essential services with gaps analysis
- Assessment of what a local link to government might look like

**Develop a Plan**  
March 2010

Develop a comprehensive plan for regionalized public health in New Hampshire based on assessment findings

## What *Might* a Primary Public Health Entity Look Like?

### Core Staff

- Public Health Administrator
- Support Staff
- Nurse or Health Educator
- Environmental Health Specialist

### Shared Multi-Regional Staff

- Epidemiologist
- Emergency Preparedness Coordinator
- Medical Consultant

**Coordinate with local health officers**

**House State food inspector for the region**

**Work under the auspices of a governmental public health council**

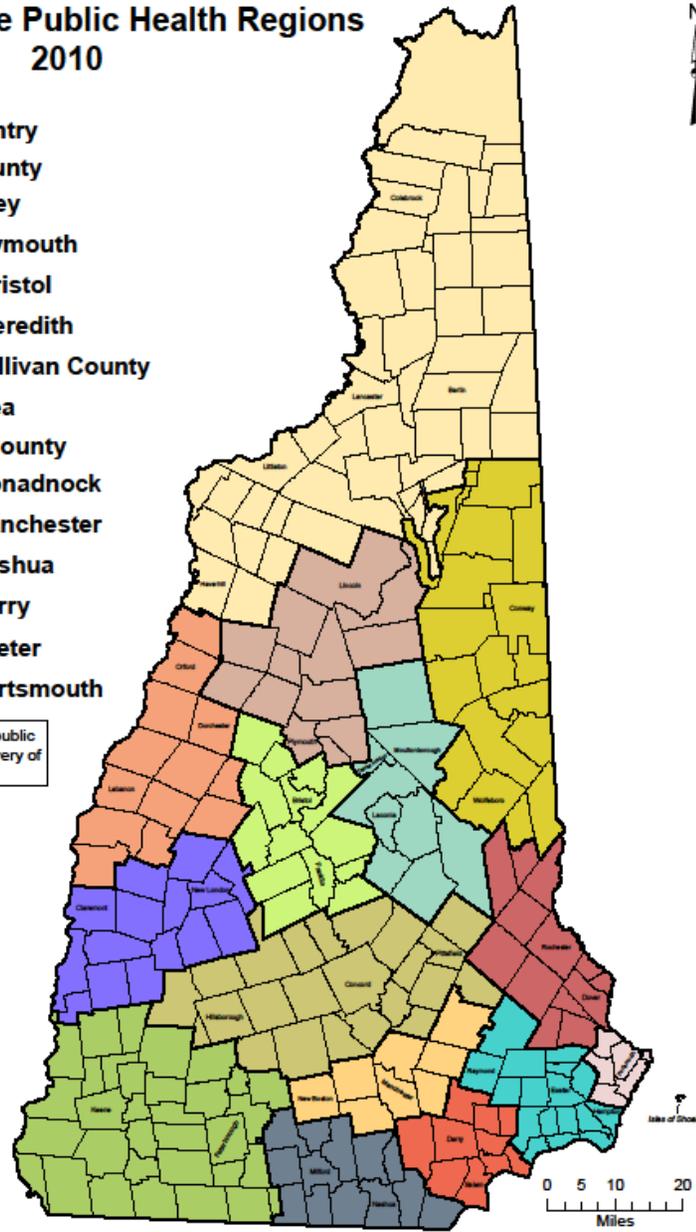
**Provide or assure for provision of the essential services possibly starting with a subset**

**Coordinate with the State on some services such as disease investigation**

# New Hampshire Public Health Regions 2010

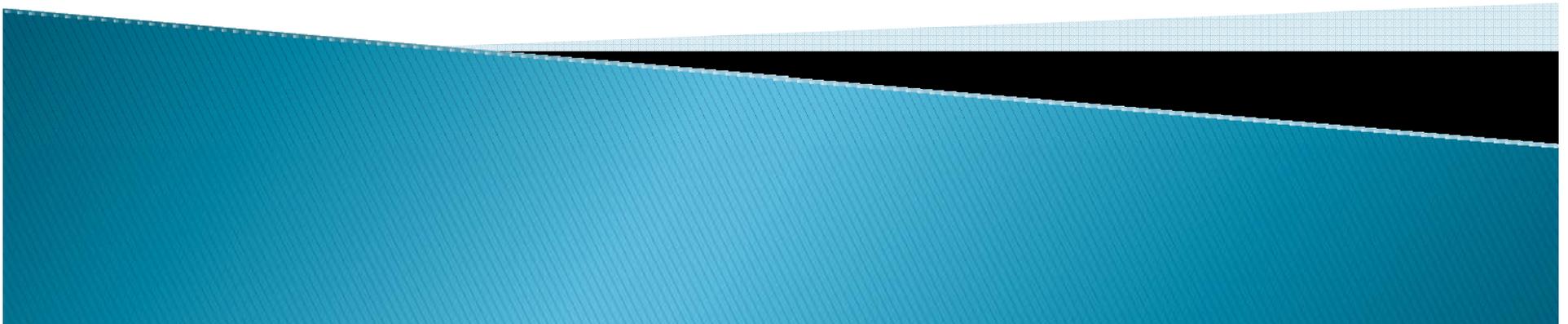
- North Country
- Carroll County
- Upper Valley
- Greater Plymouth
- Franklin/Bristol
- Laconia/Meredith
- Greater Sullivan County
- Capital Area
- Strafford County
- Greater Monadnock
- Greater Manchester
- Greater Nashua
- Greater Derry
- Greater Exeter
- Greater Portsmouth

These regions are used for public health planning and the delivery of select public health services



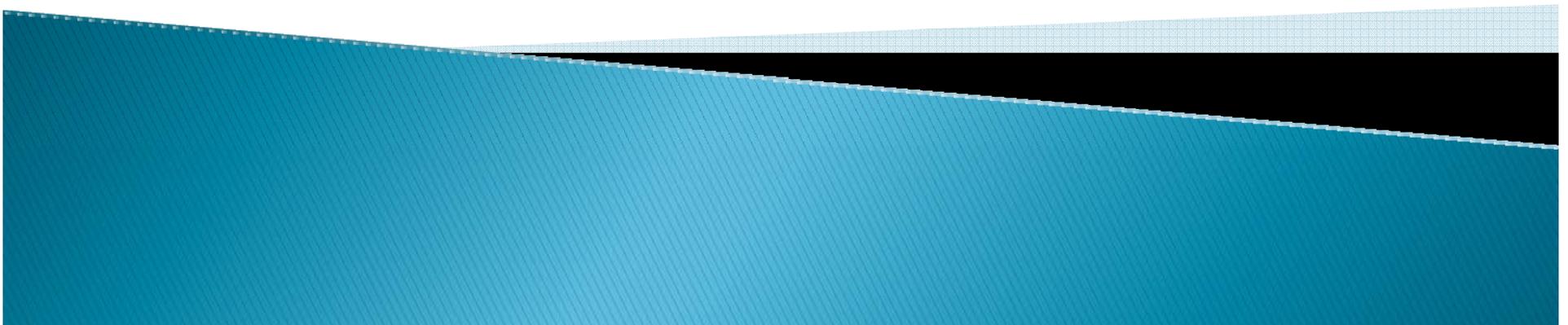
# Public Health Regions vs Public Health Networks

- ▶ Public Health Region is a geographic service area
- ▶ Public Health Network refers to the partnership of local agencies, government entities, and other stakeholders
- ▶ Lead Public Health Entity is the agency with which DPHS contracts to carry out the work of public health in the network for the whole region. Most focused on emergency preparedness.



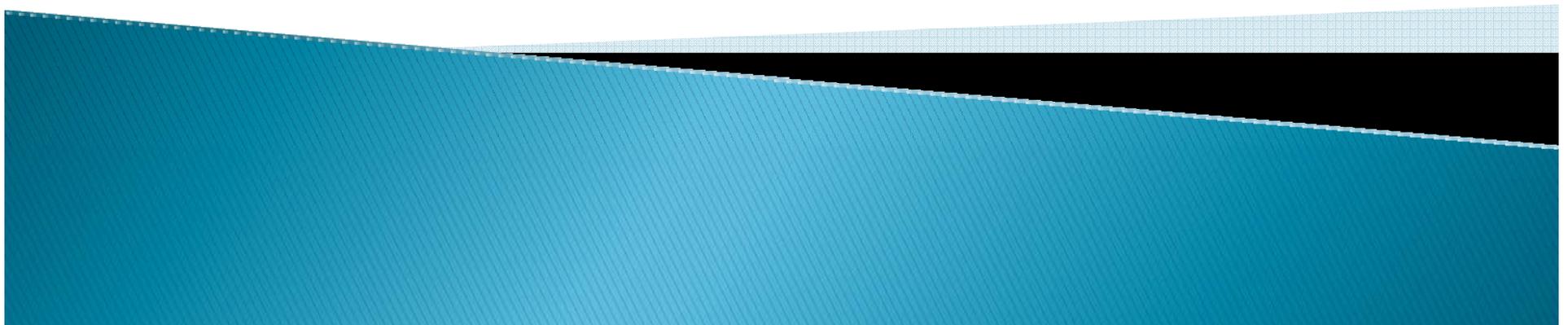
# What are we trying to accomplish through regionalization?

- ▶ We want to build on the infrastructure of the public health networks currently working primarily on emergency preparedness – so that they can expand to other public health services with an eye towards public health accreditation.



# Potential Benefits of Regionalization

- ▶ A coordinated public health infrastructure upon which to build.
- ▶ More efficient use of resources.
- ▶ Better positioning for increasingly competitive federal funds.
- ▶ Ability to measure ourselves against national standards.
- ▶ Communication and knowledge sharing among local health officers and regions.



# Approach

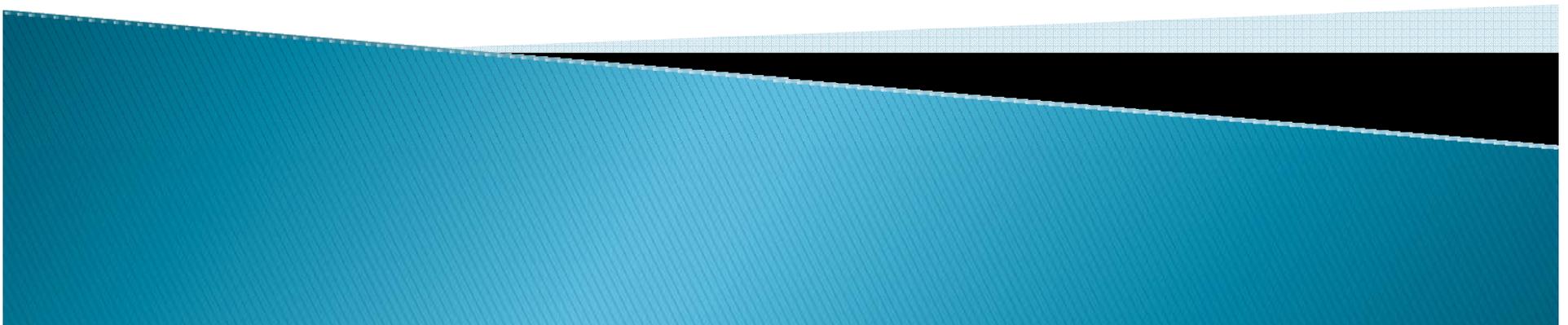
## Assessments to Help Us Determine, Resources, Costs, Needs and Approach

June 2008– March 2010

- ▶ Assessment of local/regional public health system capacity to deliver the 10 essential services– with a gaps analysis – Lea LaFave, CHI
- ▶ Assessment of what the link to government could look like. Gain input from public health partners on the ground– Jennifer Wierwille Norton
- ▶ Financial analysis of all state/local/private public health funding with consideration of efficiencies from regionalization – Patrick Bernet, FAU

# Capacity Assessment

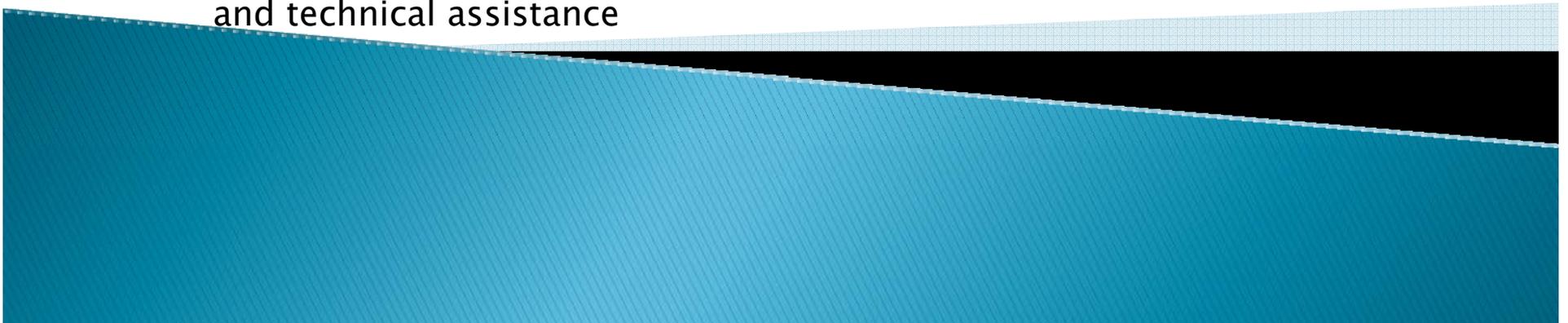
Lea Ayers LaFave, PhD  
Community Health Institute



# Capacity Assessment: Purpose

**T**o identify regional assets and determine gaps that may be addressed through regionalization.

- ▶ **Overall Goal:** A performance-based public health delivery system, which provides all 10 essential public health services throughout New Hampshire
  
- ▶ **A Primary Public Health Entity...**
  - Capacity, expertise and leadership to assure a fundamental public health presence
  - Performs some level of each of the 10 essential services
  - Collaborates extensively with systems partners in the region
  - The State DPHS provides complementary core services to these regions and technical assistance



# Capacity Assessment: Method

	No Capacity	Minimal Capacity	Moderate Capacity	Significant Capacity	Optimal Capacity
Score	0	1	2	3	4
Capacity (Planning, Staffing, Resources)	None	Minimal	Moderate	Significant	Significant
Activity (when applicable)	None	None	Minimal	Moderate	Significant
Supporting Documentation	No documentation available		If asked to produce documentation, you could produce it.		

# Capacity Assessment: Findings

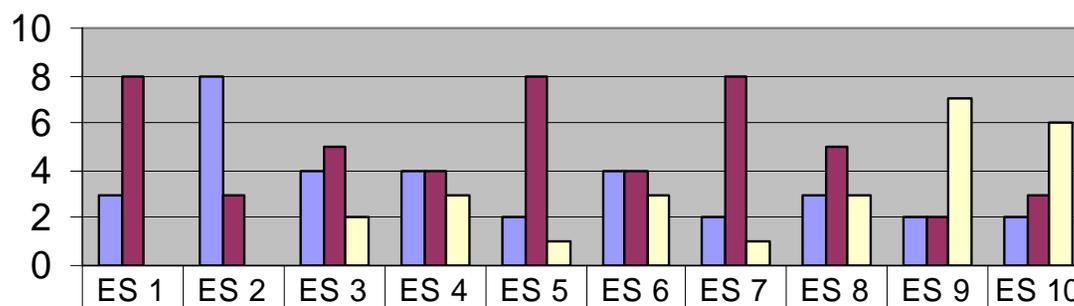
Ranking of Aggregate Public Health Capacity Scores by Essential Service (n=12)

Capacity Ranking	ES	Description	Aggregate Mean Capacity Score	Range	SD
1	ES 7	Link People to Needed Services	2.75	1.0-3.8	0.92
2	ES 3	Inform and Educate	2.55	1.0-3.2	0.41
3	ES 2	Diagnose and Investigate	2.42	1.6-2.9	0.38
4	ES 4	Mobilize Communities	2.24	1.1-3.4	0.7
5	ES 1	Monitor Health Status	2.06	1.1-2.6	0.59
6	ES 9	Evaluate and Improve	2.05	1.0-3.0	0.49
7	ES 8	Assure a Competent Workforce	2.00	0.2-3.0	0.87
8	ES 5	Develop Policies and Plans	1.90	1.2-3.1	0.59
9	ES 10	Research	1.86	0.0-3.0	0.93
10	ES 6	Enforce Public Health Laws	1.62	0.3-2.8	0.70

# Capacity Assessment: Findings

State Contribution to Regional Capacity (n=11)

Number of Regions Responding



	ES 1	ES 2	ES 3	ES 4	ES 5	ES 6	ES 7	ES 8	ES 9	ES 10
■ Sufficient	3	8	4	4	2	4	2	3	2	2
■ Insufficient	8	3	5	4	8	4	8	5	2	3
■ Insufficient Information to Score	0	0	2	3	1	3	1	3	7	6

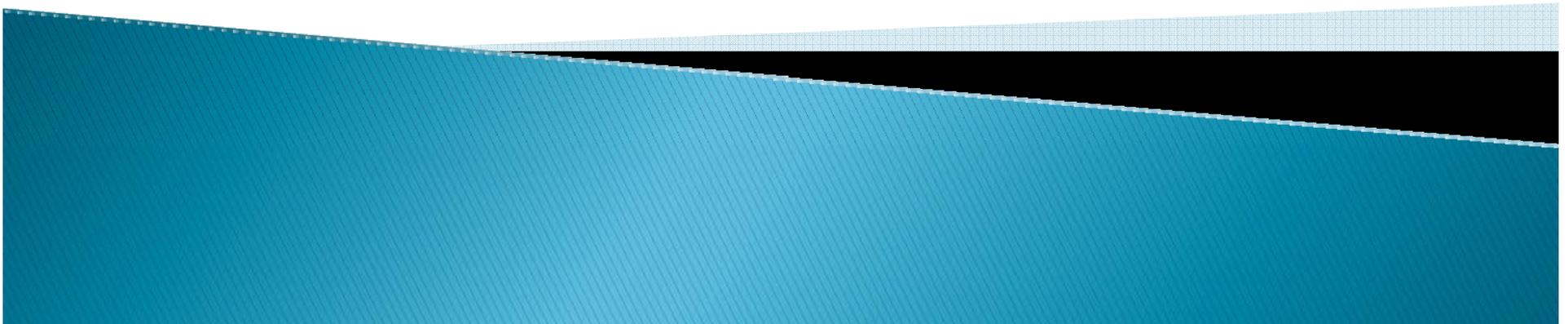
Essential Service

# Capacity Assessment: Learning

- ▶ Greater capacity in regions with more longstanding PH network entities and those that address broader PH issues beyond preparedness
- ▶ Partners perceive benefits from a regional system that coordinates across issues, agencies and essential services
- ▶ Regions benefit from coordinated health assessments and planning; could use state support
- ▶ Need to improve:
  - Partnerships beyond PHEP
  - Workforce capacity
  - QI
  - Evaluation
  - Coordination

# Governance Assessment

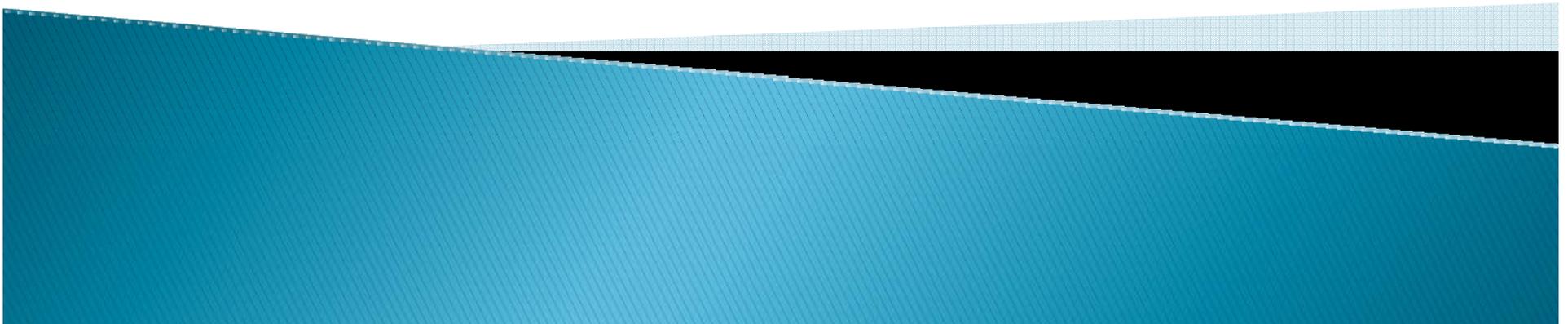
Kate Frey, Legislative Liaison, DPHS  
Jennifer Wierwille Norton, Consultant



# Purpose of Governance Assessment

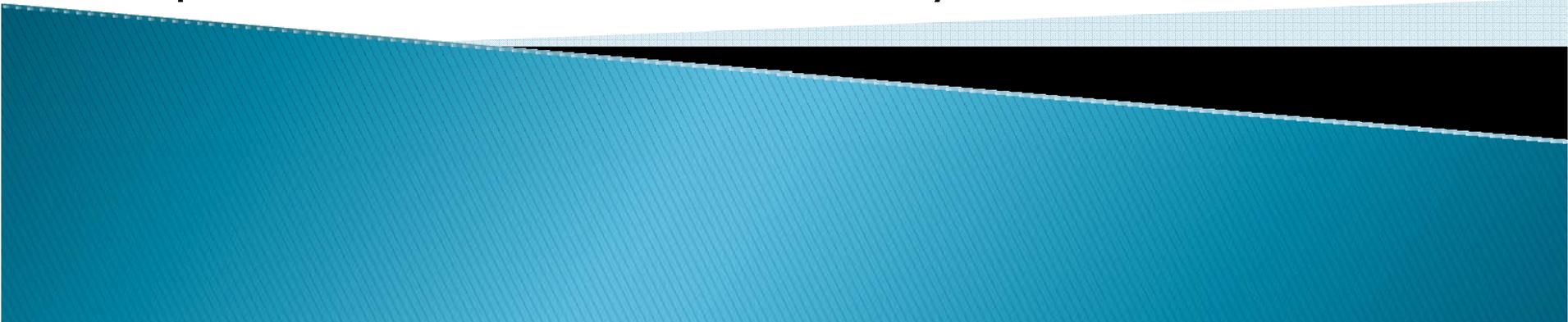
## Goal:

- ▶ To gain an understanding of what the governing structure will look like as the state develops public health regions.
- ▶ To educate communities about the role government plays in public health. (assessment, policy development, assurance)
- ▶ To use what we've learned from assessments to propose necessary statute changes to support regional efforts.



