Moving Towards a Regional Public Health System in NH

Meeting

August 22, 2008

Regionalization Goal

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

A Primary Regional Public Health Agency

- 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

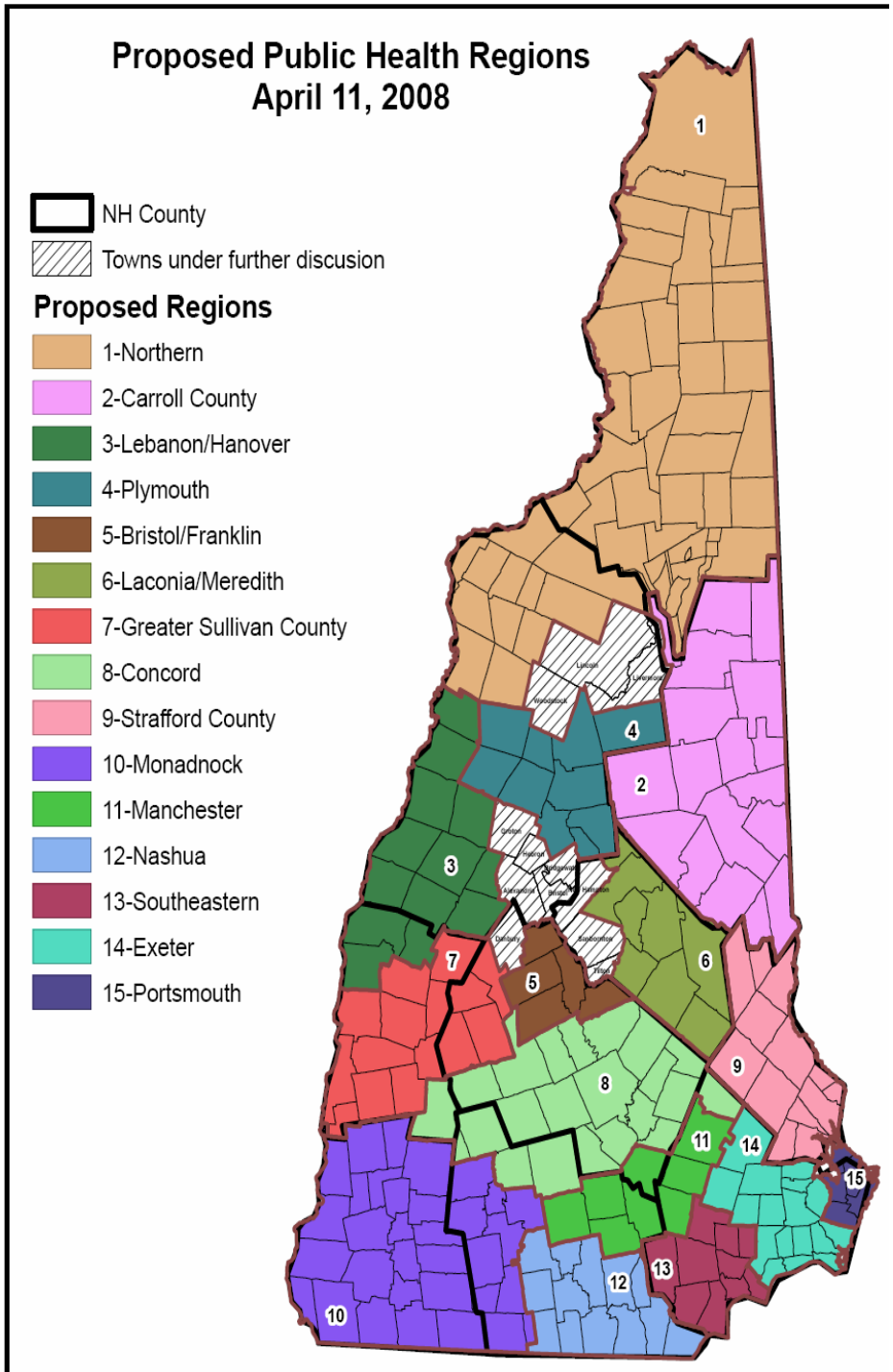
Proposed Staffing

- Administrator
- Support staff
- Health educator/marketing staff
- Nurse (?)
- Environmental health specialist

