- CCH recommends that Curry County directly operate the following Public Health services:
  - Communicable Diseases (CD)
  - Public Health Emergency Preparedness (PHEP)
  - Environmental Health (EH)
  - Safe Drinking Water Program (SDW)
  - Vital Statistics (VS)
  - Women, Infants, & Children (WIC)
  - Immunization School Exclusion Program
  - Public Health Modernization (State-wide and Regional)
  - Tobacco Prevention Education Program (TPEP)
  - Reproductive Health Community Participation & Assurance of Access
  - Alcohol & Drug Prevention Education Program (ADPEP)

- CCH recommends that Curry County consider contracting these services out to local providers:
  - Public Health Practice (PHP -Immunizations)
  - School Based Health Center (SBHC) *CCH has Mental Health SBHC grant approval (these funds are part of the Public Health funding from the State and the grant funds need to continue to be awarded to CCH – this will require a separate contract with the County)
  - Title V Programs
  - Perinatal & Maternal Health (CaCoon, Babies First)

- CCH and Curry County work mutually on returning Public Health to Curry County. This process will ensure Curry County can exercise the public health authority granted by the State of Oregon.
- CCH will assist Curry County with the following:
  - Ask current CCH Public Health employees to apply for the County equivalent position.
  - CCH has an employee that meets all of the minimum qualifications of the PHA and the employee is interested in a County position, should the County provide PH Services. The employee would be available on 10/1/19.
  - Provide all current work product that is not HIPAA sensitive to Curry County to continue the work and prevent an interruption in services.
  - Complete all CCH reporting on Public Health programs no later than January 31, 2020 and submit to Curry County for processing.
  - Discuss potential contracts with Curry County to provide direct client services (reproductive health, immunizations).
  - Provide Curry County with all State purchased equipment (WIC computer, SBHC Immunization refrigerator & freezer, PHEP Satellite Phone, mobile immunization freezer).
  - Provide Curry County with PHEP equipment & supplies purchased or provided by Curry County or the State.

Oregon Health Authority

Public Health Division - Chapter 333

Division 14
STANDARDS FOR STATE AND LOCAL PUBLIC HEALTH AUTHORITIES

333-014-0580
Local Public Health Authority Governance

As provided in ORS 431.413(3) and ORS 190.110, a local public health authority may contract or enter into an agreement with an entity to perform public health services or activities but that entity may not perform any function, duty or power of the local public health authority related to governance. Functions, duties and powers related to governance include but are not limited to:

(1) The exercise of any police power.

(2) Any duty of the governing body of a local public health authority under ORS 431.415.

(3) Enforcement of public health laws, including but not limited to taking an action on a license or permit as described in ORS 431.150.

(4) Ensuring due process for persons with due process rights.

(5) Issuing any order authorized under ORS 431A.010 or ORS chapter 433.

(6) Imposing civil penalties.

(7) Compelling the production of records during a disease outbreak investigation.

(8) Petitioning the court for an isolation or quarantine order under ORS 433.121 to 433.142.

(9) Taking any action authorized during a declared public health emergency under ORS 433.441.

Statutory/Other Authority: ORS 431.149
Statutes/Other Implemented: ORS 431.413
History:
PH 31-2017, adopt filed 12/22/2017, effective 01/01/2018

Please use this link to bookmark or link to this rule.

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Health

Fiscal Year 2018 Local Governmental Public Health Investment - FINAL 5/8/2019

County	Population*	Local Expenditures (less exclusions[1])	In Kind Support[V]	Total Local Investment	Per Capita Total Local Investment	County General Fund (exclusions not removed)	Per Capita GF
Oregon	**4,195,300**	$ 69,230,127	$ 812,425	$ 70,042,552	$ 16.70	$ 51,741,007	12.33
BAKER	16,765	$ 278,170	$ 83,594	$ 361,764	$ 21.58	$ 230,000	13.72
BENTON	93,590	$ 1,791,995	$ -	$ 1,791,995	$ 19.15	$ 1,791,995	19.15
CLACKAMAS	419,425	$ 5,019,520	-	$ 5,019,520	$ 11.97	$ 2,105,163	5.02
CLATSOP	39,200	$ 446,000	$ -	$ 446,000	$ 11.38	$ 461,000	11.76
COLUMBIA	51,900	$ 531,625	$ 83,703	$ 615,328	$ 11.86	$ 72,917	1.40
COOS	63,275	$ 255,216	$ 77,437	$ 332,653	$ 5.26	$ -	0.00
CROOK	22,710	$ 1,484,699	$ 99,989	$ 1,584,688	$ 69.78	$ 726,836	32.01
CURRY	22,915	$ 703,878	$ -	$ 703,878	$ 30.72	$ -	0.00
DESCHUTES	188,980	$ 3,814,900	$ -	$ 3,814,900	$ 20.19	$ 2,323,264	12.29
DOUGLAS	111,735	$ 444,652	$ -	$ 444,652	$ 3.98	$ 460,314	4.12
GRANT~	7,400	$ -	$ -	$ -	$ -		0.00
HARNEY	7,380	$ 159,509	$ 12,761	$ 172,270	$ 23.34	$ 298,214	40.41
HOOD RIVER	25,310	$ 572,647	$ 157,029	$ 729,676	$ 28.83	$ 354,031	13.99
JACKSON	219,200	$ 2,298,330	$ -	$ 2,298,330	$ 10.49	$ 1,035,572	4.72
JEFFERSON	23,560	$ 261,557	$ -	$ 261,557	$ 11.10	$ 398,534	16.92
JOSEPHINE	86,395	$ 641,298	$ 16,700	$ 657,998	$ 7.62	$ 126,000	1.46
KLAMATH	67,960	$ 542,426	$ -	$ 542,426	$ 7.98	$ 222,000	3.27
LAKE	8,115	$ 187,877	$ -	$ 187,877	$ 23.15	$ 72,924	8.99
LANE	375,120	$ 4,024,080	$ -	$ 4,024,080	$ 10.73	$ 1,791,311	4.78
LINCOLN*	48,210	$ 1,458,472	$ -	$ 1,458,472	$ 30.25	$ 189,968	3.94
LINN	125,575	$ 1,327,242	$ -	$ 1,327,242	$ 10.57	$ 988,101	7.87
MALHEUR	31,925	$ 435,955	$ 38,230	$ 474,185	$ 14.85	$ 454,501	14.24
MARION	344,035	$ 4,647,307	$ -	$ 4,647,307	$ 13.51	$ 2,140,582	6.22
MORROW	11,885	$ 702,506	$ 10,317	$ 712,823	$ 59.98	$ 598,276	50.34
MULTNOMAH	813,300	$ 25,329,190	$ -	$ 25,329,190	$ 31.14	$ 27,385,289	33.67
North Central PHD	30,970	$ 682,867	$ 89,574	$ 772,441	$ 24.94	$ 582,928	18.82
GILLIAM	1,985						
WASCO	27,200						
SHERMAN	1,785						
POLK	82,100	$ 291,010	$ -	$ 291,010	$ 3.54	$ 310,000	3.78
TILLAMOOK	26,395	$ 119,798	$ -	$ 119,798	$ 4.54	$ 87,530	3.32
UMATILLA	80,765	$ 435,117	$ 97,200	$ 532,317	$ 6.59	$ 370,221	4.58
UNION	26,885	$ 112,200	$ 41,090	$ 153,290	$ 5.70	$ 170,000	6.32
WALLOWA^	7,175				$ -		0.00
WASHINGTON	606,280	$ 8,674,852	$ -	$ 8,674,852	$ 14.31	$ 5,203,610	8.58
WHEELER	1,450	$ 1,991	$ 4,800	$ 6,791	$ 4.68	$ 1,991	1.37
YAMHILL	107,415	$ 1,553,242	$ -	$ 1,553,242	$ 14.46	$ 787,935	7.34