# Governance Assessment: Understanding the Context

Focuses on figuring out:

- ▶ Who's responsible or held accountable?;
  - ▶ Who's overseeing performance of the public health entities and who are partners?;
  - ▶ Who's assessing the degree to which the partners in the region have the necessary authority, resources and policies to provide essential public health services?;
  - ▶ Assures that the infrastructure exists to protect and promote health in the community.
- 

# How Would Regionalization Work in NH? *(As originally proposed)*

1. *Public Health Region* is established
2. *Public Health Council* is established and serves as the governing body. Members include: municipalities within the region, county government, nongovernmental organizations
3. The *public health council* designates a *lead public health entity* for the region:
  - Municipality
  - County
  - Existing private, non-profit
  - New private, non-profit for this specific purpose
  - *Another model created by the region?*

# Governance Tool - 2 Parts:

## Part I: Examining Readiness to Serve in a Governance Function

- ▶ The first part of the assessment provides a tool to measure the region's readiness to serve as governing body or Public Health Council to oversee the delivery of services and programs.

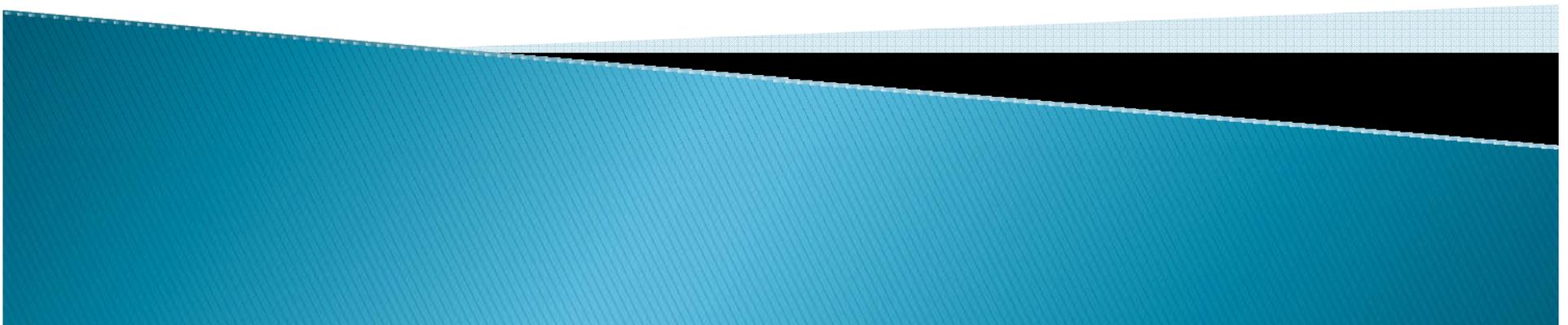
## Part II: Examining Types of Lead Public Health Entities

- ▶ Participants use part II of the tool to hold a facilitated discussion about the different options available for the region's Public Health Council to choose as a lead public health entity (type of entity).



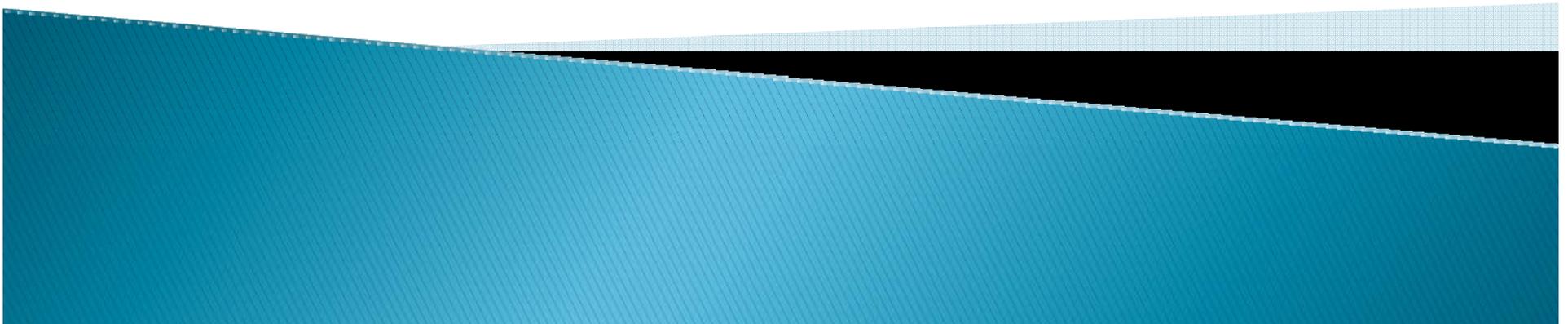
# Significant Findings

- ▶ Governance Assessment – Minimal capacity for oversight of:
  - Informing and educating the public
  - Enforcing laws and regulations
  - Evaluating the effectiveness of services
  - Assuring a competent workforce



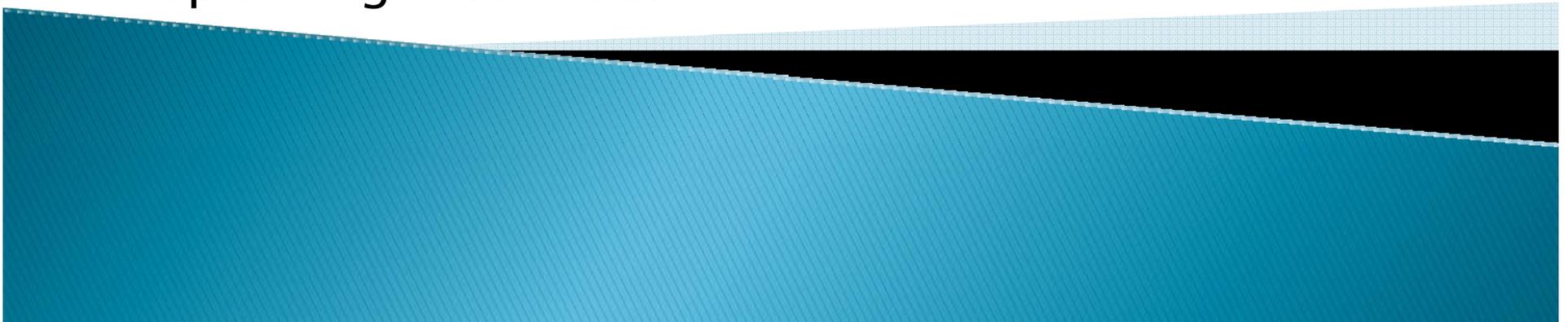
# Significant Findings

- ▶ Governance Assessment – Moderate to optimal capacity for oversight of:
  - Linking people to needed services
  - Developing policies and plans
  - Diagnosing and investigating health problems
  - Mobilizing community partnerships
  - Monitoring health status.



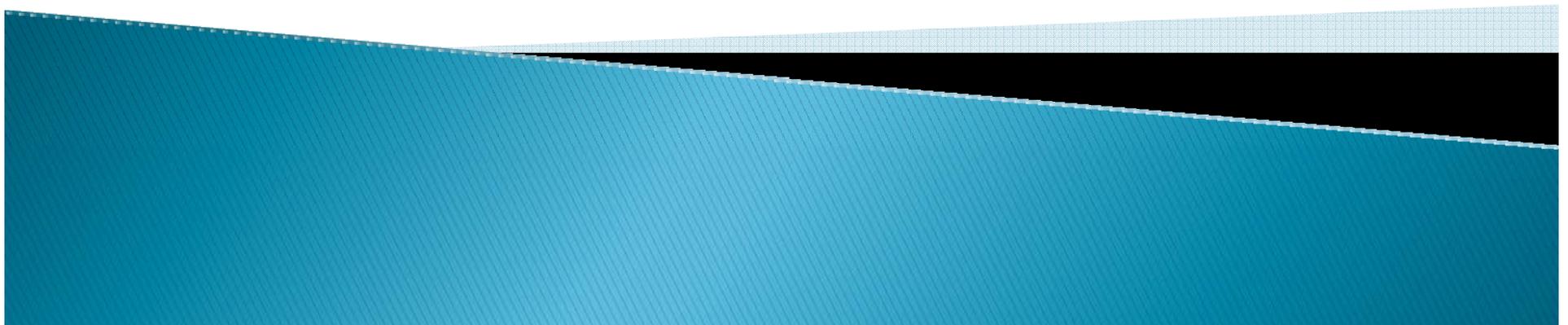
# Key themes and concerns

- ▶ One model may not work in NH
- ▶ Regional public health councils may not work
- ▶ Build on the base
- ▶ Towns benefit from regionalization
- ▶ Regionalizing can improve coordination
- ▶ Can strengthen role for health officers
- ▶ What about \$
- ▶ State's role
- ▶ Spanning 2 counties?



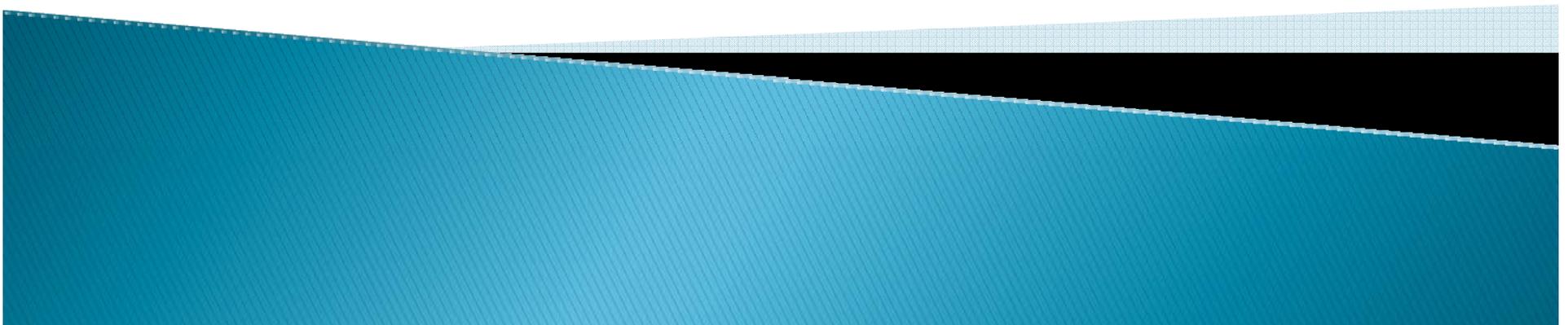
# Municipal Assessments

Neil Twitchell, Section Chief  
Community Health Development, DPHS

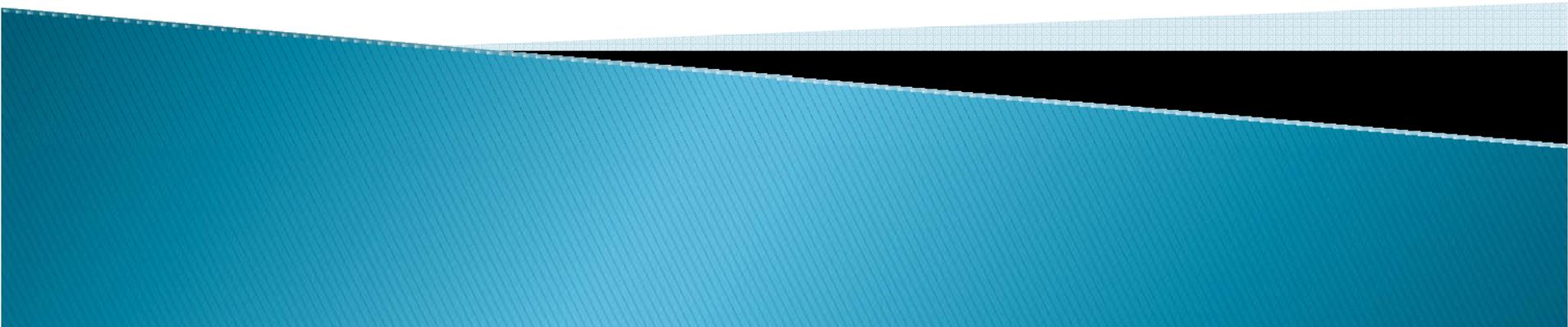


# Municipal Assessments-

- ▶ Manchester Health Department, Nashua Health Department, Berlin Health Department and Portsmouth Health Department
- ▶ Examined current capacity and capacity to provide public health services outside city limits

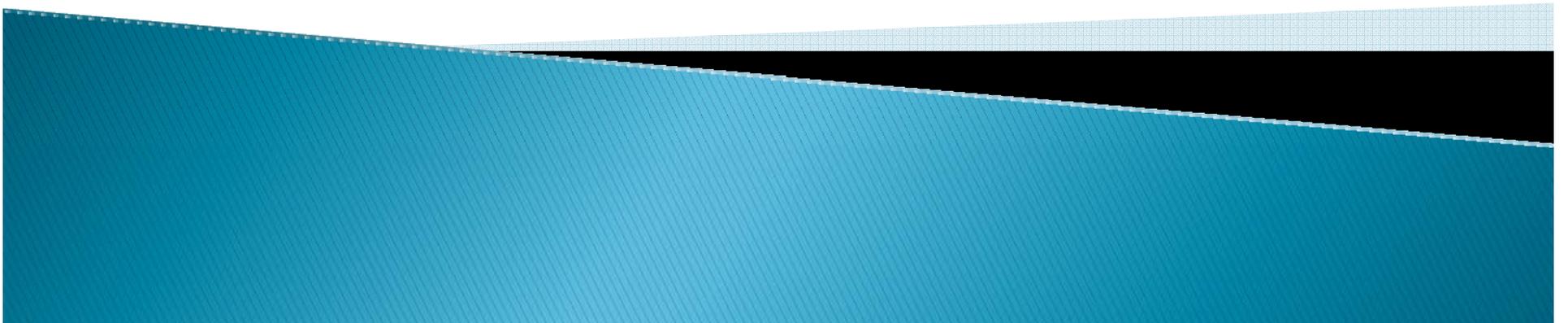


# Municipal Assessment Findings

- ▶ MHD and NHD interested in providing ph services beyond city limits with resources
  - ▶ Can provide services such as informing and educating, monitoring health status, health planning – without any legal changes
  - ▶ Enforcement of laws and provision of clinical services more problematic
  - ▶ Already provide TA to other towns
- 

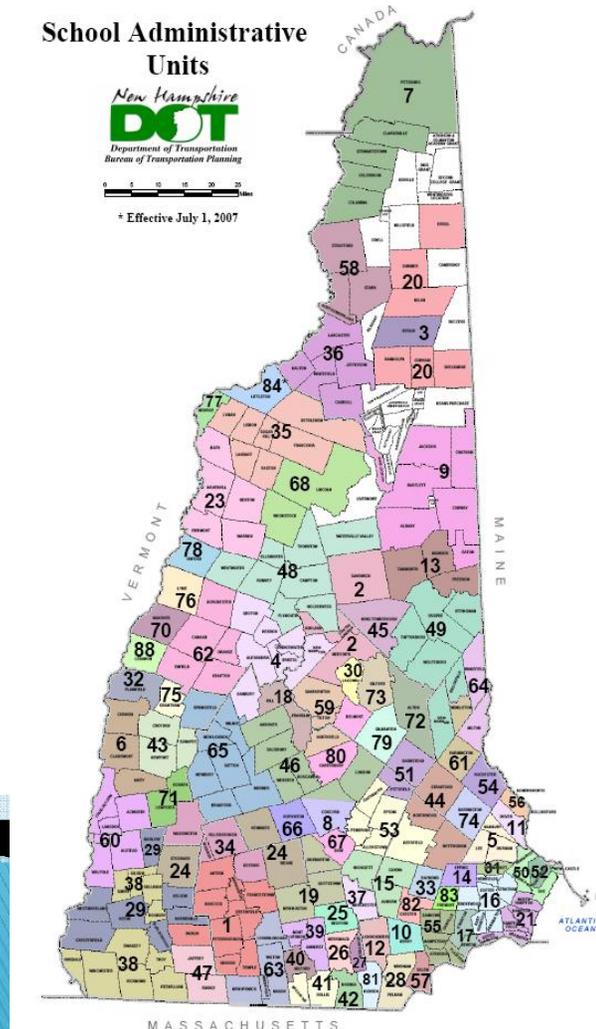
# Financial Assessment

Patrick M. Bernet, PhD  
Associate Professor  
Florida Atlantic University



# Data Sources

- ▶ This study takes advantage of a recently completed survey in New Hampshire.
- ▶ Quantifies spending through state and local agencies, and over 50 Partner providers.
- ▶ Data collection by New Hampshire Division of Public Health Services - Bureau of Public Health Systems, Policy & Performance.



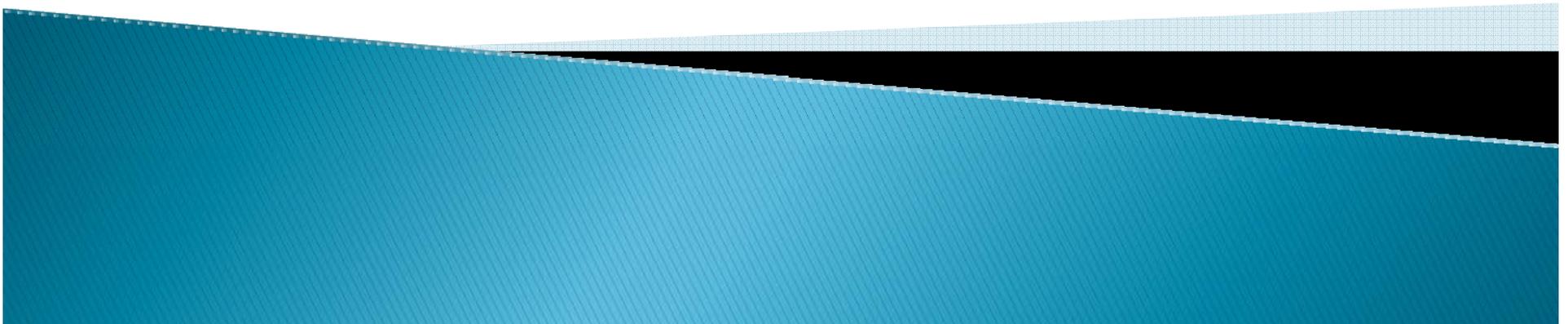
# Data Collection: State Spending

- ▶ State Contracts include public services provided by a broad range of public and private sector entities. These are funded using federal and state monies.
- ▶ State Resources include services provided by DPHS employees.