- Shared across regions/in-kind
  - Epidemiologist
  - Financial manager
  - Emergency preparedness coordinator
  - IT support
  - Medical consultant
- Coordinate with local health officers or move towards shared regional health officer

Possible Incremental Approach

- Begin with a core of essential services with the option to contract for others and possibly expand later
- Begin with a core staff using existing resources


Proposed Public Health Regions
April 11, 2008
NH County
Towns under further discusion
Proposed Regions
1-Northern
2-Carroll County
3-Lebanon/Hanover
4-Plymouth
5-Bristol/Franklin
6-Laconia/Meredith
7-Greater Sullivan County
8-Concord
9-Strafford County
10-Monadnock
11-Manchester
12-Nashua
13-Southeastern
14-Exeter
15-Portsmouth
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Next Steps- Assessments

Assessments

June 2008- March 2009

- Financial analysis of all public health funding with consideration of efficiencies of regionalization – Patrick Bernet, FAU
- Assessment of local/regional public health entities' capacity to deliver the 10 essential services with gaps analysis – Lea Lafave, CHI
- Assessment of what a local link to government might look like – Jennifer Wierwille Norton

Financial Assessment

- To gain an understanding of current public health expenditures by region and for the state as a whole
- To try to understand the potential financial implications of regionalizing select public health services

Subcommittee Met 4 times

- Amy Cullum
- Bobbie Bagley
- Betsey Andrews Parker
- Bobbie Aversa
- Elaine Belanger
- Karen Grzelak
- Megan Eastman
- Lisa Bujno
- Lindsey Vacek
- Lisa Morris
- Rick Silverberg
- Susan Laverack
- Paul Etkind
- Kerran Vigroux
- Chris Lister
- Rick Rumba

Work to Date Subcommittee

- **State Funds by Region**
- **State Resources to Regions**
- **Local Expenditures**- municipal and non – municipal funding

State Funds to Regions

- Contract Funds – examples of those to include
  - Tobacco coalitions
  - WIC
  - HIV
  - Community health centers
  - Family planning
  - Emergency planning

State Funds to Regions

- Contracts not included (examples):
  - Shared epidemiologist
  - Diabetes education
  - Asthma capacity building
  - Public health preparedness TA
  - Metabolic testing of newborns
  - Hearing testing of newborn - IT

State Funds to Regions

- Need a methodology to determine how to align funds with new regions
- For example:
  - For CHCs – total population served in a year divided into total grant for cost per client
  - Zip code sort
  - # clients per town x cost per client = amount per town
  - Aggregate by region

State Resources to Region

- Public health nurses
- Lead nurse case managers
- Lead educator
- Food protection inspectors
- STD DIS staff

Local Funding Municipal

- Obtain budgets from municipal health departments
- Where there is no health department – provide a form for each town asking;
  - Health officer salary
  - EEE spraying
  - Self inspection costs
  - Health clinics or screening
  - Nurse/physicians
  - Boards of health related expenses

Local – Non Municipal Funding

- Used contracts list as a guide
- Lead public health agency to complete
  - Include funds for which there is a subcontract/MOU/MUA
- Include
  - Federal non-state pass through
  - Direct donations/fundraising/service organizations
  - Private- includes foundations , UW
  - Non-DPHS state funds such as DOE, DES

Etc

- Use Fiscal Year 2007
- Include hospital community education
- Public health lead entity to assist in gathering information from towns/hospitals
- Letter of explanation signed from state and public health entity
- Ready to work with consultant

Governance Assessment

Goal:

- Educate communities about the role government plays in local public health.
- Gain an understanding of what the governing structure will look like as the state develops public health regions.
- Use what we've learned from assessments to propose necessary statute changes to support efforts.