Population estimates prepared by Charles Rynerson, Population Research Center, College of Urban and Public Affairs, Portland State University December 17, 2018

This table reflects all county government investments in local public health as measured by expenditures paid by county funds or other revenue generated by the county or public health district (insurance reimbursement, license fees, etc) minus exclusions outlined below during fiscal year 2018.

[1] Exclusions include: Ryan White case management, reproductive health client services, immunization clinics, clinical support, corrections health, individual dental services, primary care services, occupational health services, medical examiner services, mental health/addiction services and treatment, emergency medical services, refugee resettlement screening, animal control/shelter, and infrastructure costs directly related to these exclusions.

[V] In Kind Support: Non-cash contribution by county government of goods or services such as building space that is provided rent free. In-kind support should be valued at the fair market rate of the goods or services at the date it is received.

~ Data not included due to lack of validation

* In-kind excluded due to lack of validation

^ No longer performs local public health authority responsibilities

Health

Local Government Public Health Investment – Fiscal Year 2018

Background

Oregon Revised Statutes 431.380 requires Oregon Health Authority to adopt a funding formula for the purposes of funding foundational public health programs and capabilities. The funding formula must incorporate "a method for awarding matching funds to a local public health authority that invests in local public health activities and services" beyond base funding provided by the Oregon Legislature.

While the Legislature has not yet appropriated funds to implement the funding formula, Oregon Administrative Rules 333-014-0540 requires local public health authorities to report expenditure data annually. These data will be used to determine matching funds, if funding is available.

Expenditure Data

Oregon Health Authority and local public health authority (LPHA) representatives developed a framework to establish consistent definitions for expenditure data submission. In addition, the Public Health Advisory Board and the Conference of Local Health Officials provided input to the Oregon Health Authority Public Health Director on the data to include and exclude.

The final framework excludes some expenditures in order to meet the legislative intent to use new state funds to support public health foundational programs and capabilities. Excluded expenditures include: Ryan White program case management, reproductive health client services, immunization clinics, clinical support, corrections health, individual dental services, primary health care services, occupational health services, medical examiner services, mental health/addiction services treatment and services, emergency medical services, refugee resettlement screening, animal control/shelter services, and infrastructure costs directly related to these exclusions. All other expenditures were included.

LPHAs reported county government public health investments using funding sources such as county general fund, county or public health district fee revenue and/or county or public health district-generated third-party reimbursement. The data do not include expenditures paid by any other funding sources such as grants or other support from federal, state or private funders.

Once LPHAs reported expenditure data to the Oregon Health Authority, Public Health Division fiscal staff reviewed supporting documents to validate the data.

What is a Local Public Health Authority?

- A county government; OR
- A health district formed under ORS 431.443 (two or more contiguous counties combine for purpose of forming a public health district); OR
- An intergovernmental entity that provides public health services pursuant to agreement entered into ORS 190.010

What Does a Local Public Health Authority (LPHA) Have to Do?

- There are specific LPHA responsibilities outlined in Oregon Revised Statutes (ORS)
- Outlined in OAR 333-014-0550
- Not all of the responsibilities have to be performed directly by the LPHA, the LPHA is ultimately responsible for them
- Some of the funding the LPHA receives through the Financial Assistance Agreement (FAA) can be used to cover the costs of performing these responsibilities
- The LPHA is responsible even if the LPHA does not sign on to the FAA.

LPHA Statutory Responsibilities

1. Accepting reports of reportable disease, disease outbreak or epidemics and investigating reportable diseases, disease outbreaks, or epidemics.
2. Issuing or petitioning for isolation and quarantine orders.
3. Review of immunization records and issuing exclusion orders.
4. Making immunizations available (means ensuring the provision).
5. Duties and activities related to enforcing the ICAA, if delegated by OHA
6. Ensuring access to family planning and birth control services.
7. Licensure of tourist accommodations, including hostels, picnic parks, recreation parks and organizational camps, if delegated by OHA.
8. Licensure of pools and spas, if delegated by OHA.
9. Restaurant licensure, including commissaries, mobile units, vending machines and bed and breakfasts, if delegated by OHA.
10. Regulation of public water systems, if delegated by OHA.
11. Enforcement of public health laws under ORS 431.150.
12. The duties specified in ORS 431.413

Governance Functions of LPHA

Outlined in OAR 333-014-0580

- The exercise of any police power
- Any duty of the governing body of a local public health authority under ORS 431.415
- Enforcement of public health laws, including but not limited to taking an action on a license or permit
- Ensuring due process for persons with due process rights
- Issuing any order authorized under ORS 431A.010 or ORS 433.
- Imposing civil penalties
- Compelling the production of records during a disease outbreak investigation
- Petitioning the court for an isolation or quarantine order
- Taking any action authorized during a declared public health emergency

What Options Does the LPHA Have for Delivering Services and Governance Responsibilities?