DIVISION OF PUBLIC HEALTH FINANCIAL ASSESSMENT			<u>TOWNS</u>			ALL	ACWORTH	ALBANY	ALEXANDRIA	ALLENSTOWN	ALSTEAD
CONTRACTS	ACTUAL EXPENDITURES IN SFY 2007		<u>PUBLIC HEALTH REGIONS</u>			STATEWIDE	Monadnock	Carroll County	Bristol / Franklin	Concord	Monadnock
SERVICE	CONTRACTOR	TOTAL	<u>SOURCE OF FUNDS</u>				927	719.8	1495.9	5236.5	2068.6
			Fed'l	Gen'l	Other						
Primary Care	Ammonoosuc Community Health Service	\$ 329,056	15%	85%							
Primary Care	Avis Goodwin in Community Health Center	\$ 455,994	15%	85%							
Primary Care	Concord Hospital	\$ 375,213	15%	85%					X		
Primary Care	Coos County Family Health Services	\$ 129,473	15%	85%							
Primary Care	Families First of the Greater Seacoast	\$ 196,550	11%	89%							
Primary Care	Health First Family Health Care	\$ 326,450	15%	85%				X			
Primary Care	Lamprey Health Care	\$ 545,350	14%	86%							

# Data Collection: Municipal Spending

- ▶ Expense information:
  - Health office salary and related expenses
  - Mosquito spraying
  - Restaurant inspections (if separate)
  - Immunization clinics and other screenings
  - Public health nurses and doctors
  - Board of Health expenses
  - Emergency Preparedness Planning
  - Other





# Spending by Source and Category - Amount

Service	Source				Total	Service % of total
	State Contract	State Resources	Municipal	Non-municipal		
Direct Services	10,035,454	0	0	11,354,489	21,389,943	46%
Emergency Preparedness	3,567,874	0	64,159	80,632	3,712,665	8%
Injury Prevention	286,128	0	0	363,696	649,824	1%
Tobacco Prevention	698,113	0	0	418,061	1,116,174	2%
Substance Abuse Prevention	2,624,972	0	0	799,941	3,424,913	7%
Preventing the Spread of Disease	234,452	1,573,752	1,031,705	19,997	2,859,906	6%
Promoting Healthy Behaviors	1,210,923	0	0	5,385,941	6,596,864	14%
Protecting Against Environmental Hazards	95,674	415,130	0	70,133	580,937	1%
Salaries / Administrations	0	0	4,301,286	0	4,301,286	9%
Other	0	0	657,349	997,062	1,654,411	4%
<b>Total</b>	<b>18,753,591</b>	<b>1,988,882</b>	<b>6,054,499</b>	<b>19,489,952</b>	<b>46,286,924</b>	
Source % of total	41%	4%	13%	42%		

- ▶ Direct services are supported roughly equally from State contract funds (\$10,035,454) and Partner funds (\$11,354,489).

# Spending by Source and Category - % of Total

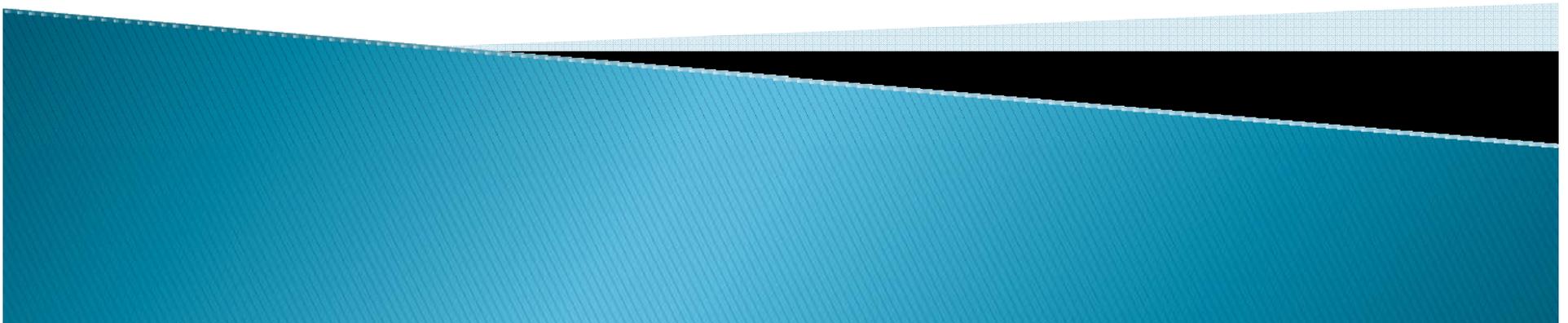
	Source				Total
	State Contract	State Resources	Municipal	Non-municipal	
Direct Services	54%	0%	0%	58%	46%
Emergency Preparedness	19%	0%	1%	0%	8%
Injury Prevention	2%	0%	0%	2%	1%
Tobacco Prevention	4%	0%	0%	2%	2%
Substance Abuse Prevention	14%	0%	0%	4%	7%
Preventing the Spread of Disease	1%	79%	17%	0%	6%
Promoting Healthy Behaviors	6%	0%	0%	28%	14%
Protecting Against Environmental Hazards	1%	21%	0%	0%	1%
Salaries / Administrations	0%	0%	71%	0%	9%
Other	0%	0%	11%	5%	4%

- ▶ State resources are spent entirely on preventing the spread of disease (79%) and protecting against environmental hazards (21%).
- ▶ Partner spending also goes to promote health behaviors (28%).

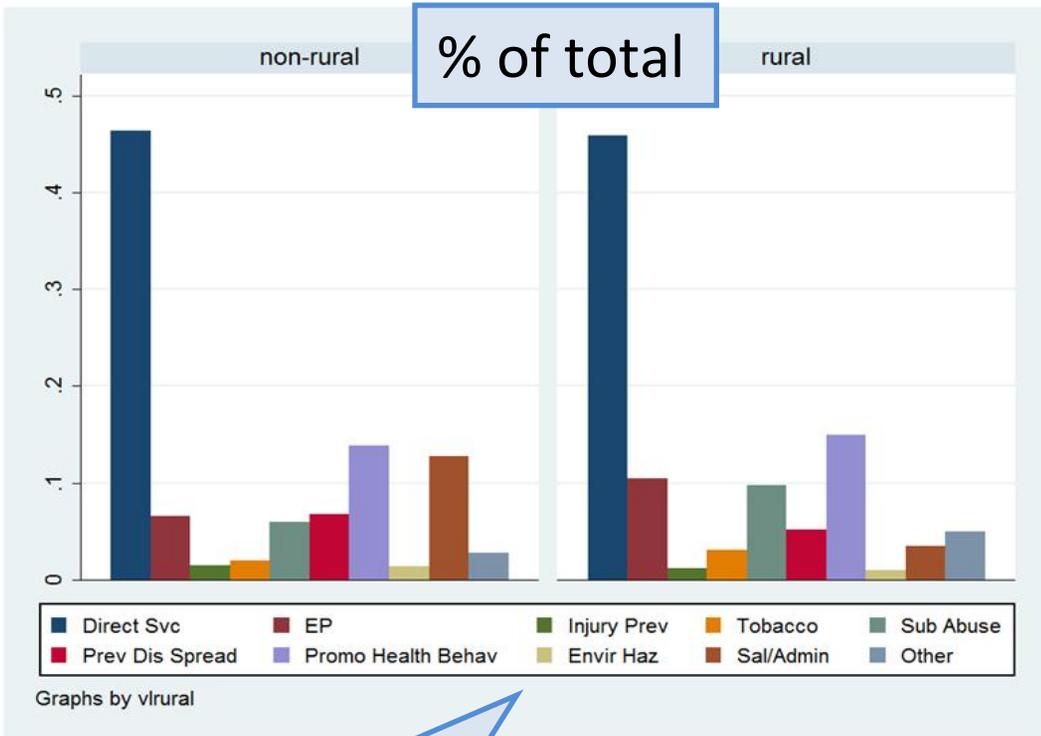
# Source of Partner Funds

	Amount	% of total
Federal	7,267,267	37%
Non-DPHS State	975,572	5%
Donations	2,375,470	12%
Private	2,765,227	14%
Other	6,106,415	31%
Total	19,489,951	

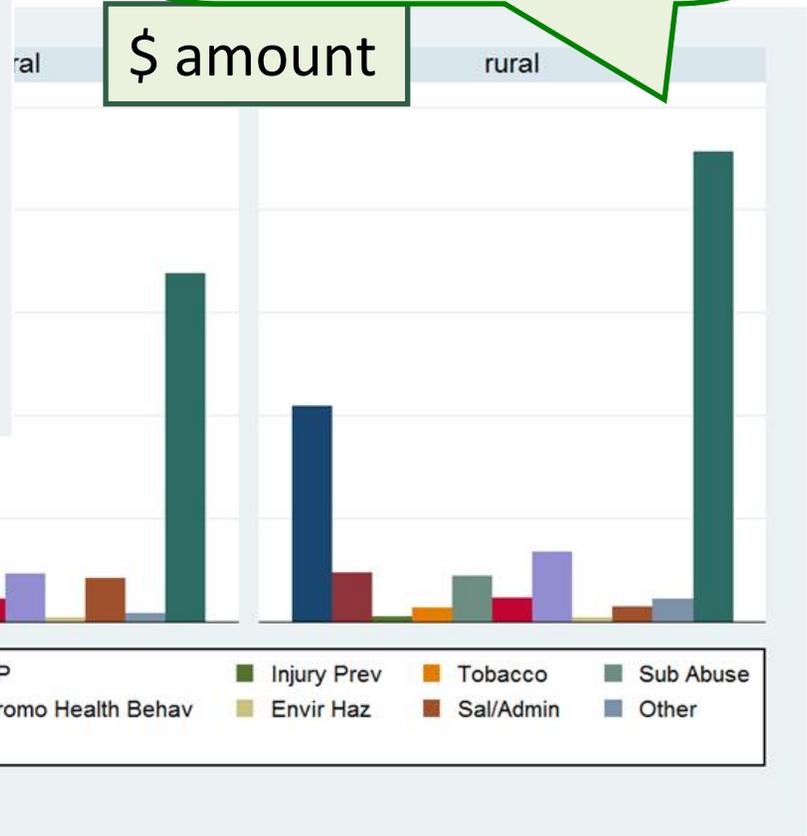
- ▶ Just 42 percent derived (indirectly) from government sources.



# Rural-Urban Differences

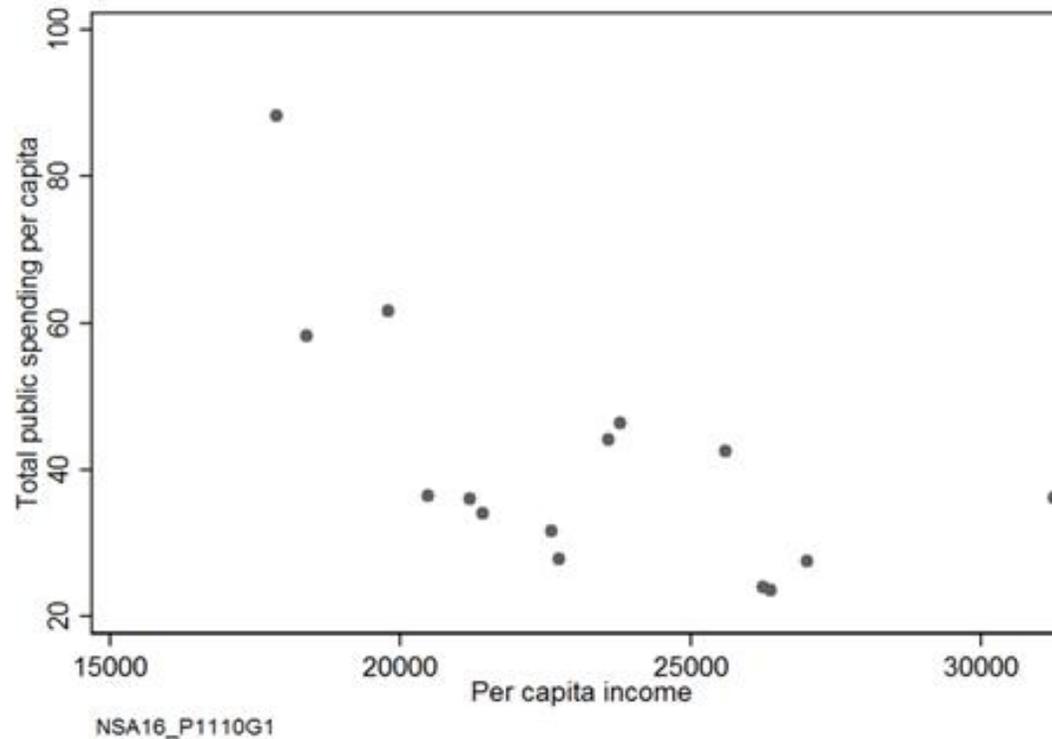


But higher costs.  
Rural areas are either spending more for the same service or getting more of all services.



Similar spending patterns (based on % of basket)

# Spending and Income



- ▶ Regions with higher incomes spend less per capita.

# Spending determinants

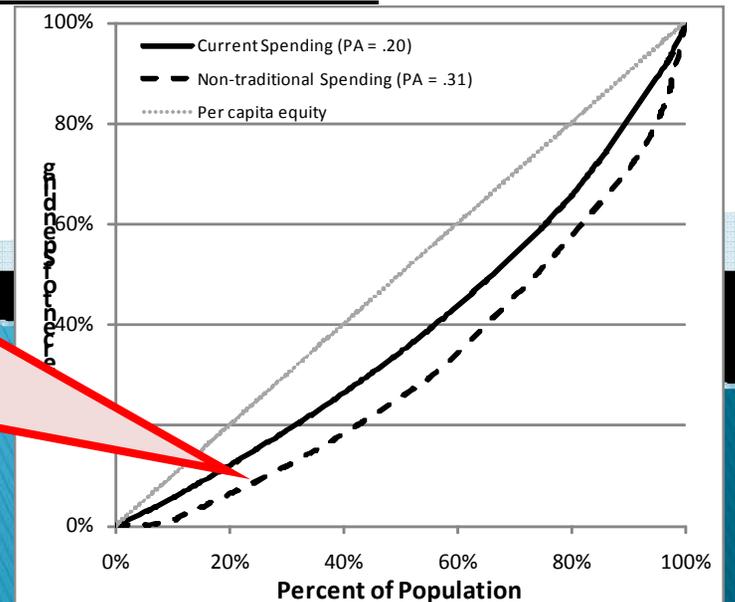
	State contract spending	State resource spending	Municipal spending	Partner spending	Total spending
Population (logged)	11,662	2,728 ***	-17,173 *	13,280	14,436
Black %	4,903,903 *	276,953 *	5,451,560	3,858,884	14,400,000
Hispanic %	2,723,961 **	-48,823	3,306,161 **	1,818,261	7,679,678 **
Female %	192,489	-13,359	271,754	279,087	508,603
Urban %	-27,021	5,648 *	-93,611	50,760	-68,044
Average Age	2,236	49	2,553	3,568 *	9,254 *
Education (average years)	-19,673 **	-819	-27,172 **	-37,290 **	-84,439 **
Poverty (200% FPL)	260,959 ***	10,664 *	198,372	127,314	597,321 *
Home value (1000s)	0.00038 ***	0.00002 **	0.00040 **	0.00032 **	0.00112 ***
Unemployment %	113,143	12,413	-30,410	252,900	453,741
Gini Index	171,056	8,056	69,258	162,584	481,436
Land area (logged)	7,890	1,726 **	-24,689 *	5,179	-13,697
Intercept	-160,507	-13,187	225,514	9,115	91,493
R-sq	0.77	0.79	0.55	0.55	0.67
N	234	234	234	237	234

# Funding Formula Analysis Tool

	Total traditional funds	All funds allocated per capita	Partner funds
Percent of total allocations moved from baseline	0%	16%	27%
Maximum increase	0%	173%	663%
Maximum decrease	0%	-88%	-99%
Senate support (# townships with over 20% increase)	0	104	85
Senate oppose (# townships with over 20% decrease)	0	73	99
House support (% population with over 20% increase)	0%	46%	31%
House oppose (% population with over 20% decrease)	0%	22%	52%
Per capita proportionality of allocations	20%	0%	31%
Poverty proportionality of allocations	18%	19%	32%

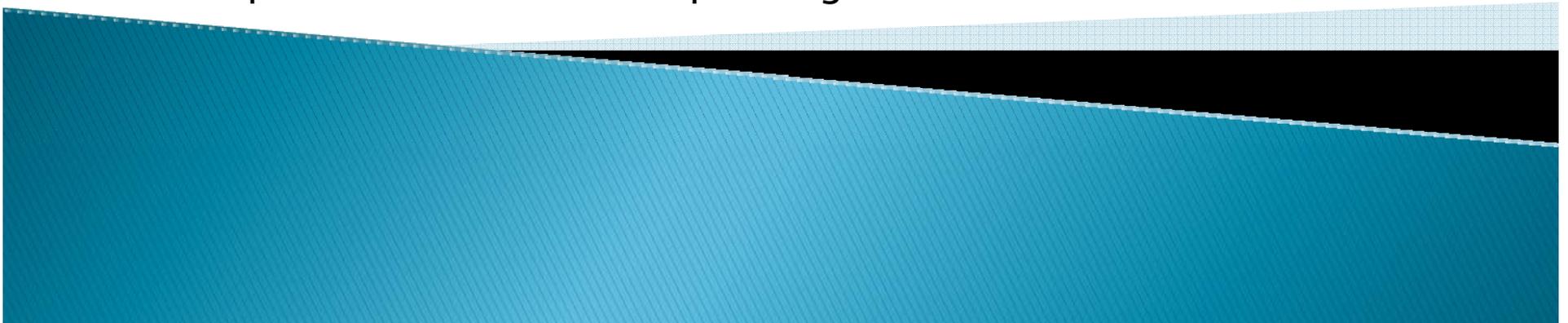
Partner funds allocated in a way that would be politically hard to pass.

Partner fund allocation is further from per capita equity (31%) than traditional funds (20%).