Governance Assessment

- Adapting the NPHPS governance tool to have a facilitated discussion with stakeholders in each region
- Select regions with different composition (health dept, NGOs, county)

Governance Assessment

- Participants include municipal / county officials, key public health service providers
- Beginning late fall
- Facilitated by Jennifer Wierwille Norton

Governance Assessment Tool

Governance

1.4 Does the BOH review health status monitoring activities?	NO MINIMAL MODERATE SIGNIFICANT OPTIMAL
Does the BOH:	
1.4.1 Periodically review reports (i.e., every 1-3 years) on the community's health (community health profile)?	NO MINIMAL MODERATE SIGNIFICANT OPTIMAL
1.4.2 Review and update, as appropriate, policies describing the frequency or quality of community health status data collections?	NO MINIMAL MODERATE SIGNIFICANT OPTIMAL
1.4.3 Develop a written plan for the continuous improvement of community health monitoring efforts?	NO MINIMAL MODERATE SIGNIFICANT OPTIMAL

Governance Assessment

- Assessment used to consider <u>future</u> implementation models, not current governance

Governance Assessment

- Propose regional public health council with oversight of public health essential services
- Propose 4 potential implementation options

Governance Assessment

- Council designates lead public health entity:
  - Existing private, non-profit
  - Municipality
  - County
  - New private, non-profit for this specific purpose

Modified NACCHO Self-Assessment Tool [DRAFT]

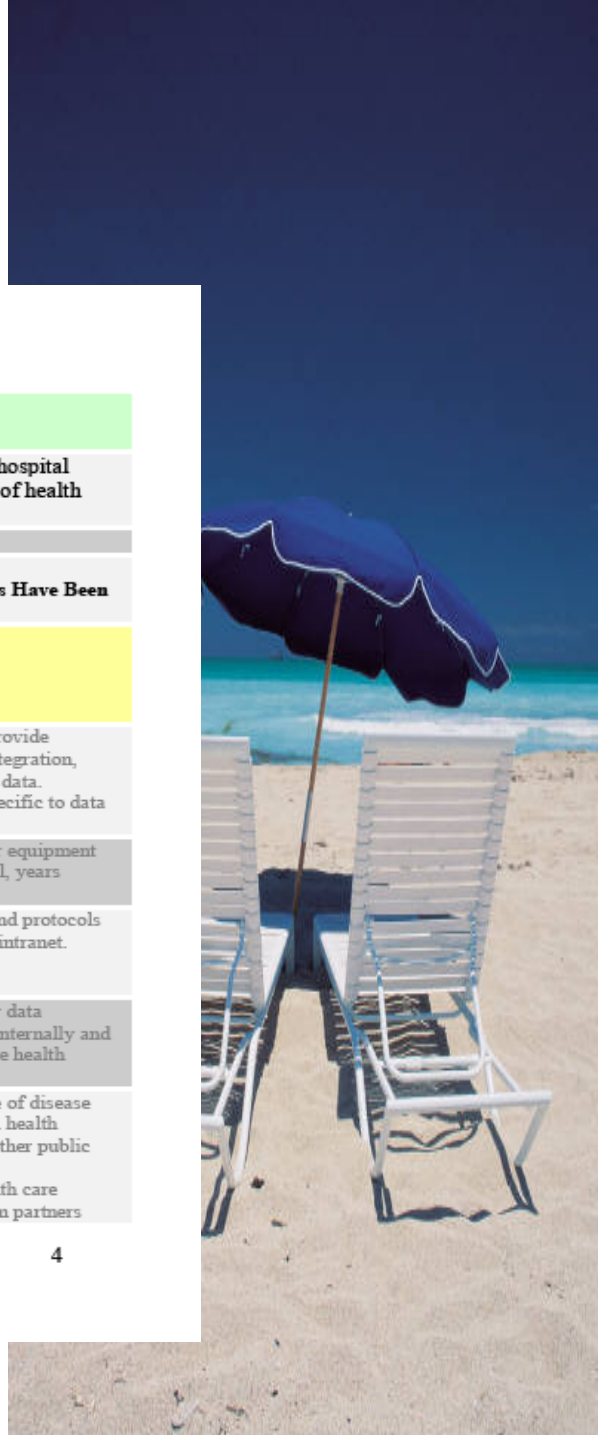
DRAFT DRAFT DRAFT

ESSENTIAL SERVICE I: Monitor health status and understand health issues facing the community

STANDARD I-A Obtain and maintain data that provide information on the community's health (e.g., provider immunization rates; hospital discharge data; environmental health hazard, risk, and exposure data; community-specific data; number of uninsured; and indicators of health disparities such as high levels of poverty, lack of affordable housing, limited or no access to transportation, etc.).