Option 1: Directly provide all local public health services and governance

Option 2: Form a public health district with at least one other adjacent county to provide all local public health services and governance

Option 3: Create an intergovernmental entity to provide all public health services and governance

Option 4: Contract with another LPHA or private entity to provide some public health services, excluding governance

Option 5: Contract with another LPHA or private entity to provide all public health services, excluding governance

Contracting for Public Health Services

- Governance functions can never be contracted out
- LPHA must still employ a local public health administrator (may make request to OHA for administrator to be less than full-time)
- Subcontractor(s) must be monitored for fiscal and programmatic compliance
- Most federal funds require a higher standard for contract administration and monitoring when subcontracting the funds out
- Relationship between health officer and LPH administrator must be clear and in writing
- Matching funds requirement for Babies First! Program to bill Medicaid
- Vital records considerations
- Applicability of ORS 236.610 (employee transfer statute)
- Ultimately the LPHA (county) is responsible for the services provided as the IGA is between OHA and the LPHA
- Setting up these arrangements takes a lot of time (~ 9 months) and requires good communication planning

What if the LPHA No Longer Wants Its Authority and Related Responsibilities?

- ORS 431.382 and OAR 333-014-0590
- If OHA does not receive funds that equal or exceed estimates for implementation of public health modernization an LPHA may transfer duties to the OHA.
- **All** authority and responsibilities must be transferred, not a portion.
- Unless agreed upon with OHA, cannot transfer responsibilities back to LPHA for at least four years

Process for Transfer of LPHA

- County government adopts ordinance or resolution to transfer LPHA to OHA no sooner than180 days from date of adoption

- Notify OHA Public Health Director in writing within two days of ordinance adoption (provide copy of ordinance/resolution when available)

- LPHA is required to fulfill contractual and statutory requirements until the date of transfer

Local Public Health Authority (LPHA) Structures

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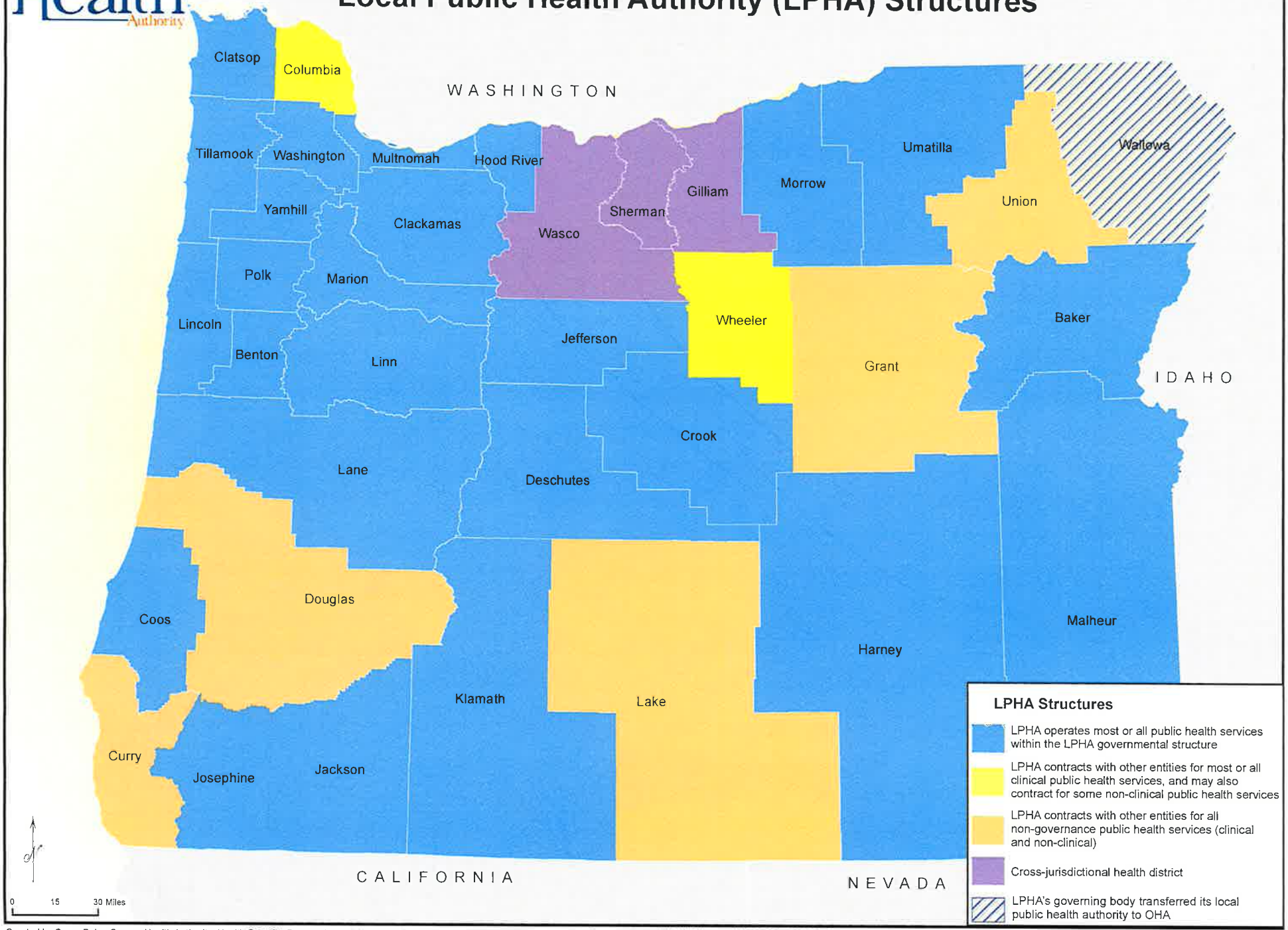