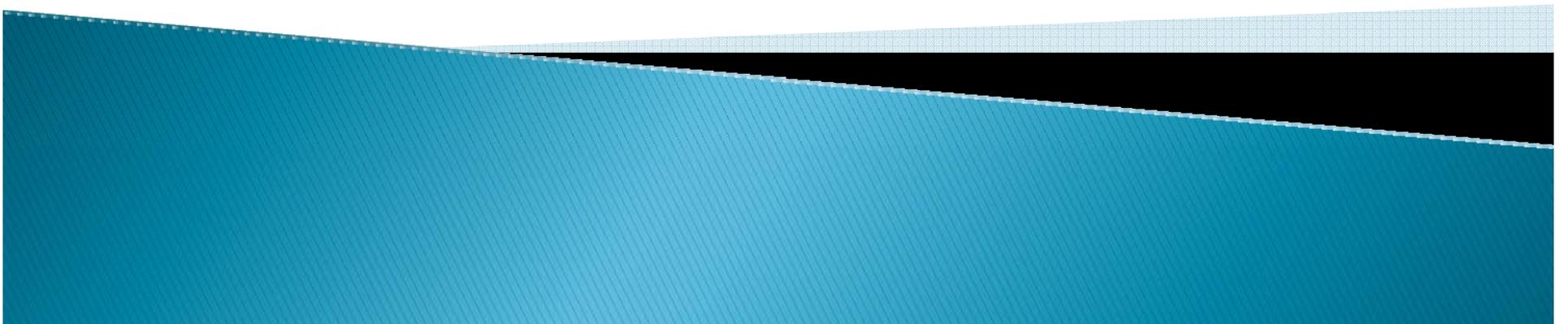


# Conclusion

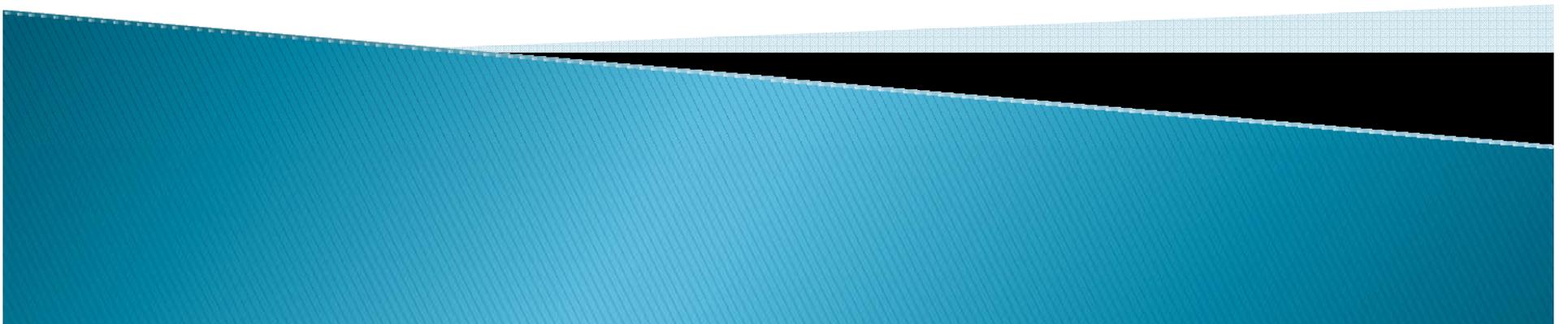
- ▶ Partner is the largest single source of public health spending in New Hampshire.
- ▶ Partner spending focuses on direct provision of care and promoting healthy behaviors.
- ▶ Only one-third of Partner spending is funded through government channels.
- ▶ Rural and urban areas have similar service baskets based on proportions, but rural areas either use more of everything or pay more per unit.
- ▶ More is spent in poorer areas.
- ▶ Spending (all sources) determinants include population, urbanization, income, home value, and land area.
- ▶ Partner funds are allocated in a way that might be politically difficult.
- ▶ Future study
  - Link health outcomes to Partner spending.
  - Explore determinants of spending mix.



# Questions and Feedback



**Break – 15 minutes**



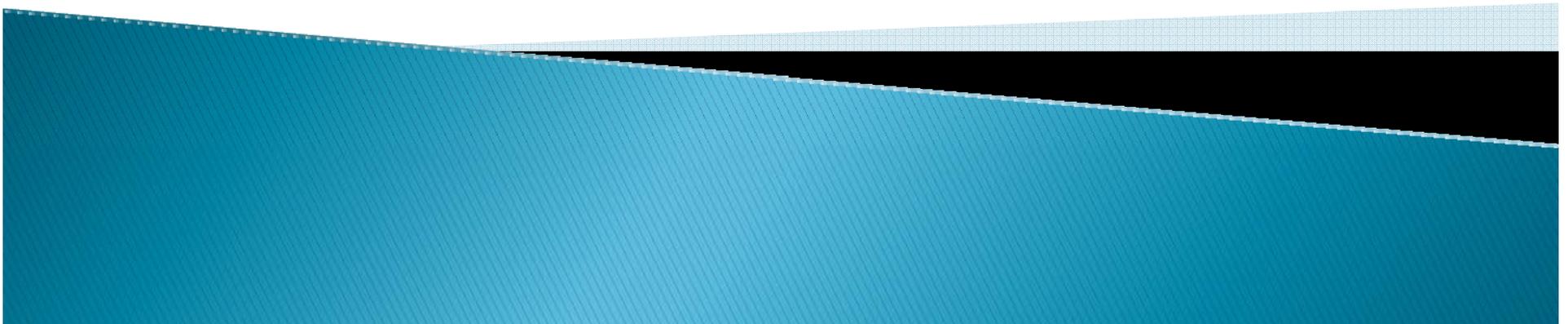
# Regionalization in NH- *Two Local Perspectives*

Yvonne Goldsberry, PhD

Greater Monadnock Public Health Network

Lisa Morris, MSW

Lakes Region Partnership for Public Health

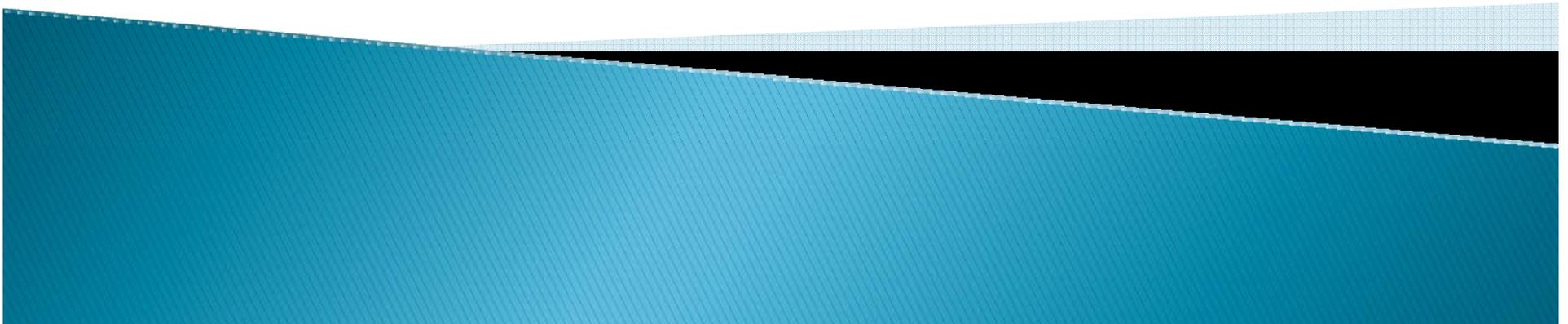


# Greater Monadnock Public Health Network (GMPHN) Regionalization Initiative

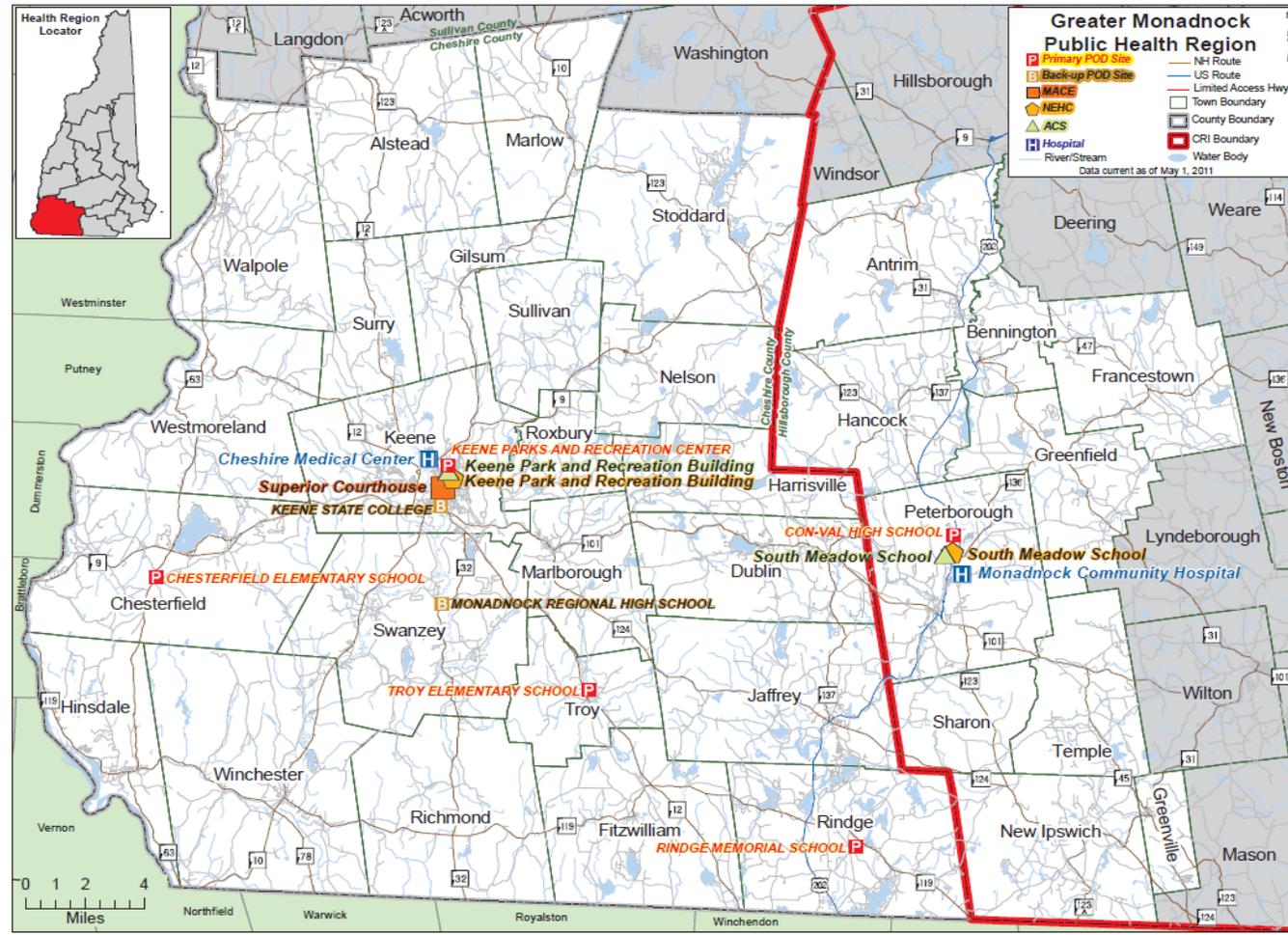


# The Challenge

- ▶ Identify the most appropriate “region”
- ▶ Build on existing capacity
- ▶ Link to local government



# Profile of the Region



▶ Monadnock Region population: ~100,000

▶ 31 towns and two small cities (Keene; Peterborough)

▶ Spans Cheshire County; part of Hillsboro County

# Existing Public Health Capacity

- ▶ GMPHN expanded to region in 2009
- ▶ Two “paid” and 31 volunteer health officers
- ▶ NHDHHS public health nurse
- ▶ Support from NHDHHS, NHDES, and NHDOS
- ▶ Growing Medical Reserve Corps

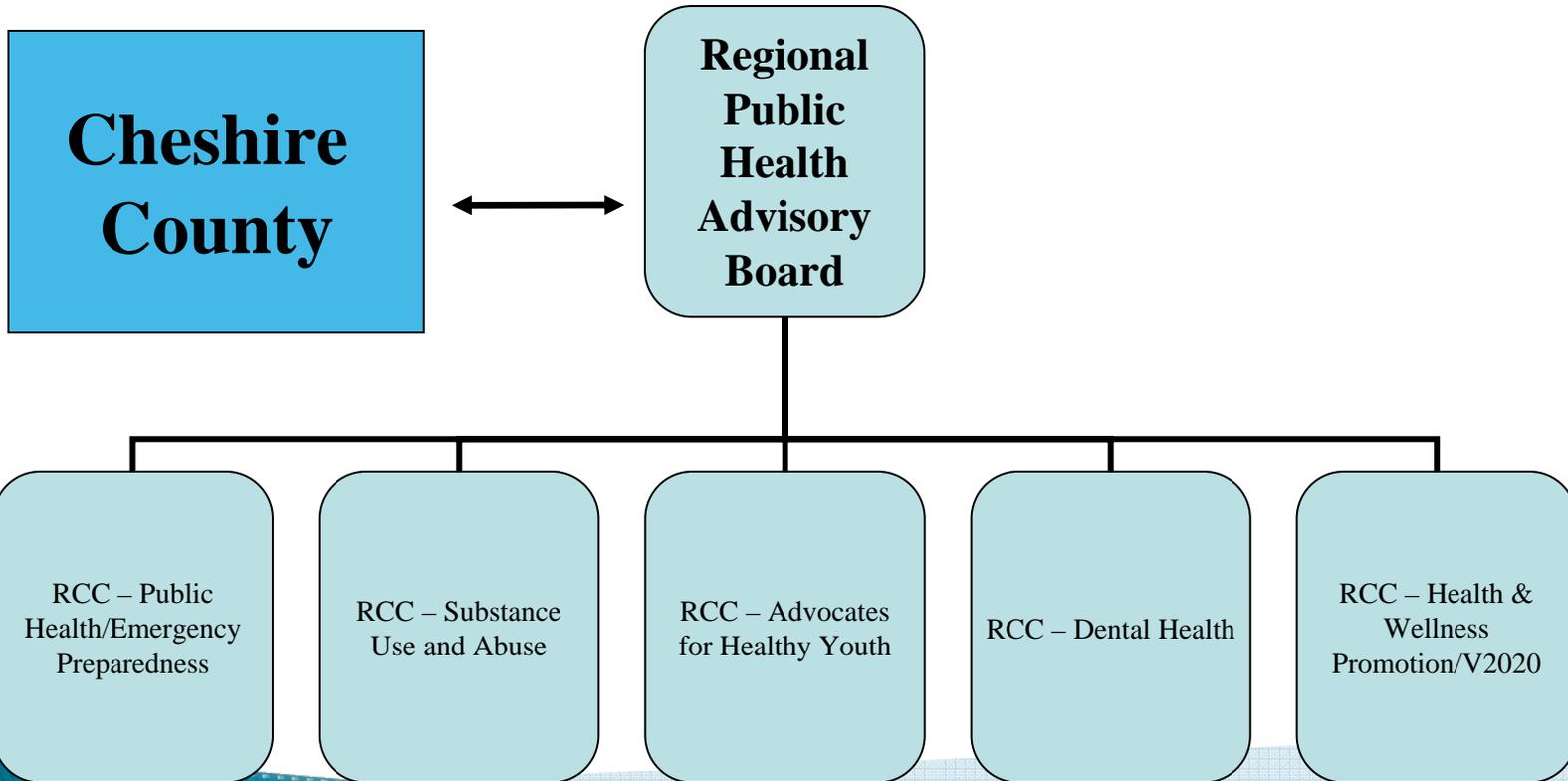


# Existing Public Health Capacity

- ▶ Two community hospitals
- ▶ Strong non-profits for core services
- ▶ Colleges and Universities
- ▶ Broad-based community health coalition (Council for a Healthier Community)

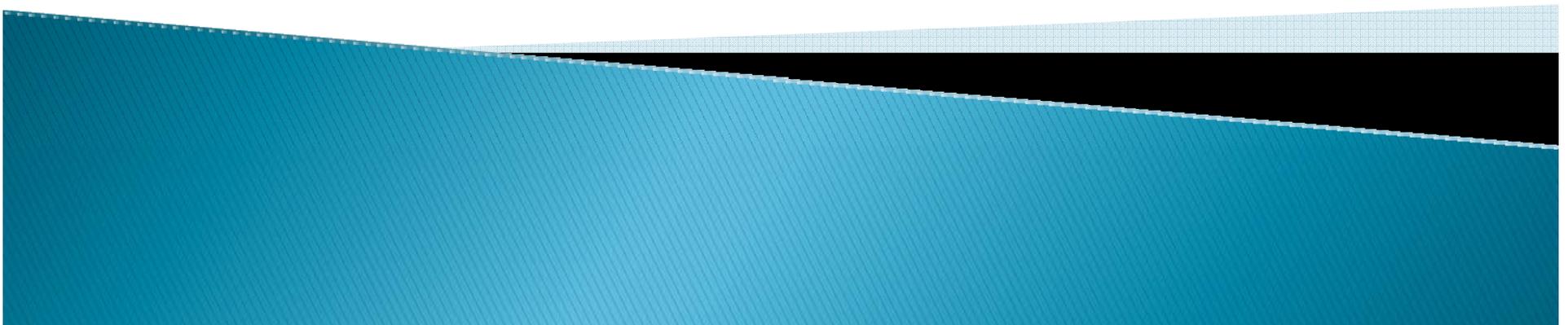


# Proposed Structure for Regionalization



# Underlying Assumptions

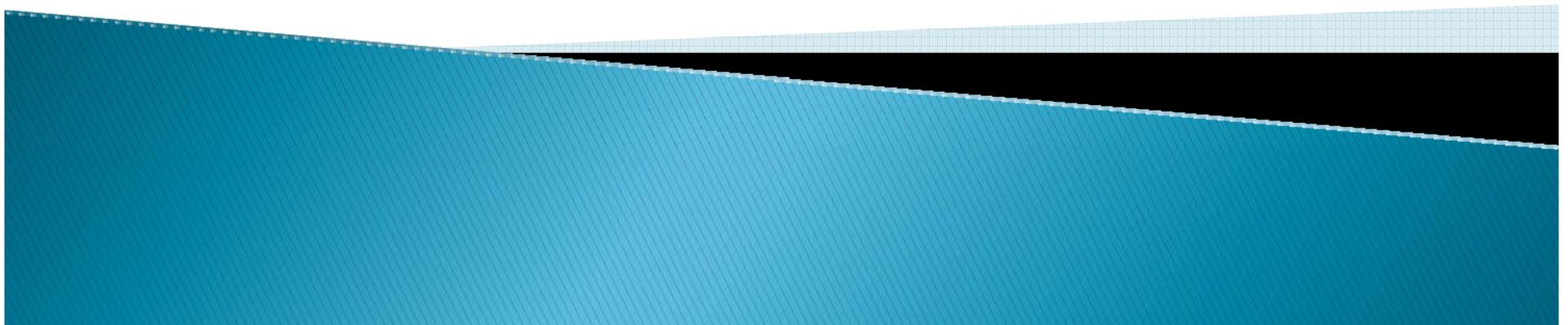
- ▶ The work of the Regional Health Advisory Board is advisory in nature
- ▶ Membership will be a broad-based representation of the Greater Monadnock region, not limited to public health service providers



# RHAB Membership

- ▶ Stakeholder and geographic balance

- City/town representatives
- Law enforcement
- Healthcare industry
- Business community
- Public school district
- Faith-based community
- County government
- Social service/non-profit organizations
- Colleges/universities



# RHAB Responsibilities

- ▶ Help identify and encourage action planning to ensure community public health needs are met without unnecessary duplication.
- ▶ Coordinate the needs assessments and data collection activities for the region.
- ▶ Advise and make recommendations, as appropriate, to Cheshire County Commission on funding opportunities.
- ▶ Make recommendations within the Greater Monadnock region and to the state regarding priorities for service delivery based on needs assessments and data collection.