FOCUS: DATA COLLECTION, PROCESSING and MAINTENANCE

Operational Definition Indicators	Capacity Score			Topic	Documents and/or Activities That Demonstrate Indicators Have Been Met
	Lead organization(s)	Additional regional expertise/services	Mean [leave blank]		
1. LHD staff has expertise and training to collect, manage, integrate and display health-related data.				Data	▪ Assess competency level of staff that provide expertise in collection, management, integration, displaying, and reporting health related data. ▪ Provide names, degrees and training specific to data related activities.
2. LHD uses appropriate equipment and technology.				Data	▪ Written description of current computer equipment and technology including brands, model, years purchased.
3. LHD maintains and uses an information system(s) (e.g. email, shared electronic database files, intranet).				Data	▪ List internal communication methods and protocols for use e.g. e-mail, databases, files and intranet.
4. LHD has an electronic linkage with local and statewide databases.				Data	▪ List of databases used and protocols for data collection, analysis and reporting both internally and with external health care providers, state health department and others as appropriate.
5. An electronic disease reporting system exists between the LHD, health care providers, and others in the community who are potential disease reporters e.g. Schools, hospitals.				Data	▪ Has process and protocols for exchange of disease reporting information between the local health department, health care providers and other public health system partners. ▪ Current electronic and paper list of health care providers and other public health system partners



PH Capacity Assessment

- What is each region's capacity to function as a local health department
- What gaps are there around the state that lend themselves to regionalization?

Phase in

- Phase one group – MLC-2
  - Sullivan County
  - Greater Monadnock
  - Strafford County
  - Coos County
  - Mascoma Valley Health Initiative*

- *MLC-3 –

  Caring Communities Network of the Twin Rivers
  Lakes Region Partnership for Public Health
  Mascoma Valley Health Initiative

- All others

RWJ Multi-State Learning Collaborative - 3

- To advance ph accreditation and quality improvement in public health
- Third round of funding – 16 states – FL, MT, NH, OK, WA, SC, MI, MN, NJ, WI, IA, KS, MO, ID,IL,NC

Preparing for Accreditation

- Regionalization and building the public health infrastructure

- **Overall Goal:** A performance-based public health delivery system, which provides all 10 essential public health services throughout New Hampshire

- Repeat National Public Health Performance Standards State Level Assessment

Quality Improvement Learning Teams (QuILTs)

QuILTS:

- 2 cohorts, 3 each, 15 month
- (CCNTR, LRPPH, MVHI)

- Linkage– health status to capacity indicators

  Interest areas:

  - Health Status: Reducing risk factors for chronic illness
  - Capacity: Health improvement planning