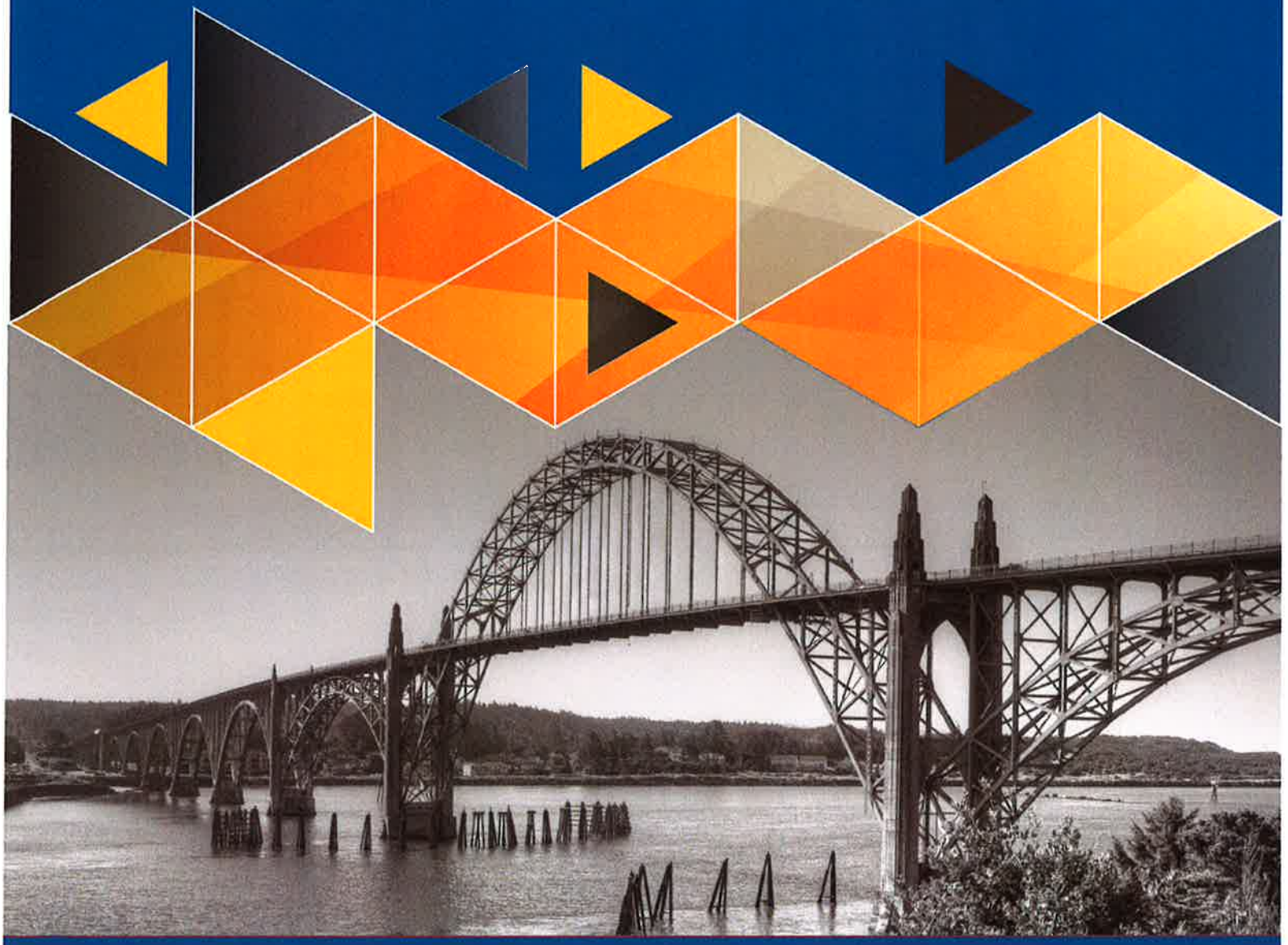
Created by Carey Palm, Oregon Health Authority; Health Security, Preparedness & Response Program. The information contained herein is derived from digital databases of HSPR GIS. HSPR will not accept responsibility for any errors, omissions or positional accuracy. There are no warranties, expressed or implied, accompanying this product. However, notification of any errors will be much appreciated. 503.381.9579 CAREY.L.PALM@STATE.OR.US NAD1983 OR Lambert Projection

Updated 9/9/19.

Local Public Health Authority Resource Guide

For governing bodies of Oregon's local public health authorities and local public health administrators

December 2018



Oregon Health Authority
PUBLIC HEALTH DIVISION

Acknowledgements

The primary authors for this report were:

- Kim La Croix, public health systems consultant, Oregon Health Authority Public Health Division
- Andrew Epstein, public health systems consultant, Oregon Health Authority Public Health Division
- Danna Drum, strategic partnerships lead, Oregon Health Authority Public Health Division

Oregon Health Authority Public Health Division would also like to thank the following resource guide key informants for sharing experiences in their communities:

- Bob Dannenhoffer, MD, local public health administrator and health officer, Douglas County; executive director, Douglas Public Health Network.
- Tricia Mortell, MPH, RD, local public health administrator, Washington County
- Mike Weber, local public health administrator, Josephine County

Contents

Background and objectives

Background

Local public health authorities (LPHAs) throughout Oregon are changing how they deliver public health services and activities in response to community needs, fiscal constraints and public health modernization. This resource guide will provide information LPHAs and health administrators may need as they navigate transitioning public health services or programs.

What is a local public health authority?

- A county government
- A health district formed under ORS 431.443 (two or more contiguous counties combine for purpose of forming a public health district)
- An intergovernmental entity that provides public health services under ORS 190.010.

Objectives of this guide

The governing bodies of LPHAs will:

- Describe the general structure of Oregon's public health system and options for how public health services are delivered within an LPHA jurisdiction
- Identify the legal and governance requirements of an LPHA
- Understand how public health is funded in Oregon and how funding is distributed to LPHAs
- Recognize best practices for engaging in a thoughtful community process to ensure basic public health protections
- Understand required processes to effectively implement and monitor subcontracts for delivering public health services
- List key evaluation questions to assess effectiveness of public health delivery models.

PUBLIC HEALTH DIVISION
Office of the State Public Health Director
Kate Brown, Governor

Oregon Health Authority

800 NE Oregon St.
Portland, OR 97232

Dear Elected Officials and Local Public Health Leaders,

Oregon's changing public health system is actively innovating to provide core public health functions while maintaining flexibility to meet new health challenges in every area of the state. Achieving the goal of better health for all Oregonians requires all of us to evaluate how public health services are currently delivered in our communities and determine if there are new and different models that will result in better health outcomes and gained efficiencies. Local communities are best positioned to make those determinations.

We hope this guide will be one of the resources you use as you examine and possibly re-imagine public health in your community. Public health is complex. Some public health functions can only be performed by government; other functions, depending on each community's context, may be better suited for other local or regional partners. This guide distinguishes those governmental functions and outlines some potential public health delivery models you might consider if you determine new models are needed for your community.

If you have additional questions after reviewing this guide, we are here to help. Please do not hesitate to contact us at 971-673-1222.

Together we can modernize Oregon's public health system so all Oregonians can be healthy where they live, work, play and learn.

Respectfully,

Lillian Shirley

Lillian Shirley, BSN, MPH, MPA
Public Health Director
Oregon Health Authority, Public Health Division

Chapter 1

Public health overview

Oregon's public health system overview

Having a basic understanding of Oregon's public health system will help inform decisions about the best way for your LPHA to structure public health services within your jurisdiction. This chapter covers what a local public health authority must do and options for delivering services and governance responsibilities.

Resources in this chapter include:

- Oregon public health system overview
- Local public health authority overview

What is public health?