# Ongoing Challenges

- ▶ Expand membership of the RHAB
- ▶ Enhance dedicated financial resources
- ▶ Clarify role of current partner organizations
- ▶ Formalize link to County

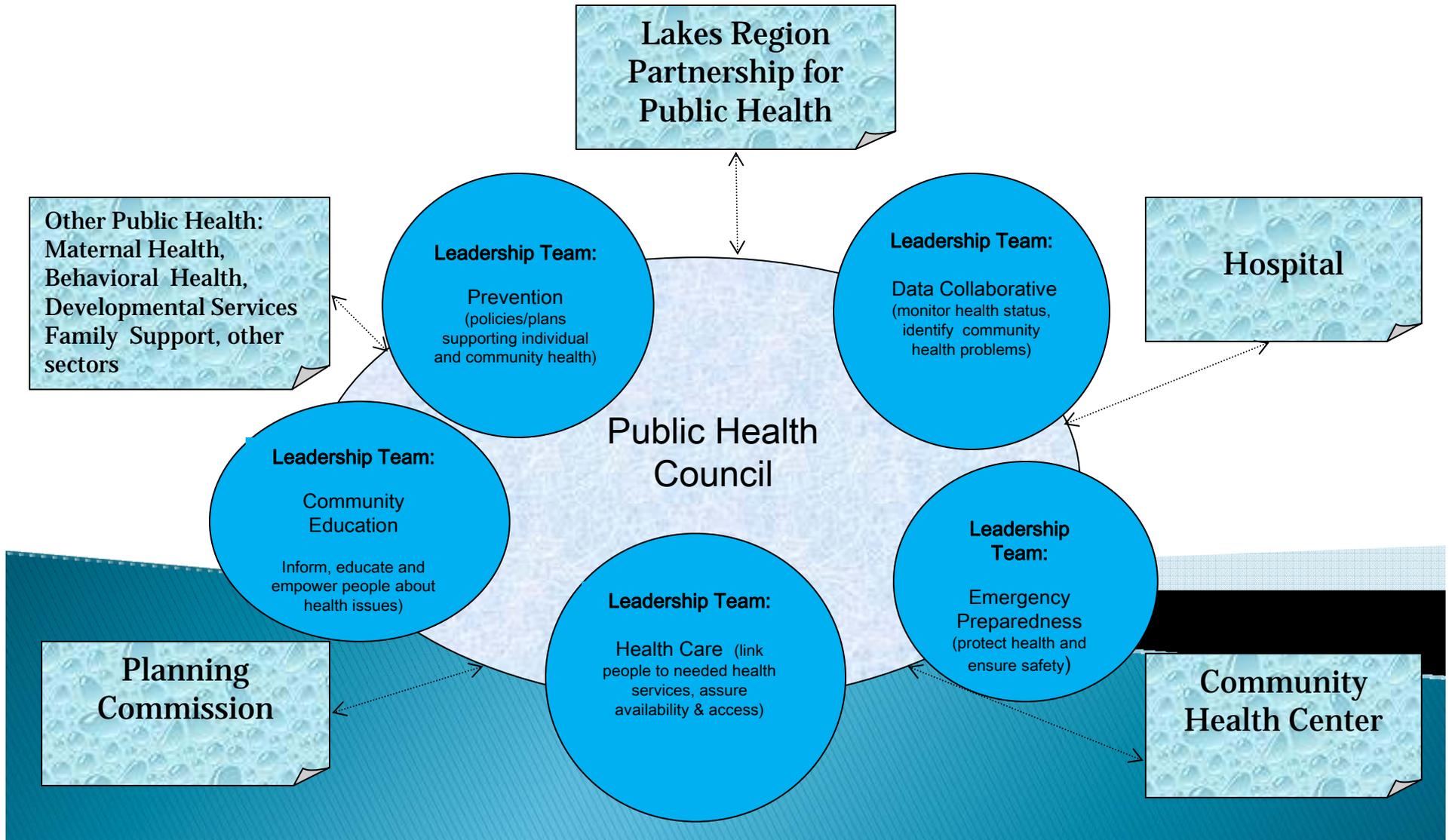


# Thank You



Yvonne Goldsberry, PhD, MPH  
Senior Director Community Health Cheshire Medical Center  
/Dartmouth Hitchcock Keene  
[ygoldsberry@cheshire-med.com](mailto:ygoldsberry@cheshire-med.com)

# Lakes Region Partnership for Public Health Community Engagement Model



# ***Organizational Roles and Responsibilities***

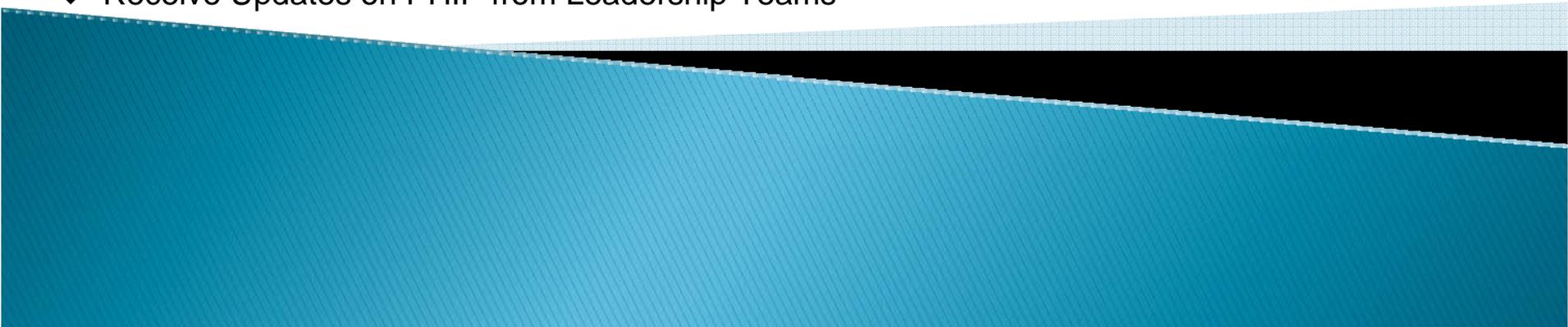
## *LRPPH/OTHER AGENCIES Board of Directors*

Has governance authority and holds liability

## *Public Health Council (Advisory)*

*Membership:* Representatives/community leaders from sectors: government, health and human service organizations, school, law enforcement, faith, business, citizen, civic, emergency management, other

## *Responsibility*

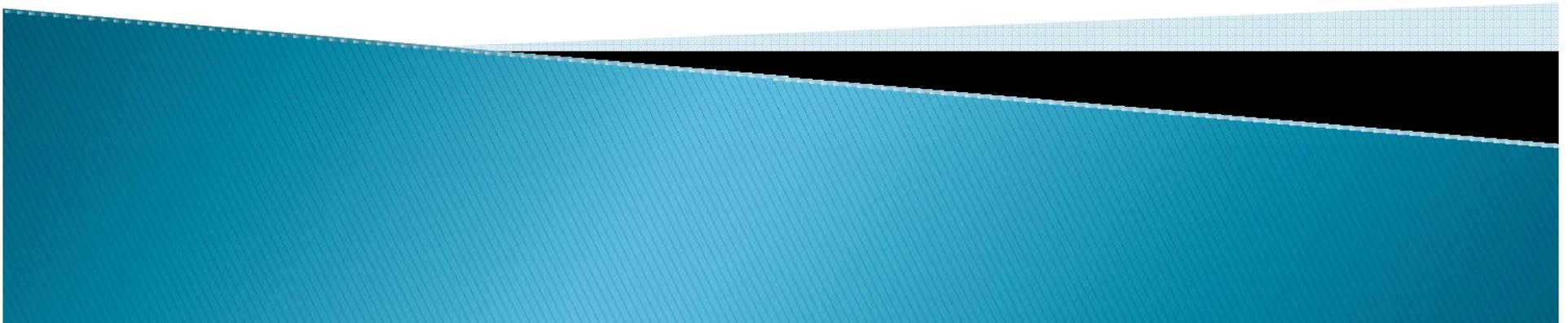
- ❖ Educated/informed in key aspects of Public Health: 10 essential services, public health services inventory, evidenced based practices, legislation
  - ❖ Develops and monitors regional Public Health Improvement Plan (PHIP)
  - ❖ Makes recommendations to LRPPH , other agencies, Leadership Teams
  - ❖ Education/Advocacy (community, legislative)
  - ❖ Receive Updates on PHIP from Leadership Teams
- 

# *Leadership Teams LT (advisory):*

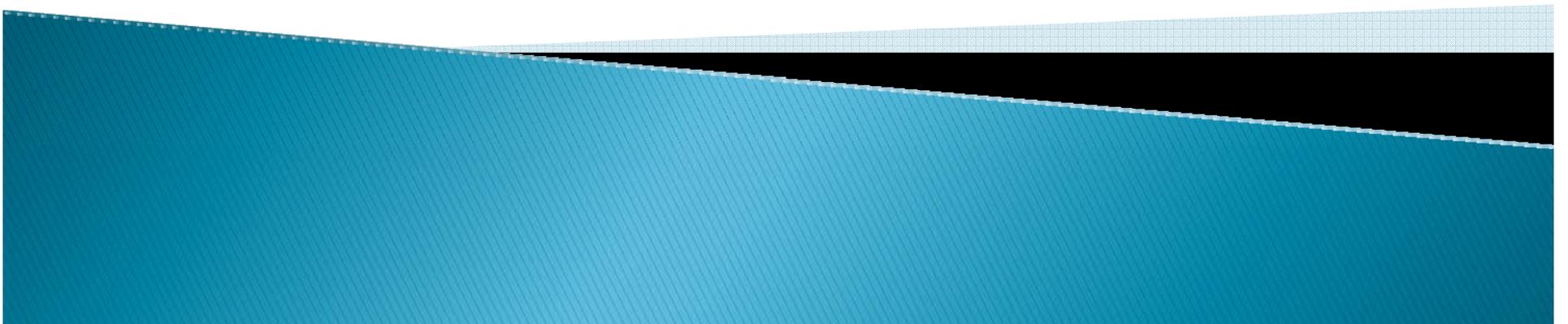
**Membership:** Representatives with experience, stakeholders

## **Responsibility:**

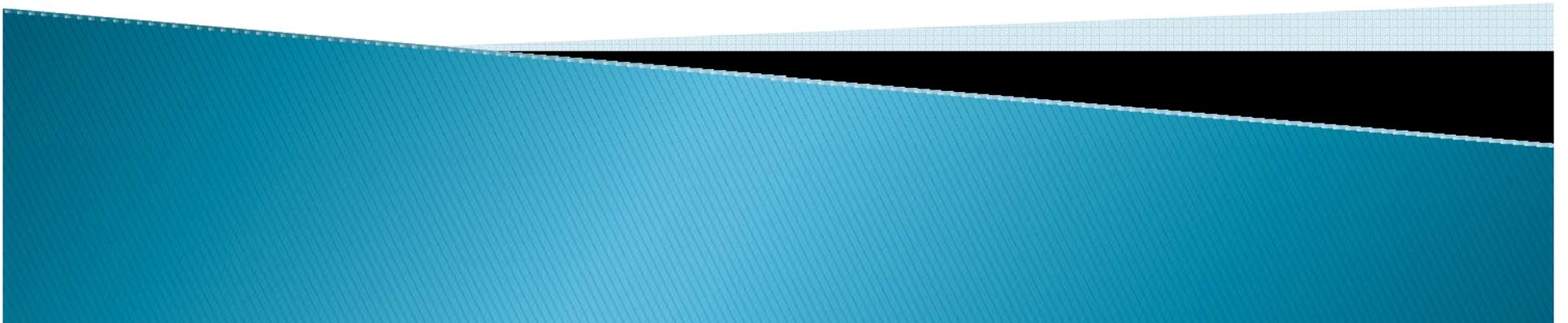
- ❖ Educated/informed in key aspects of topic area: 10 essential services, public health services inventory, evidenced based practices, legislation
- ❖ Utilizes assessment data to determine strengths and needs
- ❖ Develops regional plan for topic area
- ❖ Makes recommendations to Public Health Council
- ❖ Assists in development of regional public health improvement plan
- ❖ Education/Advocacy (community, legislative)
- ❖ LT members should be aware of the work of all LT's
  - One member of each LT participates on Public Health Council



**Questions ?**



# Recommendations and Rationale

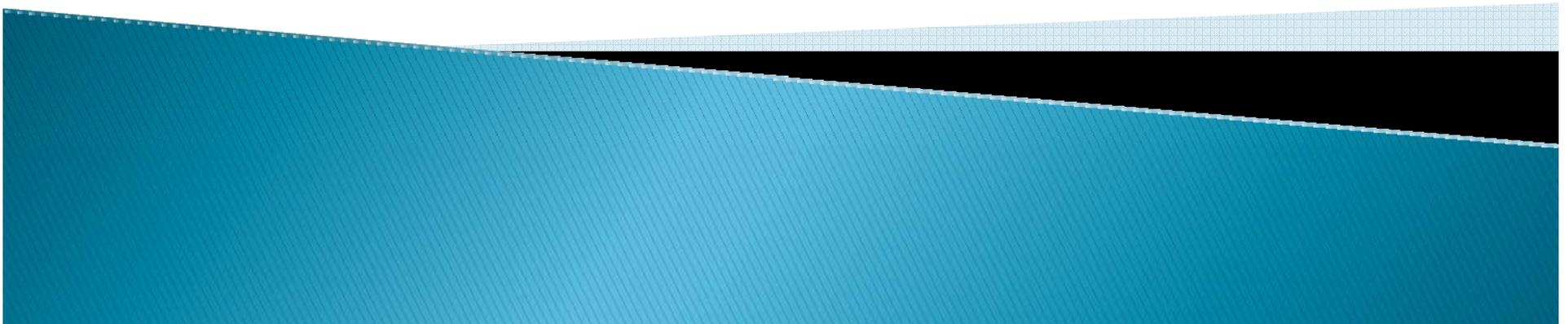


# Recommendation #1

*DPHS and public health partners across the state should continue to seek and direct funding towards the public health regions to build local public health infrastructure to meet the identified health priorities in the state and the capacity needs identified through these assessments. DPHS should also advocate that other public and private funders utilize this regional alignment when funding public health services.*

## Rationale

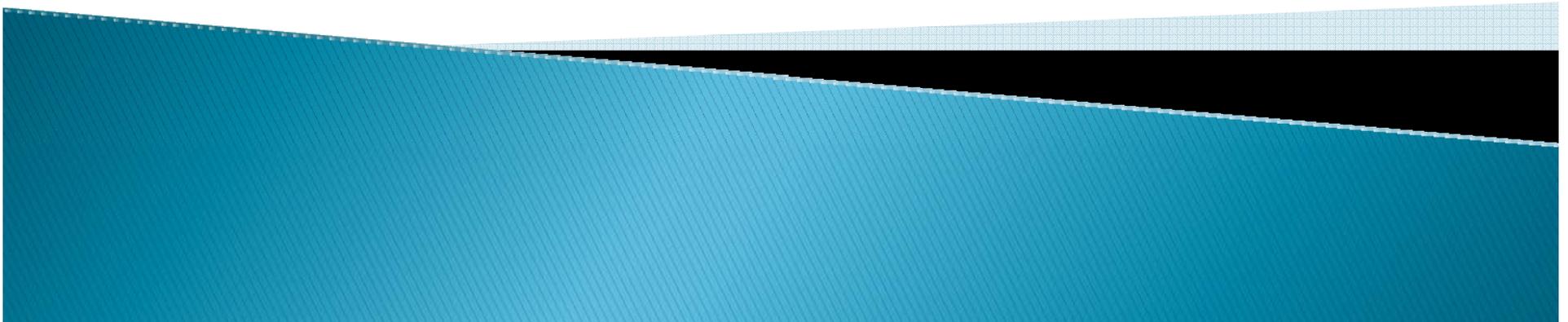
- Directing funds in this way continues to build on existing infrastructure, enabling regions to address additional public health essential services and priority health issues.



# Recommendation #2

*DPHS and public health partners across the state should seek resources to support epidemiologists<sup>[1]</sup> to be shared among public health regions.*

[1] An epidemiologist is "An investigator who studies the occurrence of disease or other health-related conditions or events in defined populations. The control of disease in populations is often also considered to be a task for the epidemiologist". Last J, Spasoff R, Harris S. A dictionary of epidemiology. Oxford University Press, New York, 2000.

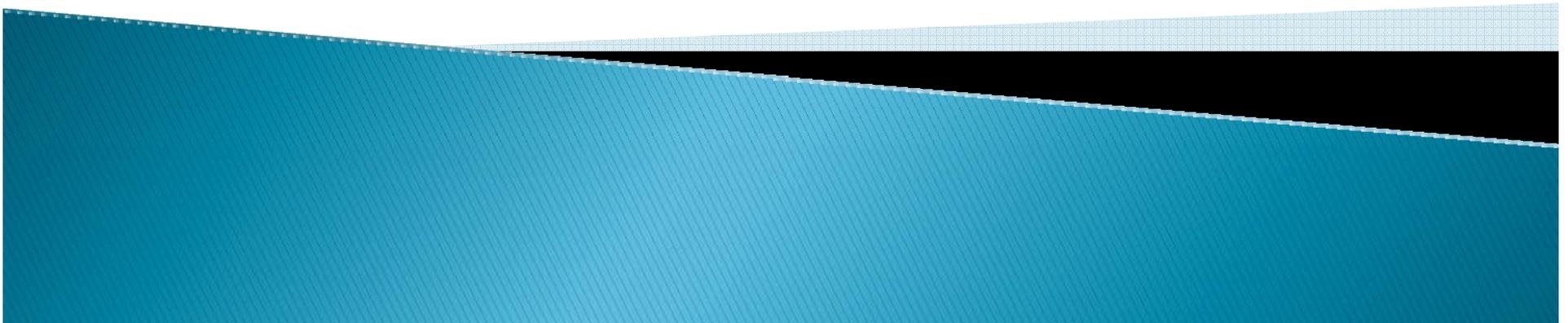


# Recommendation #3

*DPHS and public health partners across the state should assist public health regions to conduct community health assessments.*

## Rationale

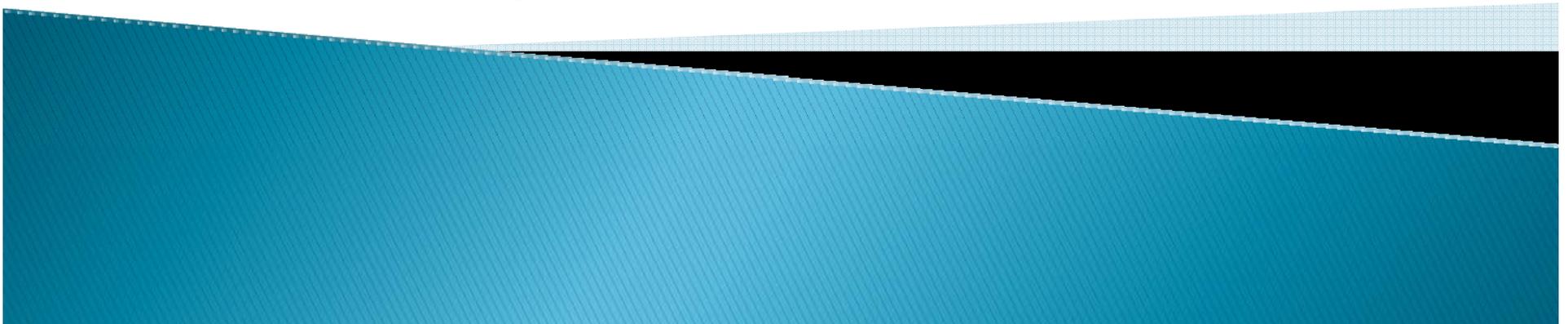
- Public health regional partners would benefit from additional resources and technical assistance to collect and analyze data to develop comprehensive and coordinated community health assessments in collaboration with other partners.
- Public health regional partners could also utilize resources and technical assistance to develop and monitor community health improvement plans in partnerships with other community stakeholders.



# Recommendation #3 Cont.

## Rationale

- Community health assessments and community health improvement plans are prerequisites for a public health entity to be accreditable, these should be priorities in every public health region. While non-governmental agencies cannot apply for accreditation, these two items serve as a foundation for public health practice. DPHS can act as a broker of other available resources in these areas such as technical assistance and funds from the National Association of County and City Health Officials.
- A regional epidemiologist can assist in enhancing ties to academic institutions to develop collaborative approaches to evaluation in public health regions.