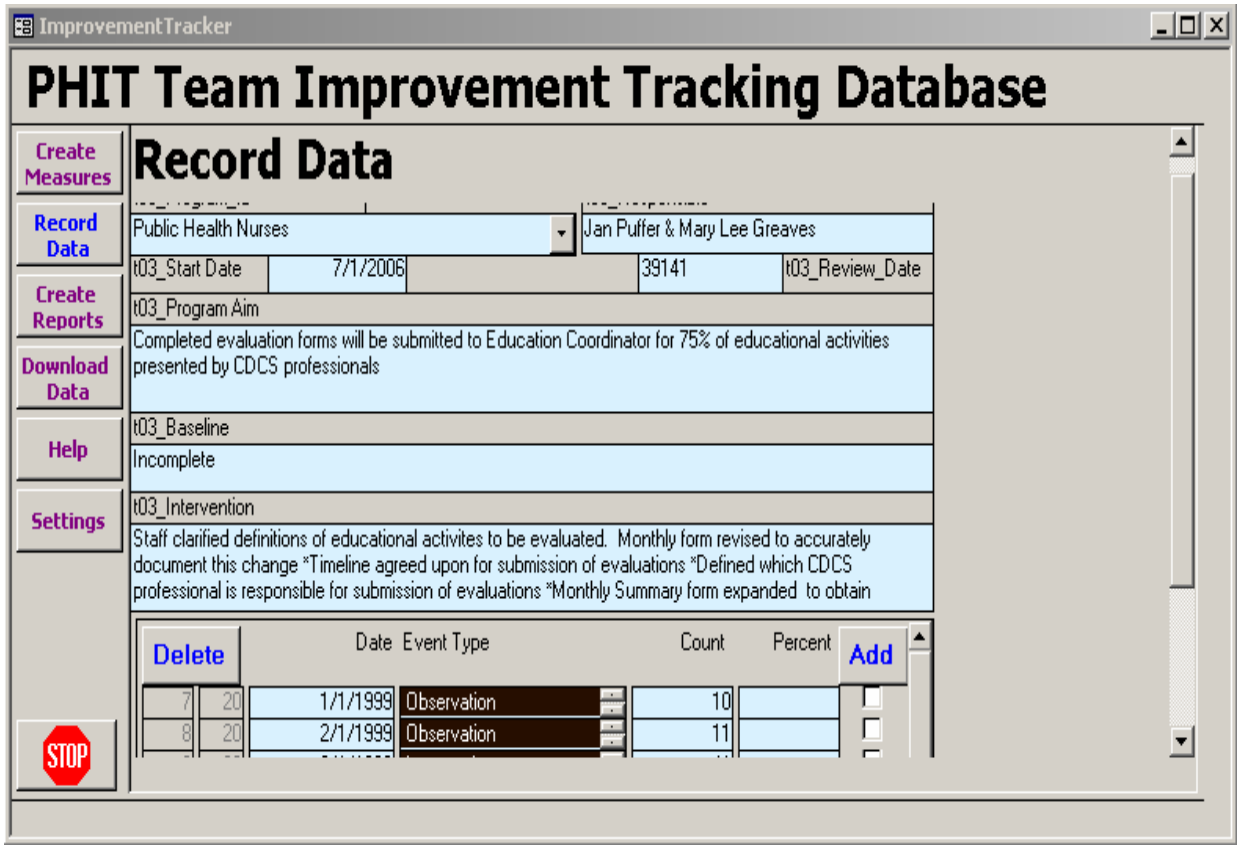
- Aligned with state health priorities and strategic plan

Kickoff Event
September 26th, 2008

8 AM-4 PM -Centennial Inn, Concord

- Keynote Speaker
  Bonnie Zell, MD, MS
  Senior Advisor for Partnership Development
  Division of Healthcare Quality Promotion
  Office of the Director, CDC
  IHI George W. Merck Fellow, 2006-2007
  - Science of QI
  - Application to Public Health
    - National & Local Initiatives
  - QuILT Work Session & Discussion
  - Tracking Tool Training

PHIT Tracking Tool



Most interesting…

- Links with other work
  - DHHS Public Health Improvement Team (PHIT)
  - PHIT Tracking Tool
    - To simplify process of tracking improvement initiatives
  - Partnering with UNH through the CDC Assessment Initiative
    - Develop web-based performance measure module in HealthWRQS application
  - Developing relationships with international QI experts at The Dartmouth Institute for Health Policy and Clinical Practice www.dartmouth.edu/~cecs/
  - Personal research
    - Ayers, LR, Beyea, SC, Godfrey, MM, Harper, DC, Nelson, EC, and Batalden, PB (2005). Quality Improvement Learning Collaboratives. Quality Management in Health Care, 14(4), 234-247.

Hopes and Long Term Goals…

- Demonstrate the value of public health through evidence
- Build capacity
- Foster learning communities of practice
- Create a culture of QI simultaneously through regionalization

Resulting in….

…an accreditable public health system built from the ground up…

Next Steps - Pilots

Pilots

June 2008–June 2009

- Develop a plan to implement the proposed new model in selected regions

- Questions?