Public health refers to all organized measures to prevent disease, promote health and prolong life among the population as a whole. (1)

Public health activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases.

Oregon's public health system

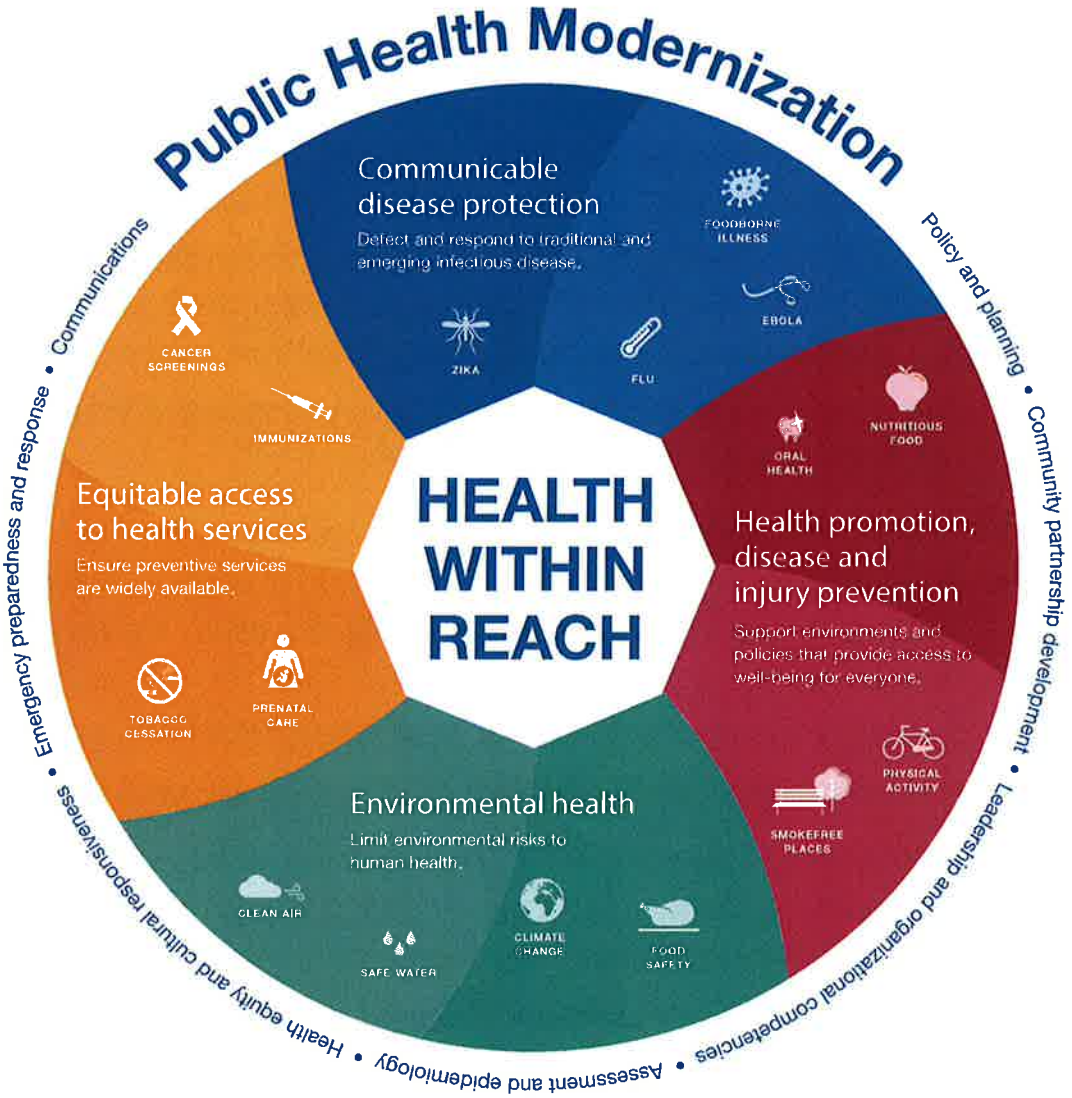
Oregon has a decentralized public health structure. The Oregon Health Authority (OHA) Public Health Division (PHD) delivers state public health.

Oregon has 36 counties. Thirty-three have local public health authorities, but three counties came together as one health district (Wasco, Sherman and Gilliam). One county, Wallowa, transferred its local public health authority

to OHA in 2018. The public health system is comprised of state public health, local public health, tribes and other entities. The system is organized to support the health of all Oregonians where they live, work, learn and play.

Public health modernization

Public health modernization ensures basic public protections critical to the health of all Oregonians and future generations. These include protection from communicable diseases and environmental risks, health promotion, prevention of chronic diseases and injury, and responding to new health threats.



Local public health authority overview

What is a local public health authority?

- A county government or
- A health district formed under ORS 431.443 (two or more contiguous counties combine for purpose of forming a public health district) or
- An intergovernmental entity that provides public health services pursuant to agreement entered into under ORS 190.010.

What does a local public health authority (LPHA) have to do?

- Specific LPHA responsibilities are outlined in Oregon Revised Statutes (431.001 through 431.550) and in Oregon Administrative Rules (OAR 333-014-0550).
- While the LPHA does not have to directly perform all its statutory responsibilities, the LPHA is ultimately responsible for them.
- Some of the funding the LPHA receives through the Intergovernmental Agreement for the Financing of Public Health Services (PH IGA) can be used to cover the costs of performing these responsibilities.
- The LPHA is responsible for its statutory responsibilities even if the LPHA does not enter into the PH IGA.

LPHA statutory responsibilities

- Accepting reports of reportable diseases, disease outbreak or epidemics and investigating reportable diseases, disease outbreaks or epidemics
- Issuing or petitioning for isolation and quarantine orders
- Review of immunization records and issuing exclusion orders
- Making immunizations available (i.e., ensuring the provision)
- Duties and activities related to enforcing the Indoor Clean Air Act (ICAA), if delegated by OHA
- Ensuring access to family planning and birth control services

- Licensure of tourist accommodations, including hostels, picnic parks, recreation parks and organizational camps, if delegated by OHA
- Licensure of pools and spas, if delegated by OHA
- Restaurant licensure, including commissaries, mobile units, vending machines and bed and breakfasts, if delegated by OHA
- Regulation of public water systems, if delegated by OHA
- Enforcement of public health laws under ORS 431.150
- The duties specified in ORS 431.413.