# Recommendation #4

*DPHS should work with other state level entities to assist regions to strengthen and diversify regional partnerships.*

## Rationale

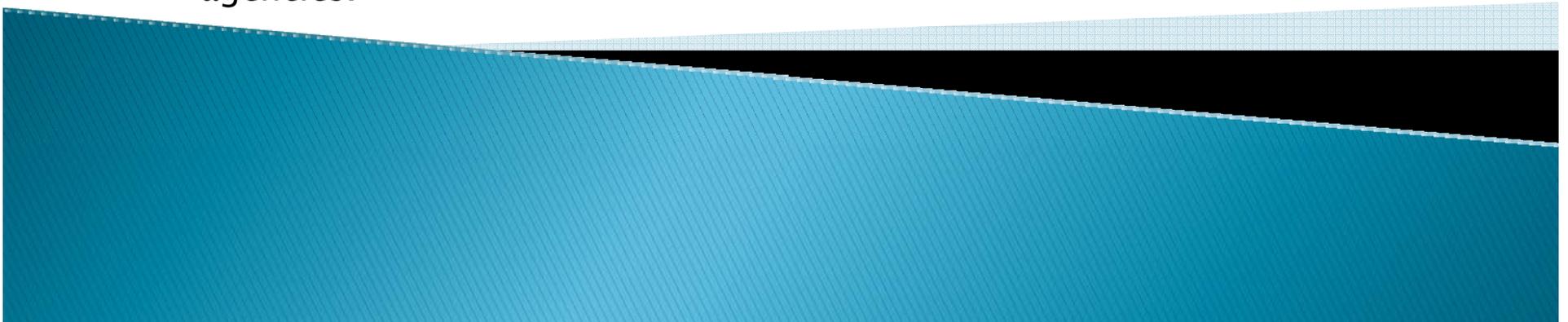
- While all public health networks have experience and have built extensive collaborations with emergency preparedness partners, fewer have established such relationships with partners to address broader public health issues. Existing efforts are also not well coordinated across various health issues or populations. The Center for Excellence provides technical assistance in building collaboratives with the Regional Networks established through the Bureau of Drug and Alcohol Services (BDAS). DPHS should explore how these resources can be expanded to public health networks.
- 

# Recommendation #5

*A regional public health system in New Hampshire should be built upon existing public health networks and the infrastructure that has been established, recognizing the unique characteristics and structures existing in various regions. DPHS and BDAS should continue to work to align their respective regional initiatives to create efficiencies, eliminate duplication, and build upon the strengths of the two systems.*

## Rationale

- Many services are not provided to all communities in a public health region. There is no consistent geographic area (i.e. the public health region) used by the DPHS and other funders across various funding streams. This leads to confusion and fragmentation of service delivery; reduces access to public health services; and creates logistical and administrative burdens for local agencies.

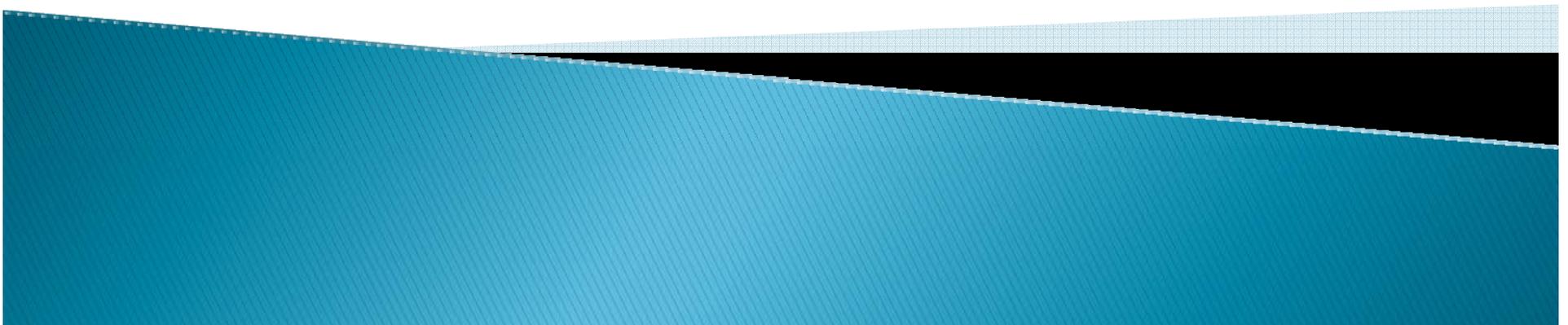


# Recommendation #6

*DPHS should fully investigate other models for regional structure and framework including: Fish and Game; Regional Planning Councils; HAZMAT; and the NH Solid Waste Districts.*

## Rationale

- Lessons could be learned from these groups particularly around crossing jurisdictions.

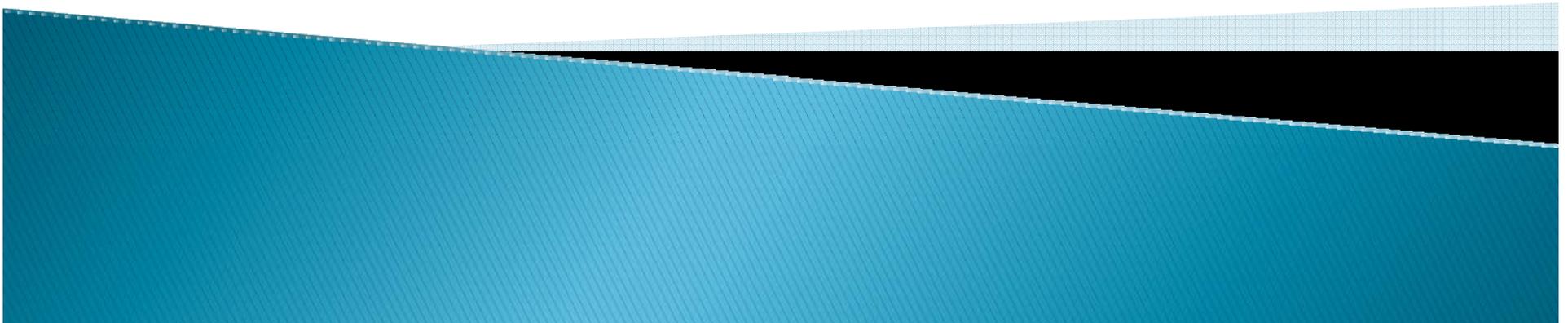


# Recommendation #7

*The Public Health Improvement Services Council should explore how to maximize existing training resources available in the state to assure a competent public health workforce including but not limited to the Masters in Public Health Programs at the University of New Hampshire and Dartmouth, the Institute for Local Public Health Practice, the two New Hampshire Area Health Education Centers, the Community Health Institute, and the Public Health Training Centers at Dartmouth and Boston University.*

## Rationale

- Most public health regional partners lack the capacity to provide development opportunities to assure a competent workforce and to engage with academic institutions to benefit from and contribute to evidenced based practice.

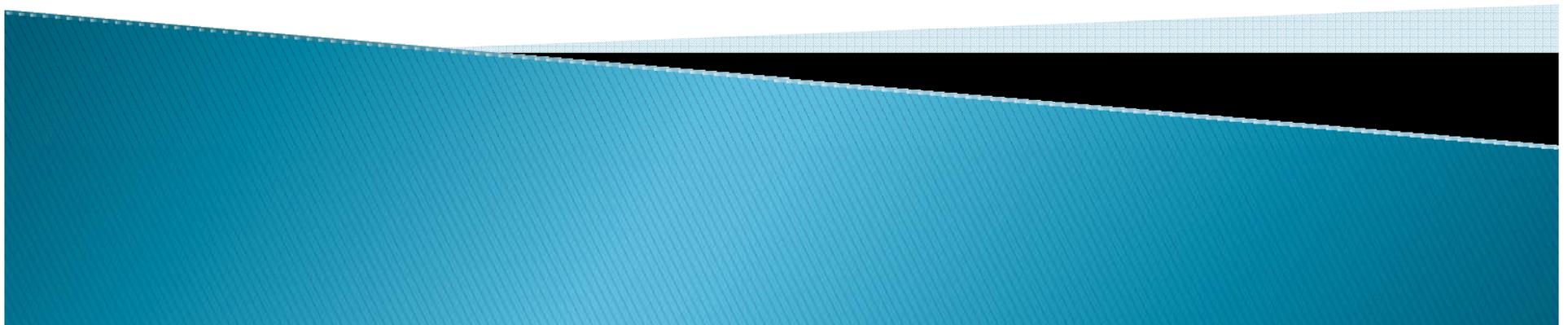


# Recommendation #8

*DPHS should utilize resources available through the National Public Health Improvement Initiative to provide training for regional public health staff in quality improvement methods.*

## Rationale

- Limited resources call for assuring that all public health services provided are quality services. Training regional public health staff in quality improvement methods and providing support to carry out quality improvement methods can assist to improve services.



# Recommendation #9

*DPHS should reconsider the concept of regional public health councils as a link to government for regional public health networks and more fully explore the structure and attributes of existing, successful regional collaboratives that mimic the public health council model. The Public Health Improvement Services Council should continue to serve at the state level in an advisory capacity to public health regionalization efforts.*

## Rationale

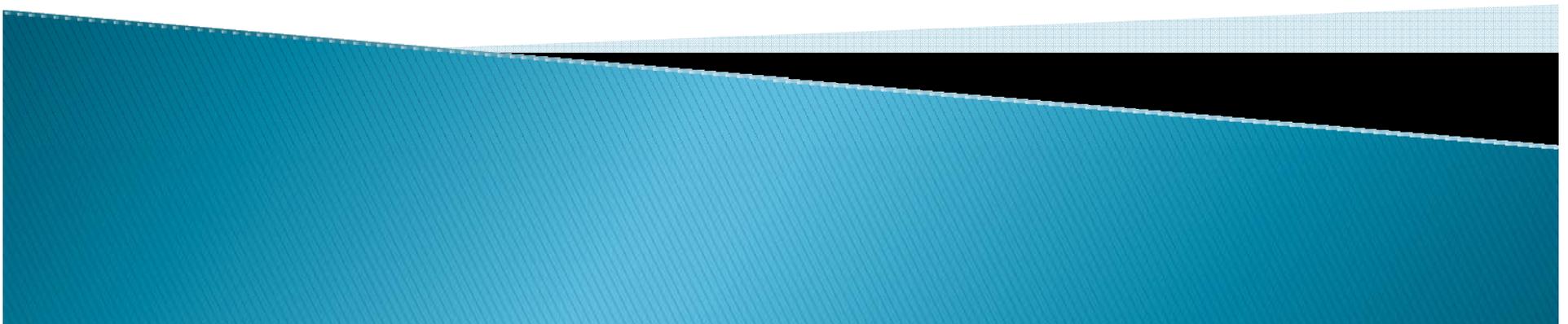
- Many questions were raised in response to the proposed regional public health council. For example, “What is the relationship between a public health council and existing board of directors of a non-profit public health network?” It may be that until and unless there is financial support at the state and local level to create government-based health departments that the link between private, not-for-profits, and a governmentally linked public health council is not a sound fit.



# Recommendation #9 Cont.

## Rationale

- Partners in several regions have developed high-level leadership councils that provide oversight and coordination of public health efforts. While these are not formally linked to government, they do carry out some of the same functions through a voluntary, grassroots, collaborative system. DPHS should provide opportunities for partners to share these successes.
- When the concept of regional public health councils were discussed, partners asked if there would be a state level council overseeing regional councils and public health matters. The Public Health Improvement Services Council was created for the purpose of developing and monitoring public health improvement plans and has been advising DPHS relative to public health infrastructure development. This council is comprised of a broad group of public health stakeholders representing key facets of the public health system. It is prudent to continue to look to them for expertise, with or without regional public health councils.

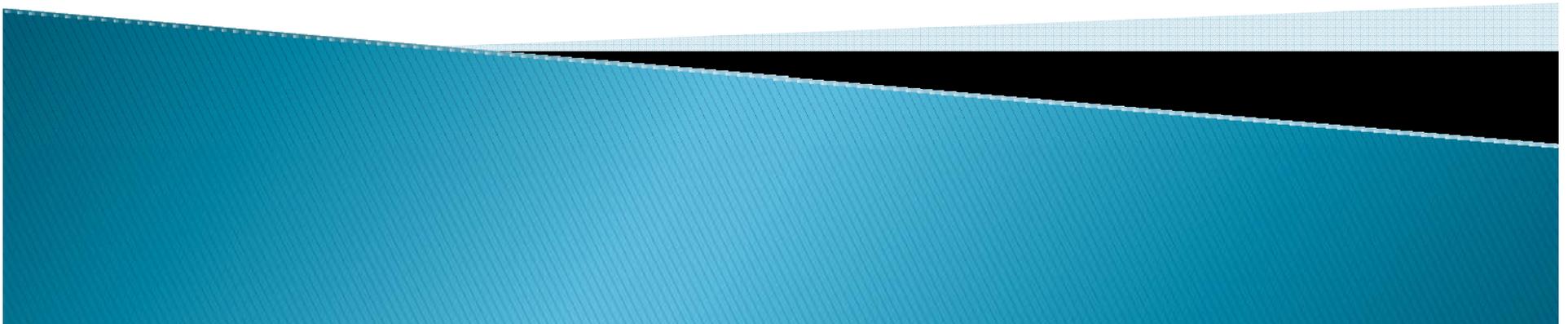


# Recommendation #10

*DPHS should continue to work with municipal health departments to expand their reach into their respective regions, especially in the areas of health assessment and planning, mobilizing partnerships, and educating the public.*

## Rationale

- Established municipal health departments have tremendous expertise that could be shared beyond municipal boundaries for a number of essential services when resources are available. The expansion of services related to inspection and enforcement raises legal issues that require additional exploration.

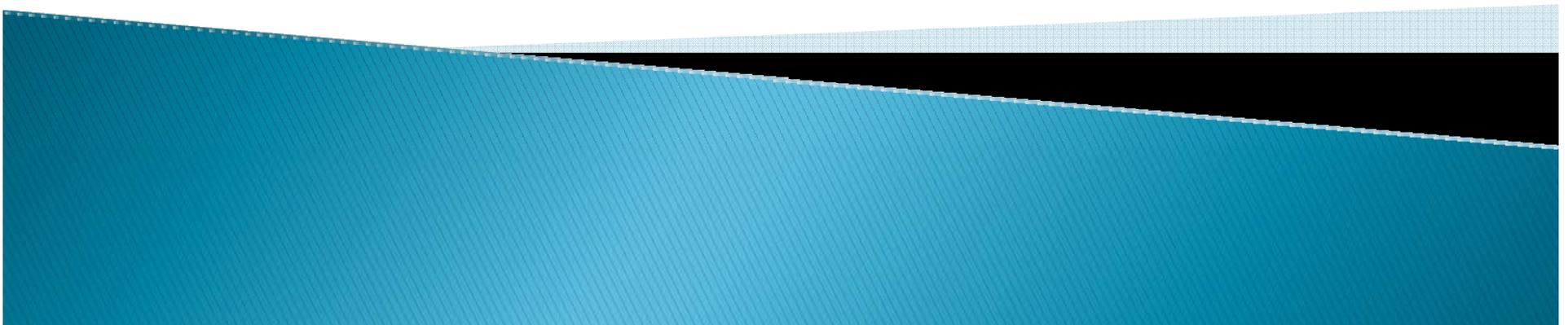


# Recommendation #11

*DPHS should continue to explore mechanisms to create regional professional and credentialed health officers who can carry out inspection and enforcement activities at the regional and local levels.*

## Rationale

- Local health officers frequently expressed the need for a more formalized system of training and support to assure a consistent level of professionalism.

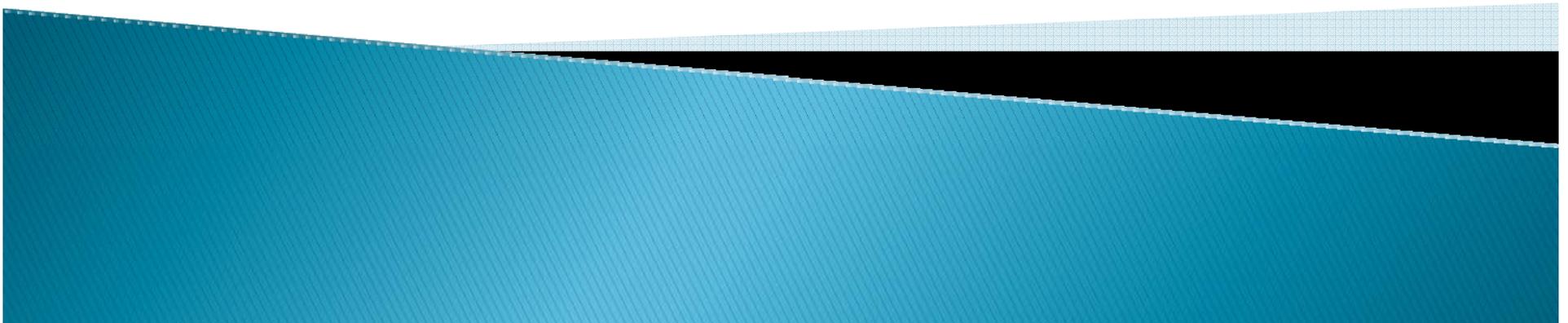


# Recommendation #12

*DPHS and/or public health networks should broker conversations with hospitals regarding the use of community education funds.*

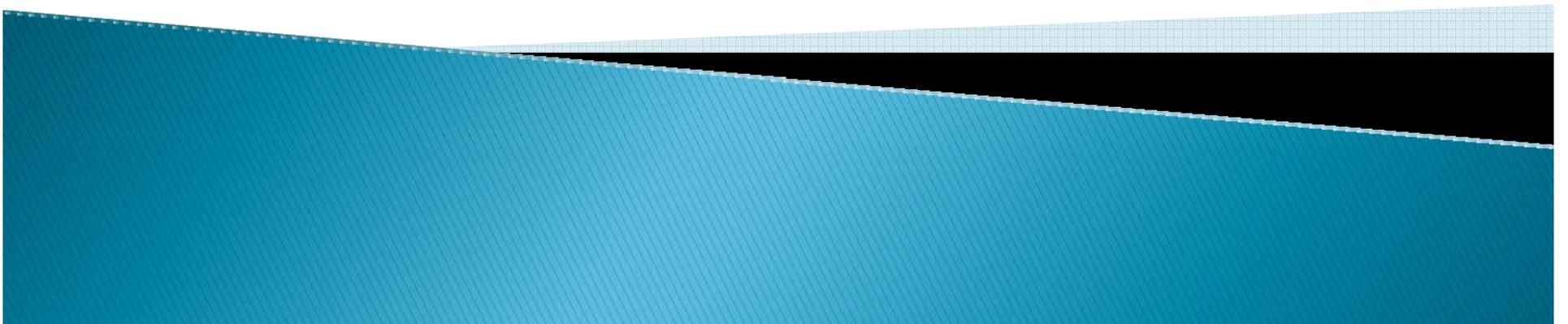
## Rationale

- These funds contribute substantially to health promotion activities in communities and should be based on needs identified through community assessments. This is an area with tremendous potential for community collaboration.