LPHA governance functions (Outlined in OAR 333-014-0580):

- The exercise of any police power
- Any duty of the governing body of a local public health authority under ORS 431.415
- Enforcement of public health laws, including but not limited to taking an action on a license or permit
- Ensuring due process for persons with due process rights
- Issuing any order authorized under ORS 431A.010 or ORS 433
- Imposing civil penalties
- Compelling the production of records during a disease outbreak investigation
- Petitioning the court for an isolation or quarantine order
- Taking any action authorized during a declared public health emergency

What options does the LPHA have for delivering services and governance responsibilities?

Option 1:
Directly provide all local public health services and governance.
This is the structure that most LPHAs in Oregon use.

Option 2:
Form a public health district with at least one other adjacent county to provide all local public health services and governance.

Option 3:
Create an intergovernmental entity to provide all public health services and governance.

Option 4:
Contract with another LPHA or private entity to provide some public health services.

Option 5:
Contract with another LPHA or private entity to provide all public health services, excluding governance.

Local structures

Five of the 33 local public health authorities in Oregon contract 100% of their non-governance public health services to other entities. These counties are Curry, Douglas, Wheeler, Grant and Union. Of these five, the county government is investing county general funds into three. (2) Wasco, Sherman and Gilliam counties have formed the North Central Public Health District. A number of LPHAs contract for specific public health services. See Chapter 3, "LPHA structures and options," for a map of local public health authority structures.

Six counties also provide full primary care through a county-run federally qualified health center. These counties are Benton, Clackamas, Lane, Lincoln, Multnomah and Lincoln. (3)

Chapter 2

Legal and governance considerations

Following the rules

Federal and state statutes, administrative rules and regulations, local ordinances and other funding requirements outlined in the Public Health Intergovernmental Agreement (IGA) for the Financing of Public Health Services (FAA) and the IGA for Environmental Public Health Services dictate how public health services must be delivered. This chapter sorts through the legal jargon and provides clear guidance on statutorily required programs and activities and local public health authority governance responsibilities.

Resources in this chapter include:

- Required LPHA governance functions
- Health administrator roles and responsibilities
- Health officer roles and responsibilities
- Vital records guidance

Required LPHA governance functions

Oregon statutes state that the following activities must be done by the local public health authority. A contractor would not be able to perform them because these activities involve governance functions.

Local Public Health Authority Governance (OAR 333-014-0580)

As provided in ORS 431.413(3) and ORS 190.110, a local public health authority may contract or enter into an agreement with an entity to perform public health services or activities but that entity may not perform any function, duty or power of the local public health authority related to governance. Functions, duties and powers related to governance include but are not limited to:

1. The exercise of any police power
2. Any duty of the governing body of a local public health authority under ORS 431.415
3. Enforcement of public health laws, including but not limited to taking an action on a license or permit as described in ORS 431.150
4. Ensuring due process for persons with due process rights
5. Issuing any order authorized under ORS 431A.010 or ORS 433
6. Imposing civil penalties
7. Compelling the production of records during a disease outbreak investigation
8. Petitioning the court for an isolation or quarantine order under ORS 433.121 to 433.142
9. Taking any action authorized during a declared public health emergency under 433.441.

Examples

Some practical examples of the above functions include:

- Environmental health functions such as issuing licenses or other orders (e.g., cease and desist orders for non-compliant restaurants). A contracted entity may do restaurant inspections, but only the LPHA may issue licenses, civil penalties or other orders.
- School exclusion orders for lack of immunizations, exclusions from work or school due to communicable disease. A contracted entity may run the reports, but only the LPHA may enforce the orders.
- Petitioning the court for quarantine for tuberculosis (TB). A contracted entity may test and treat someone with TB, but only the LPHA can petition for a quarantine order.

Local public health authority governance

Program element (PE)* or intergovernmental agreement (IGA)	Statutory responsibility PE Helps Fund (OAR 333-014-0550)	Governance function included in PE (OAR 333-014-0580) Functions only the governmental public health authority can do
PE 1 – State support for public health	Communicable disease reporting and investigation, isolation and quarantine orders	Compelling the production of records during a disease outbreak investigation Petitioning the court for an isolation or quarantine order
PE 3 – Tuberculosis	Communicable disease reporting and investigation, isolation and quarantine orders	Compelling the production of records during a disease outbreak investigation Petitioning the court for an isolation or quarantine order
PE 10 – Sexually transmitted disease	Communicable disease reporting and investigation, isolation and quarantine orders	Compelling the production of records during a disease outbreak investigation Petitioning the court for an isolation or quarantine order

* Program elements are the programmatic and service deliverables in the IGA for Financing of Public Health Services (PH IGA). They describe the services the local public health authorities provide based on the agreement with the Oregon Health Authority. Each program element is negotiated with the Conference of Local Health Officials.

Program element (PE)* or intergovernmental agreement (IGA)	Statutory responsibility PE Helps Fund (OAR 333-014-0550)	Governance function included in PE (OAR 333-014-0580) Functions only the governmental public health authority can do
PE 12 – Public health emergency preparedness	Communicable disease work, public health emergencies, isolation and quarantine orders in emergency	Taking any action authorized during a declared public health emergency under ORS 433.441
PE 13 – Tobacco prevention and education	Duties and activities related to enforcing the Indoor Clean Air Act	N/A. OHA issues civil penalties related to ICAA violations.
PE 46 – Reproductive health	Ensuring access to family planning and birth control services	N/A
PE 43 – Immunization services	Immunization record review, exclusion orders, making immunizations available	Enforcement of school exclusion orders
PE 50 – Drinking water services	Regulation of public water systems	N/A. OHA issues civil penalties related to drinking water systems violations.
Environmental health IGA	Licensure of tourist accommodations, restaurants, and pools and spas	Enforcement of public health laws, such as taking action on a restaurant license or permit
		Imposing civil penalties

Health administrator roles and responsibilities

Each local public health authority (LPHA) is required to appoint a local public health administrator (administrator) to supervise the LPHA's public health programs and public health activities.

Recommended administrator qualifications - OAR 333-014-0520(1)

- Bachelor's degree
- Public health work experience and education that demonstrates competency in the foundational programs and foundational capabilities.

ORS 431.418 (1) Each local public health authority shall appoint a qualified local public health administrator to supervise the activities of the local public health authority. In making an appointment under this subsection, the local public health authority shall consider standards for selection of local public health administrators prescribed by the Oregon Health Authority.

Notification to OHA – OAR 333-014-0520 (2)

When the LPHA appoints a local public health administrator, the LPHA must provide notice of the appointment to OHA along with a copy of the administrator's resume or curriculum vitae.

Terms of employment

OAR 333-014-0520(3) states that each LPHA shall employ a full-time local public health administrator unless OHA approves the LPHA's request for less than full time. The request must be submitted in writing by the governing body of the LPHA to the state public health director with the following information:

- The number of hours per week the LPHA intends the administrator to work and
- How the administrator, if working less than full time, can fulfill the requirements in ORS 431.418(3).

OHA will inform the LPHA in writing whether the request to have a less than full-time administrator is approved or denied. The decision will be based on whether OHA determines that the administrator can fulfill the requirements in ORS 431.418(3) working less than full time. OAR 333-014-0520(4)

An administrator shall serve until removed by the appointing LPHA, and may not engage in an occupation that conflicts with the administrator's official duties. ORS 431.418(4)

An administrator shall receive a salary fixed by the appointing board and shall be reimbursed for actual and necessary expenses incurred in the performance of duties. ORS 431.418(5)

Administrator relationship to the LPHA

Because the administrator is responsible for governmental public health functions, he or she must be employed by and receive a salary from the LPHA. Selection of an administrator may not be delegated by the LPHA to a contractor. If the governing body of an LPHA chooses to contract some or all non-governance public health services to other entities, the

administrator must remain employed by the LPHA at a sufficient level to be able to perform governance functions, or supervise others who are employed by the LPHA to perform governance functions as delegated by the administrator. (LPHA contractors may not perform functions, duties or powers related to governance, including those listed in OAR 333-014-0580.)

Administrator roles and responsibilities

The administrator is accountable to the governing body of the LPHA for supervision of the LPHA's activities.

If the administrator is a physician licensed by the Oregon Medical Board, the administrator shall serve as the local health officer for the LPHA. If not a physician, the administrator shall employ or otherwise contract for services with a local health officer.

Duties of the administrator as stated in ORS 431.418(3) include:

- Appoint, subject to the approval of the governing body of the LPHA, individuals to carry out the duties of the administrator under ORS 431.001 to 431.550 and 431.990 and any other public health law of this state
- Act as the administrator of the LPHA and supervise the officers and employees appointed
- Provide the governing body of the LPHA information concerning the LPHA's activities and submit an annual budget for the approval of the governing body of the LPHA
- Act as the agent of OHA in enforcing state public health laws and rules as may be requested by OHA. Perform any other duty required by law.

Health officer roles and responsibilities

Each local public health authority (LPHA) is required to have a health officer to advise the local public health administrator on medical and paramedical aspects of the public health activities and services delivered by the LPHA.

ORS 431.418 (2) When the local public health administrator is a physician licensed by the Oregon Medical Board, the local public health administrator shall serve as the local health officer for the local public health authority. When the local public health administrator is not a physician licensed by the Oregon Medical Board, the local public health administrator shall employ or otherwise contract for services with a local health officer who is a physician licensed by the Oregon Medical Board to perform the specific medical responsibilities requiring the services of a physician. A physician employed or whose services are contracted for under this subsection is responsible to the local public health administrator for the medical and paramedical aspects of the public health programs administered by the local public health administrator.

Qualifications

If the local public health administrator is a licensed physician in Oregon, he or she shall also serve as the local health officer for the LPHA. When the local public health administrator is not a licensed physician, the LPHA shall employ or contract for services with a local health officer.

Health officer relationship to the LPHA

The health officer must be connected to the LPHA through a written agreement indicating the relationship between the health officer and the LPHA. The health officer may have many roles outside of the LPHA (e.g., medical director for a subcontractor of the LPHA, primary care provider). When acting in the health officer role, the health officer must act as part of the LPHA (e.g., petitioning the court for a quarantine order). The local public health administrator may not delegate selection of a health officer to a contractor.

Health officer roles and responsibilities

The health officer is accountable to the local public health administrator for the medical and paramedical aspects of public health programs administered by the local public health administrator.

Duties of the health officer may include:

- Providing routine medical direction and consultation to the LPHA's clinical and population health programs
- Reviewing and signing standing orders and protocols and
- Providing medical guidance during outbreaks.

In addition, health officers may also provide leadership or support for broader community-wide efforts related to communicable disease control, health promotion and prevention, environmental health, access to preventive services and emergency preparedness and response.

Some LPHAs have adopted cross-jurisdictional sharing arrangements related to the health officer role. Multnomah, Washington and Clackamas counties have a regional model with a tri-county health officer who oversees a team of three deputies. Functionally, each deputy reports to its county's local public health administrator, while the team approach enables coverage and surge capacity throughout the tri-county area. Some other LPHAs (e.g., Benton and Linn counties) have entered into agreements where neighboring LPHAs' health officers may provide backup health officer services when needed.

Suggested components to include in a health officer agreement:

- Supervision — who supervises the health officer and how the supervision occurs
- Scope of work — medical and other responsibilities
- Payment — amount (may vary for different duties such as base pay and during emergencies
- Office support — space and services, computer support
- Attendance at trainings, meetings and conferences — required or recommended trainings (e.g., OR-Epi)
- Outside work — requires the health officer to provide information on the nature of outside work.

Vital records guidance

Background

State and local governments in Oregon are responsible for issuing certified copies of vital records for events that occurred within Oregon.

Most county vital records offices in Oregon issue birth and death records for six months following the date of the event. Primary tasks also include issuing certified copies of death and birth records that occurred within six months, registering death records, collecting fees for the records and providing general assistance to families, funeral directors and public health partners related to vital records. These duties are outlined in ORS 432.035 and OAR 333-011-0205.

Governance

The issuance of vital records is a governance function, meaning that the functions must be overseen by a government agency. County registrars must be government employees. However, if the county registrar can ensure compliance of all operations of the county vital records office, the county registrar may designate deputy county registrars who are not employees of a government entity.

The following instructional memo (2017-10) clarifies roles, responsibilities and notification requirements related to county registrars and deputy county registrars.

PUBLIC HEALTH DIVISION
Center for Health Statistics
Kate Brown, Governor

Oregon Health Authority

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October 24, 2017

TO: County Registrars & Deputy County Registrars

FROM: Jennifer A. Woodward, Ph.D.
State Registrar
Center for Health Statistics

RE: Instructional Memo (2017-10)
County and Deputy County Registrar Roles and Responsibilities

This Instructional Memo is a supplement to Instructional Memo (2016-06) and **does not** replace Instructional Memo (2016-06).

Oregon has a statewide vital statistics system. This means the state registrar is responsible ensuring that all laws and regulations are followed throughout the state. The state registrar works cooperatively with county vital records offices to provide secure records and consistent service across the state. To support these goals, Oregon law requires county registrars and deputy registrars to comply with all instructions of the state registrar. (ORS 432.035)

While the great majority of vital records requirements are in statute (*Chapter 432 – Vital Statistics*) and administrative rule (*Chapter 333, Division 11*), procedures or other instructions supported by law are sometimes needed. These procedures are shared through Instructional Memos (IM) such as this one.