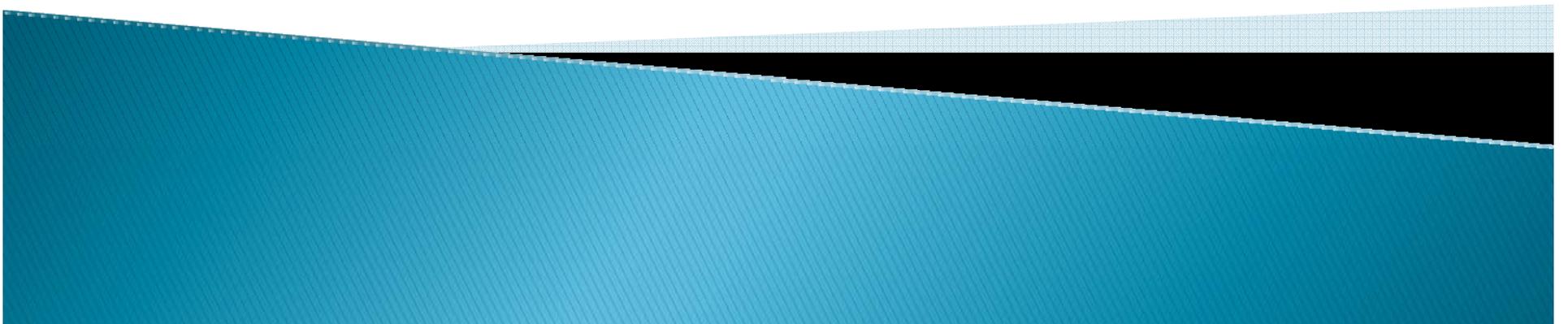


# Clarifying Questions

Discussion to take place in breakout sessions

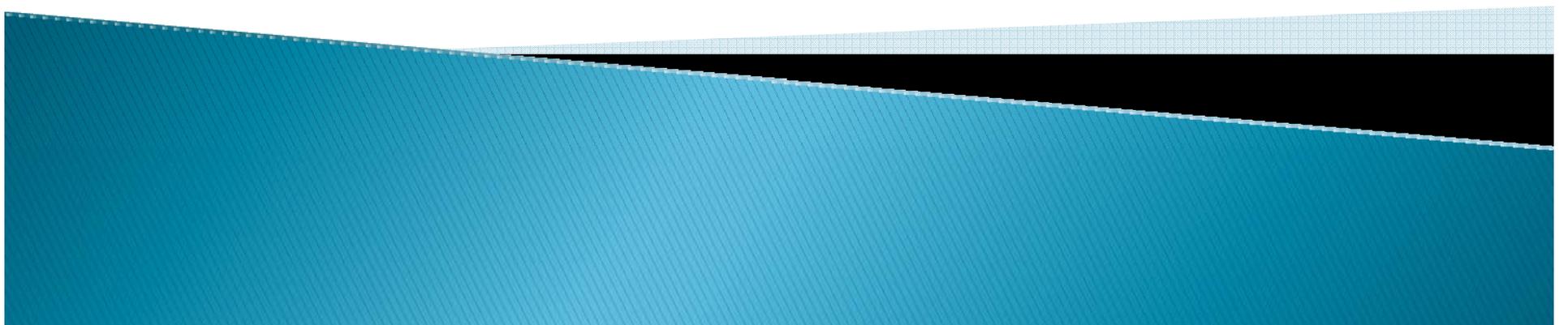


# Lunch- Recognition



# Panel Discussion

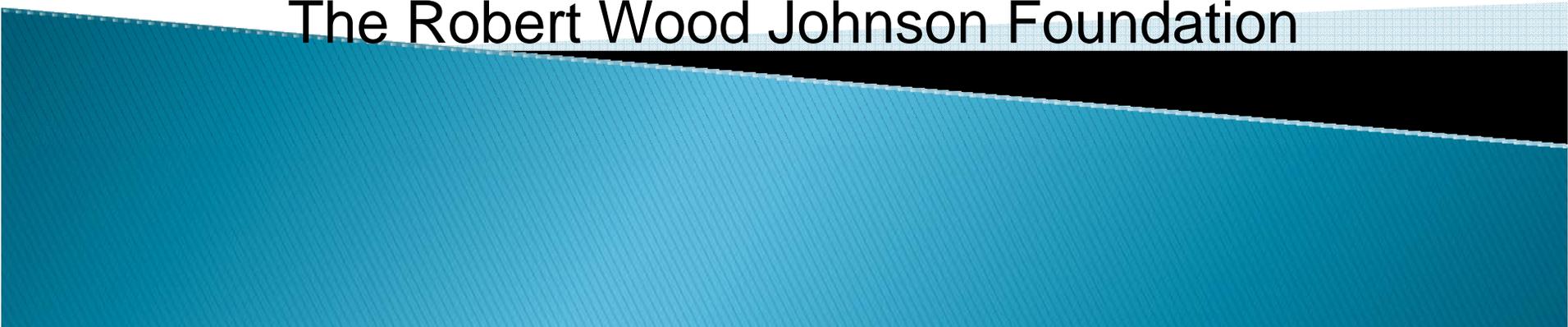
National and State Perspectives



# Supporting Public Health Infrastructure

Abbey K. Cofsky  
Program Director

The Robert Wood Johnson Foundation



# **Regionalization and Cross Jurisdictional Sharing in Local Public Health**

**New Hampshire Public Health  
Regionalization Initiative**

**September 1, 2011**

**Patrick Libbey**

# “Shared Capacity in Public Health”

Organizations:

ASTHO

NACCHO

NALBOH

PHAB

CDC

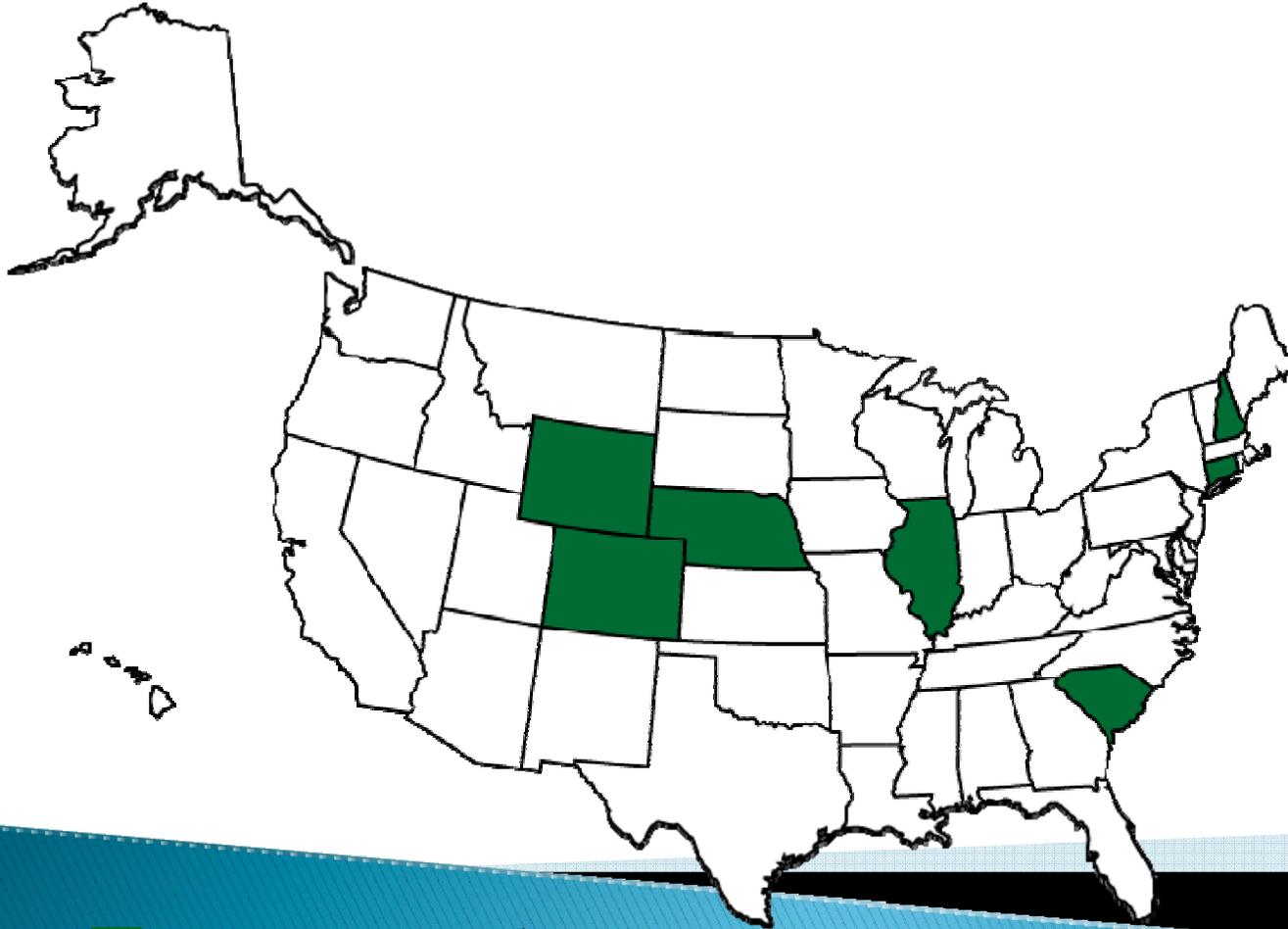
HRSA

NACo

NGA

USCM

NCSL



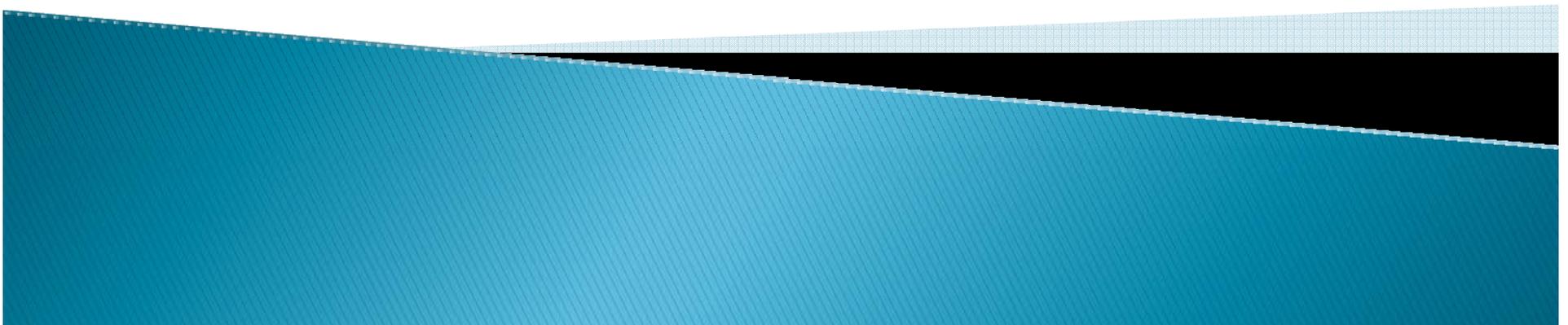
■ States reviewed



## Lay of the Land

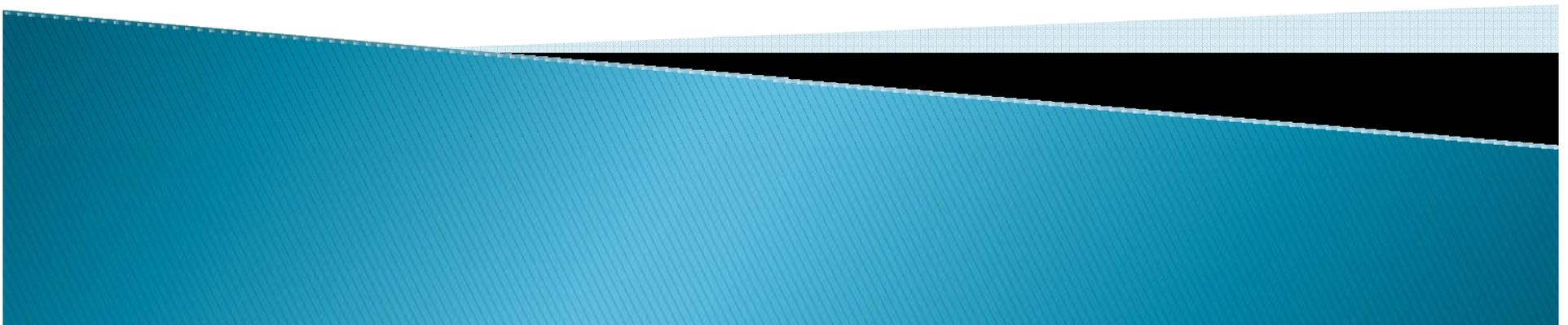
# General Observations

- ▶ Gap in elected policy officials' understanding
- ▶ Differences within the public health practice community
- ▶ Regionalization is occurring but may not result in improved performance
- ▶ No common language or frame of reference



# Cross Jurisdictional Sharing Is Occurring

- ▶ Wide range of cross jurisdictional sharing
- ▶ Historical and some new multi-jurisdiction regionalization
- ▶ Broad program area, e.g., preparedness, changing cross jurisdiction sharing
- ▶ Inventory and documentation lacking

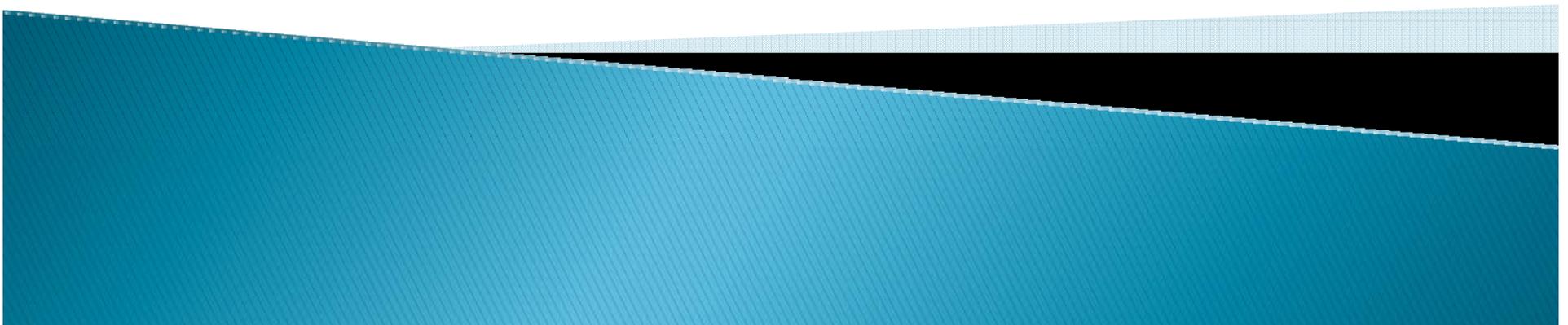




**Moving Forward**

# Considerations for Moving Forward

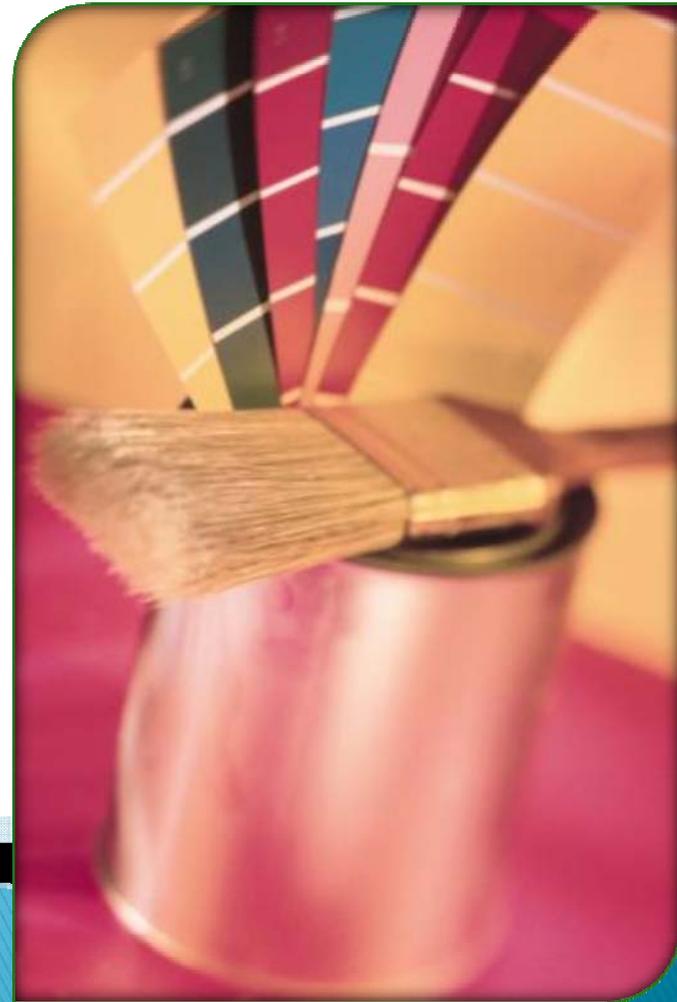
- ▶ Means, not an end – a spectrum of options
- ▶ Understanding context
- ▶ Involvement of elected officials



# Spectrum of Options

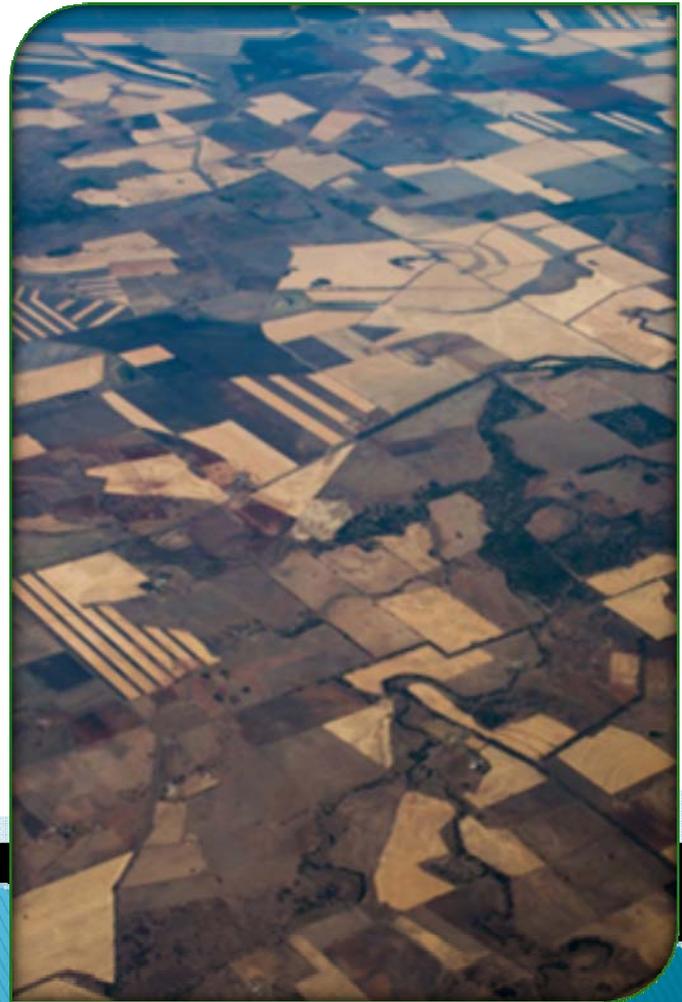
## Multiple dimensions

- ▶ Relative formality and legal basis
- ▶ Nature of what is being shared
- ▶ Duration and time
- ▶ Degree and nature of financial commitment
- ▶ Governance and oversight



# Understanding Context

- ▶ Local health departments operate as a part of or are influenced by local general purpose government.
- ▶ Can't analyze, model, or create performance expectations without considering context.
- ▶ Community-centric characteristics exert influence on local public health.

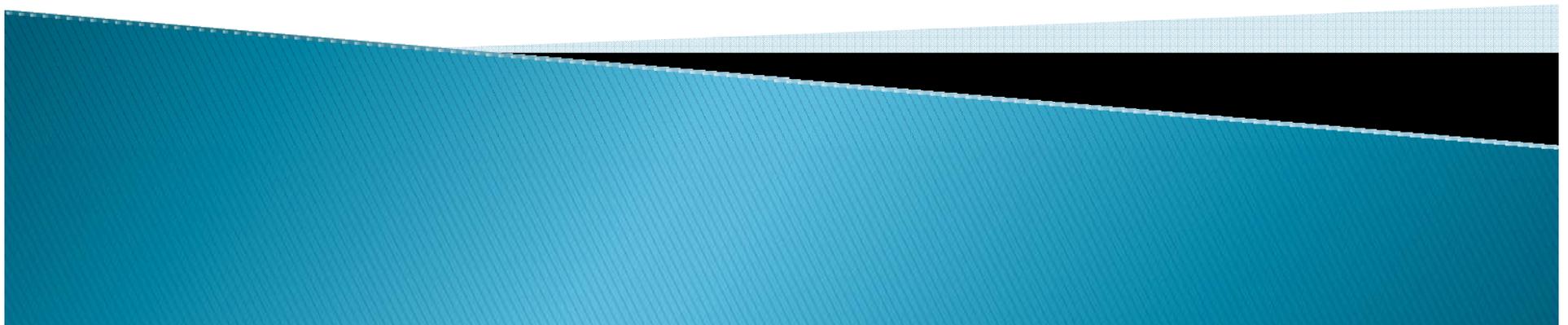




**Success**

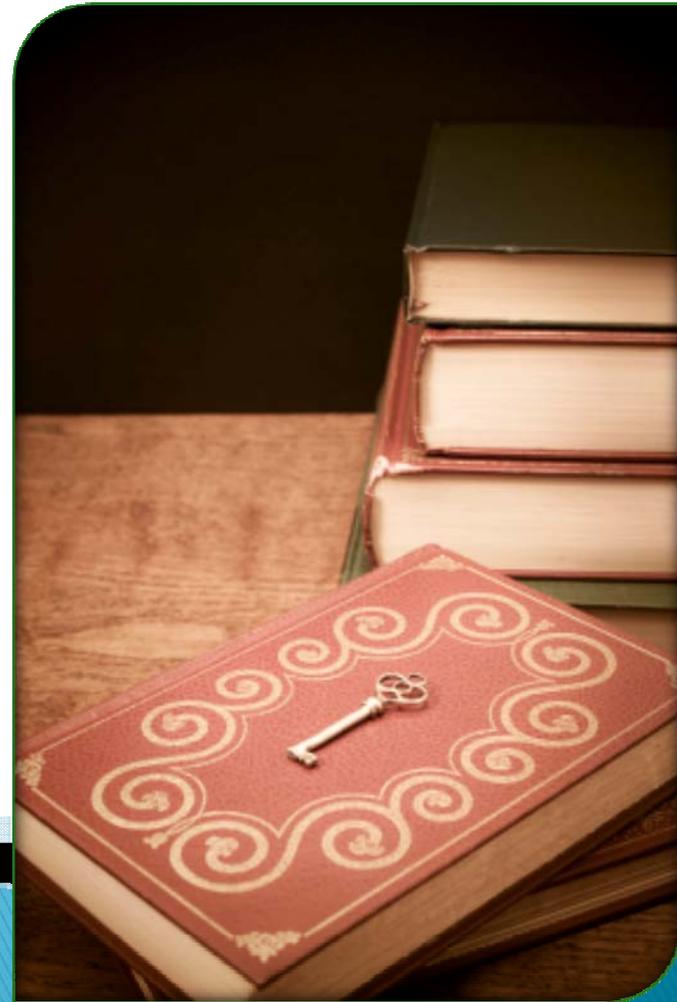
# Conditions Associated With Success

- ▶ Clarity of purpose
- ▶ Cultural and historical context
- ▶ Willingness
- ▶ Actual role in governance
- ▶ Incentives, especially financial



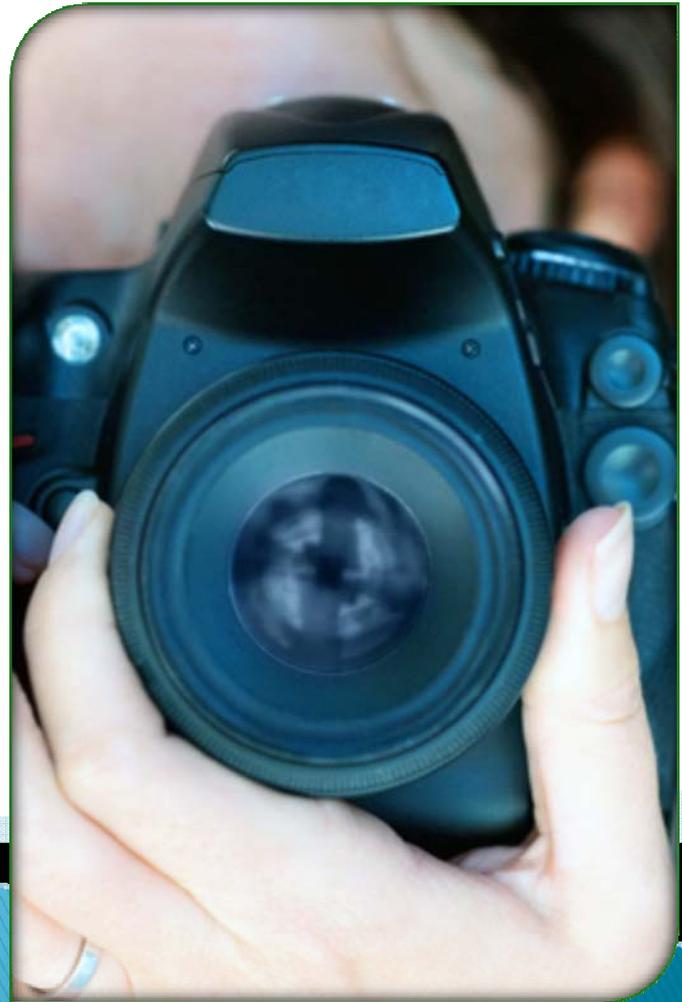
# Cultural & Historical Context

- ▶ Elected policy makers do not see public health as separate from the jurisdiction's political and contextual environment.
- ▶ Local government is a political environment.
- ▶ Jurisdictions often see themselves in competition.



# Role in Governance

- ▶ Intensity of oversight varies based on nature of endeavor
- ▶ Elected officials' focus tied to finance, liability, or significant change in relationship
- ▶ Public health leaders' focus tied to ensuring public health need of their jurisdictions will be met



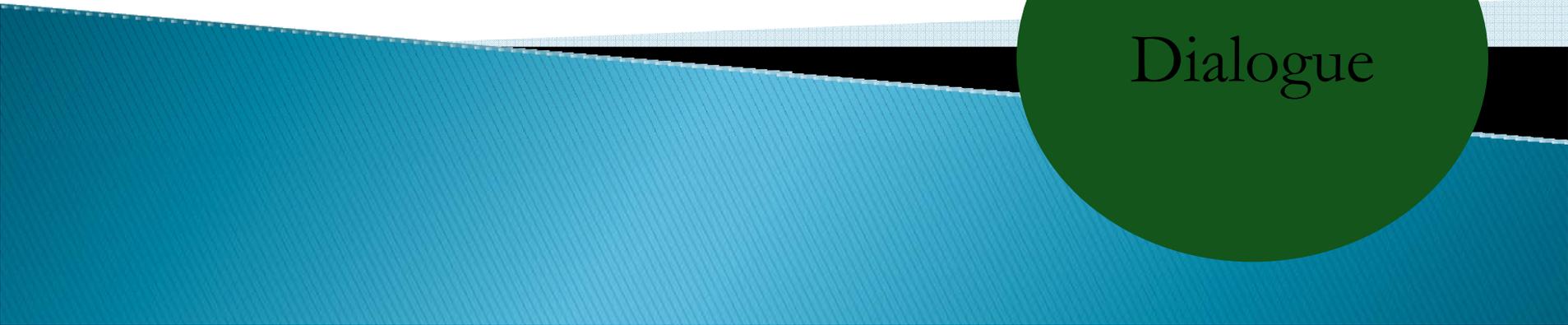


Questions?

# Shared Public Health Services



Dialogue





**Public Health Law Network**

# **Shared Accountability and Regional Governance The North Carolina Story**

Gene W. Matthews, JD, Director  
Southeastern Regional Center  
Public Health Law Network  
North Carolina Institute for Public Health  
UNC Gillings School of Global Public Health

[gmatthews@publichealthlawnetwork.org](mailto:gmatthews@publichealthlawnetwork.org)

[www.publichealthlawnetwork.org](http://www.publichealthlawnetwork.org)





## Public Health Law Network

### ➤ Benefits of accreditation

**“We’re working towards accreditation, but for me that is not the goal, it’s kind of a side benefit. The goal is to operate more efficiently.”**

-Local public health administrator

**“We’ve seen some agencies that got recognition [for being accredited] from their local government structure that meant more money for them, or better access to the mayor’s office.”**

-Director of a nonprofit public health institute



## Public Health Law Network

- Regional partnerships: contrasting views

**“There’s no way we could have moved forward...if the locals weren’t on board .”**

--State public health institute leader

**“If you are a home rule state, don’t pretend that a need to share services doesn’t exist. As we look at accreditation...it’s the elephant in the room.”**

--Health official from a home rule state



## Public Health Law Network

- Regional partnerships: contrasting views

**“It’s the region that enables the counties to do what they need to do, not the other way around.”**

--Public health attorney from a rural state

**“ *Regionalization* is a dirty word.”**

--County health officer

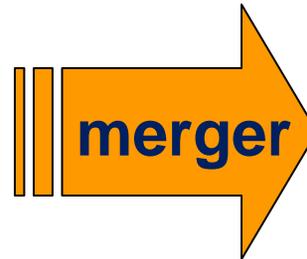
# Evolving Organizational Changes Faced by Public Health Agencies

1. **Local Health and Human Services Agency Consolidations**
2. **Cross-Jurisdictional LHD collaborations**
3. **FQHC and LHD Partnerships**
4. **Nonprofit Hospitals and LHD collaborations**
5. **Quasi-independent public health authorities**

<http://www.publichealthlawnetwork.org/wp-content/uploads/PHLN-InitiativeFINAL.pdf>

# 1. Local HHS Agency Consolidation (County “Umbrella Agency” Mergers)

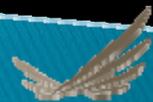
**Social Services + LHD  
+ Medicaid + WIC +  
Child Protection +  
Etc.**



**Single Local  
HHS Agency**



- **Concern about loss of “public health” identity, especially in local emergency workforce situations**
- **Local advantage of closer working relationships**



## 2. Cross-Jurisdictional LHD Collaborations

( Horizontal Regional Arrangements)

### Shared Service Arrangements



Adapted from: Ruggini, J. (2006); Holdsworth, A (2006); and  
The Strategic Vision Group; from Kaufman, N. J. Regionalization of Government Services: Lessons Learned.  
July 21, 2010 [healthlawnetwork.org](http://healthlawnetwork.org)

Robert Wood Johnson Foundation

### 3. FQHC and LHD Partnerships

- HRSA and CDC joint initiative to promote FQHC and LHD partnerships
- Potential legal issues:
  - Merger of 2 boards or creation of new 501(c)(3) entity to coordinate both organizations
  - Clarification of liability concerns and insurance
  - Documentation of governance arrangements

## 4. Collaborations Between Nonprofit Hospitals and LHDs (hospitals soon will be conducting community health needs assessments)

- Affordable Care Act implementation schedule not likely to be impacted by court challenges
- IRS Guidance is for hospitals to coordinate with public health departments
- Written memoranda of roles/responsibilities
- Alignment of jurisdictions among stakeholders
- Data sharing and reporting requirements



**Public Health Law Network**

# Community Health Needs Assessments Trains Are Leaving the Station



**STARTING  
March 23, 2012**



**MOST APPLICABLE  
LATEST TAX DATE  
December 31, 2013**

**Hospitals will be reaching out...**

**Who will engage them?**

[www.publichealthlawnetwork.org](http://www.publichealthlawnetwork.org)



## 5. Establishing Quasi-independent Public Health Authorities

- Similar to creating airport or water authorities
- Local political, tax, & financial considerations
- Plus legal issues :
  - Are these entities allowed under state law?
  - Can they exercise public health control powers?
  - Freestanding personnel systems



## Public Health Law Network

- What are options for formal agreements with binding financial commitments?

### The “pre-nup!”

“Have a meeting of the minds on the rules of the game.”

In many states, interlocal agreement acts require that participating government agencies spell out in advance:

- purpose of the agreement
- the duration
- manner of financing and maintenance of a budget -
- methods for terminating the agreement



## The North Carolina Story: an ongoing case study

- History of concern about some struggling LHDs
- 2003 Legislation proposed to regionalize all LHDs
- 2005 first state mandatory LHD accreditation law in NC
  - 4 year accreditation cycle
  - LHDs could voluntarily pick their accreditation cycle
  - One year budget hiatus in 2009-2010
- Currently **61 out of 85** LHDs accredited in NC



## Public Health Law Network

# The North Carolina Story: “TIME’S UP!”



S 433 almost enacted in June 2011

All LHDs get 3 choices to become either:

- Part of a consolidated county human services agency
- A district (multi-LHD) health department, or
- A public health authority (quasi-governmental)

Legislature reconvenes in January 2012...tick, tick, tick....



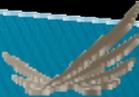
**Public Health Law Network**

## **A New Initiative in Development to Assist Public Health Agencies**

**“Evolving Legal Issues Initiative”  
Responding to a Changing Public Health Infrastructure**

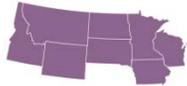
<http://www.publichealthlawnetwork.org/wp-content/uploads/PHLN-InitiativeFINAL.pdf>

[www.publichealthlawnetwork.org](http://www.publichealthlawnetwork.org)

  
Robert Wood Johnson Foundation



## Public Health Law Network



- **National Coordinating Center/Northern Region**

- Public Health Law Center at William Mitchell College of Law



- **Eastern Region**

- University of Maryland School of Law working with the John Hopkins Bloomberg School of Public Health



- **Mid-States Region**

- University of Michigan School of Public Health



- **Southeastern Region**

- UNC Gillings School of Global Public Health working with the National Health Law Program



- **Western Region**

- Sandra Day O'Connor College of Law at Arizona State University working with the University of New Mexico School of Law

[www.publichealthlawnetwork.org](http://www.publichealthlawnetwork.org)



## References

### **1. Two Page Summary of Emerging Legal Issues Project**

<http://www.publichealthlawnetwork.org/wp-content/uploads/PHLN-InitiativeFINAL.pdf>

### **2. Full Report: Accreditation Legal Structures Report: Key findings and lessons Learned from 10 State Case Study**

<http://www.publichealthlawnetwork.org/wp-content/uploads/Accreditation-Legal-Full-Report.pdf>

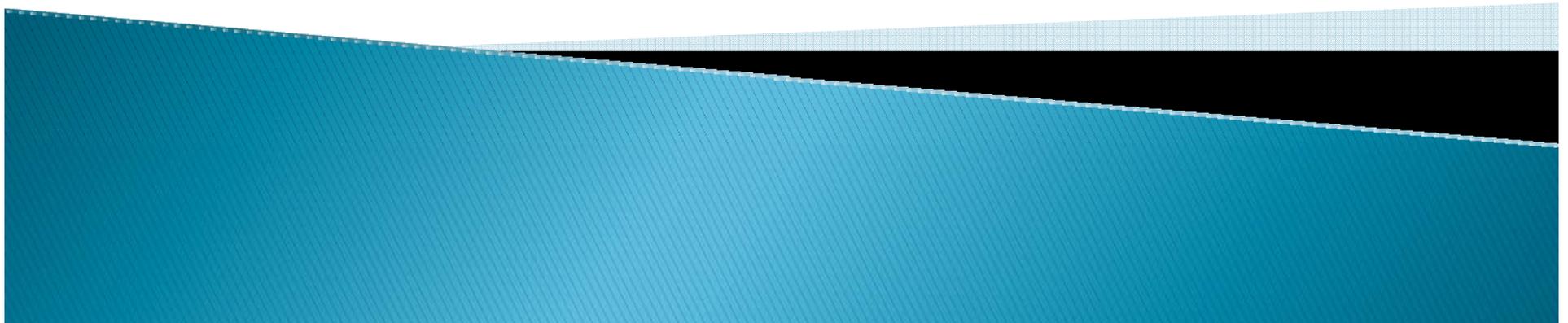
### **3. Executive Summary: Accreditation Legal Structures Report**

<http://www.publichealthlawnetwork.org/wp-content/uploads/Accreditation-Legal-Exec-Summary.pdf>

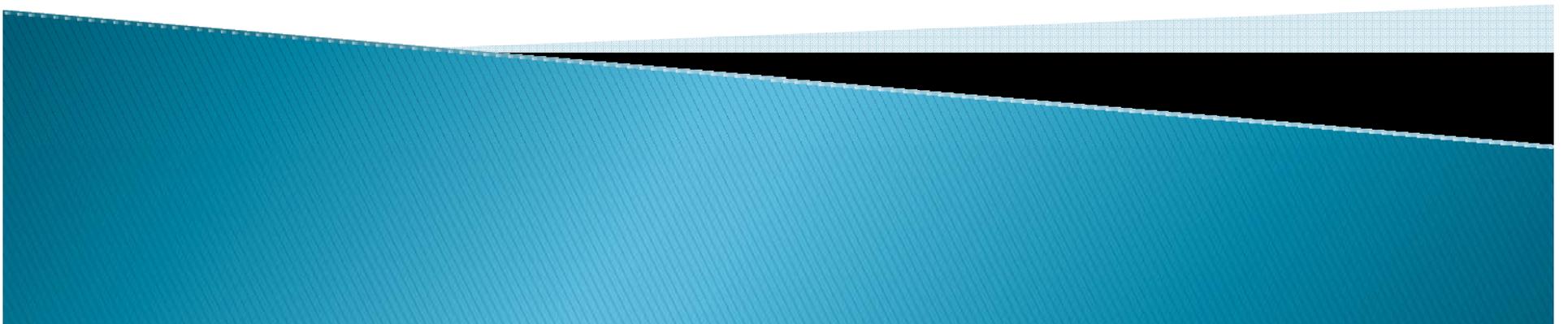
# The New Hampshire Perspective

Nicholas A. Toumpas  
Commissioner

New Hampshire Department of Health  
and Human Services



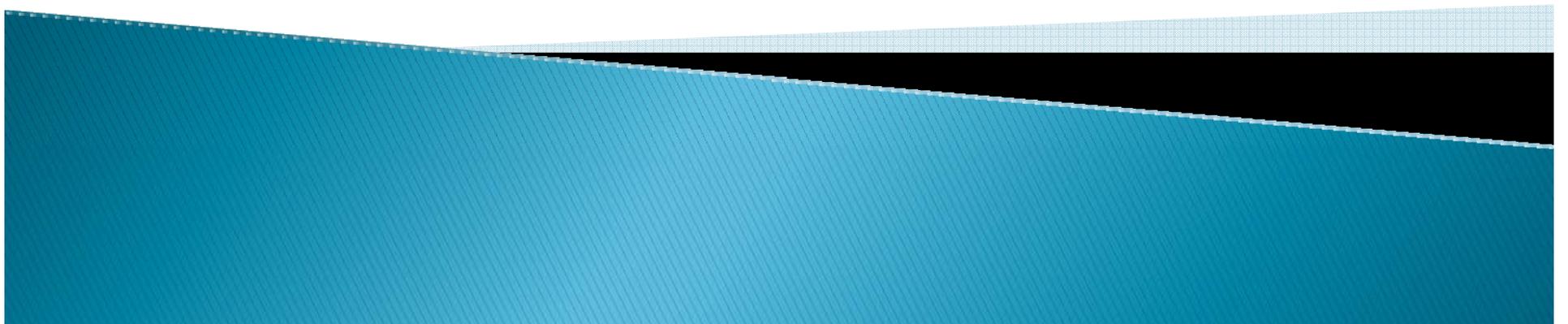
**Questions ?**



# Breakout Sessions

- ▶ See letters on your name tag
    - A- Stay in large room with Joan Ascheim
    - B- Merrimack Room with Kate Frey
    - C-Concord Room with Neil Twitchell
  - ▶ Review recommendations- see handout
  - ▶ Determine top 3 priority recommendations
  - ▶ Determine if there are any other recommendations
  - ▶ Chose note taker and reporter to report out on these upon reconvening
  - ▶ Submit your complete recommendation feedback form
- 

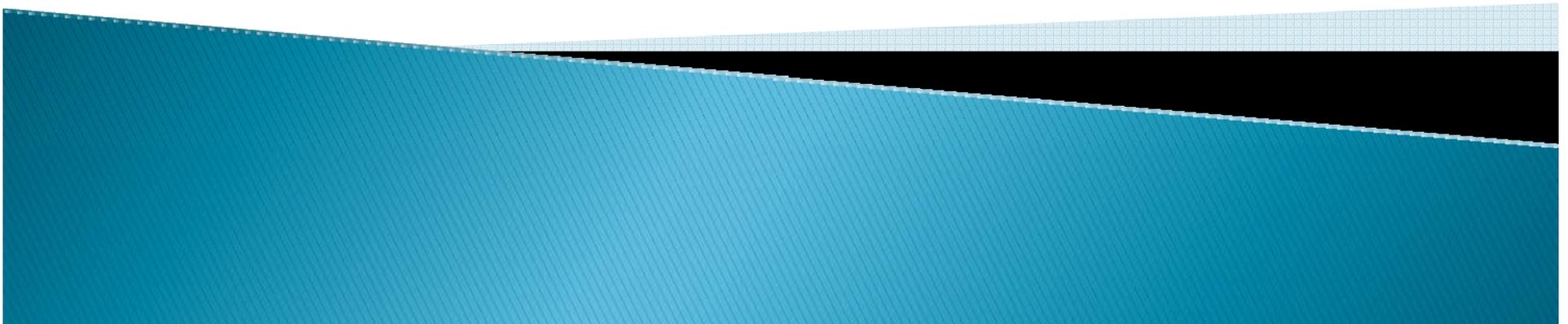
# **Review of Key Points and Recommendations**



# Next Steps

- ▶ Finalize report and recommendations based on feedback
- ▶ DPHS/Public Health Improvement Services Council decide on policy/implementation approach
- ▶ Slides and the report can be found at:

<http://www.dhhs.nh.gov/dphs/iphnh/publications.htm>



**Final Questions?**

**Thank you!**