The purpose of this Instructional Memo is to clarify the roles and responsibilities of the county registrar and deputy county registrar. According to ORS 432.035, "the state registrar shall designate for each county a government employee or, to the extent allowed under state and federal law, an employee of a local public health authority as defined in ORS 431.003, to act as a county registrar." Current law, ORS 431.003(7), defines a local public health authority as one of the following:

(1) A county government;

(2) A health district formed under ORS 431.443; or

(3) An intergovernmental entity that provides public health services pursuant to an agreement entered into under ORS 190.010 (5).

Therefore, the state registrar may only appoint a county registrar who is a government employee since the definition of local public health authority only includes governmental entities.

ORS 432.035 also states that the county registrar, in consultation with the state registrar, can designate one or more deputy county registrars. In designating deputy county registrars, county registrars must:

- have sufficient contact with deputy county registrars to ensure compliance with ORS 432 Vital Statistics and OAR 333 Division 11;
- meet all compliance standards related to:

  Notification and approval of County and Deputy County Registrars

  Registration of death records

  Completion of voluntary acknowledgment of paternity forms

  Confidentiality of records

  Issuance of certified copies of birth and death records

  Collection of fees

  (Physical) Security of documents

  Penalties; and

- have sufficient control over the operations needed to meet the standards above. These compliance standards are included in the vital records review tool, IM 2016-06 and are supported by ORS 432 and OAR 333 Division 11.

If the county registrar can meet these standards and ensure that a deputy county registrar can meet the compliance standards above, the county registrar may appoint an employee of a non-governmental entity to act as a deputy county registrar. If a county registrar appoints an individual who is not a government employee as a deputy county registrar, the county registrar must have a legally binding agreement in place with the deputy county registrar or the entity for which the deputy works, requiring compliance with applicable vital records laws and state registrar instructions.

In sum, county registrars must be government employees. However, if the county registrar can ensure compliance of all operations of the county vital records office, the county registrar may designate deputy county registrars who are not employees of a government entity. The county registrar, and presumably their government office, is legally responsible for all operations at the county vital records office.

The state registrar will approve in writing county registrar appointments by issuing commission certificates annually or when staff transitions occur.

County registrars must consult with the state registrar prior to the appointment of any deputy county registrars and must provide notice to the state registrar of the appointment or removal of any deputy county registrar.

Chapter 3

Local public health authority structures and options

There are a variety of options for how public health services are delivered within an LPHA jurisdiction. All of the models have different costs and benefits, including potentially significant fiscal and programmatic implications. This chapter will review the options as well as key steps in the process of determining the most effective and efficient public health services model for a community.

Resources in this chapter include:

- LPHA options
  - » Key steps to determining the right option
  - » Cross-jurisdictional sharing (CJS) resources
  - » Principles of community engagement
- LPHA structure map

Options for delivering public health services

As noted in Chapter 1 of this guide, a local public health authority (LPHA) is defined in Oregon law as:

- A county government or
- A health district formed under ORS 431.443 (two or more contiguous counties combine for purpose of forming a public health district) or
- An intergovernmental entity that provides public health services pursuant to an agreement entered into under ORS 190.010.

While state law does not allow LPHAs to delegate their governance functions, a variety of options exist for how public health services may be delivered within an LPHA's jurisdiction.

Option 1:
LPHA directly provides all local public health services and governance. Most LPHAs in Oregon use this model.

Option 2:
County forms a public health district with at least one other adjacent county to be the LPHA and provide all local public health services and governance.

Option 3:
Create an intergovernmental entity to be the LPHA and provide all public health services and governance.

Option 4:
Contract with another LPHA or private entity to provide some public health services while retaining local public health authority. Several LPHAs use this option for providing various public health services in their jurisdictions. Some examples of services for which an LPHA contracts include, but are not limited to:

- Environmental health inspections
- Nurse home visiting services
- Immunization clinics
- Tobacco prevention activities

Option 5:
Contract with another LPHA or private entity to provide all public health services, excluding governance functions.

All of these models have different costs and benefits, including potentially significant fiscal and programmatic implications. Any contracting arrangements require the LPHA governing body to remain actively engaged and responsible for contract monitoring as well as LPHA governance functions. None of these models eliminate local governance duties and responsibilities.

Because the delivery of public health services is flexible and varies across Oregon's public health system, how does an LPHA governing body (board

of county commissioners, county court, etc.) determine the best model for its community?

Some LPHA governing bodies have convened a steering committee of local leaders, public health experts and community partners to guide the planning and implementation process for changes to local public health service delivery.

Here are some key steps in the process of determining the most effective and efficient public health services model for a community:

1. **Understand public health.**
   - » Develop a robust understanding of the comprehensive nature of public health authority and services in the community.
   - » Sometimes local leaders and community members focus on the individual services (e.g., WIC, immunizations, family planning) when considering local public health. However, developing a thorough understanding of the governmental public health functions is essential because those functions cannot be legally delegated.
   - » Talk with the local public health administrator, local public health administrators in other jurisdictions and the Oregon Health Authority Public Health Division to learn how local public health services are delivered in your jurisdiction and statewide.
   - » Review the public health-related Oregon Revised Statutes and Oregon Administrative Rules to understand the legal parameters of local public health authority.

2. **Identify strengths and opportunities through community engagement.**

   Identify what is working and not working with the current public health model in the jurisdiction by engaging with groups in your community that can provide helpful information about strengths and areas for improvement.

   The Centers for Disease Control and Prevention (CDC) defines community engagement as "the process of working collaboratively

with groups of people who are affiliated by geographic proximity, special interests or similar situations with respect to issues affecting their well-being." (4)

Key groups to engage with include:

» Local public health staff

» Local community partners, including:

- Early learning councils
- Regional health equity coalitions (RHECs)
- Coordinated care organizations (CCOs)
- Oregon's community health centers/federally qualified health centers (FQHCs)
- Community action agencies (part of Community Action Network)

» Representatives from priority populations and those who receive public health services

» Oregon Health Authority Public Health Division staff.

Genuinely engage these groups in a process to gather their input as they also have a stake in a strong public health authority in the jurisdiction. Identify multiple means through which input can be solicited such as surveys, individual meetings and community meetings.

Tips for community engagement

If the engagement opportunity is a community meeting or forum, consider including supporting factors that enable residents to participate such as providing child care and food when possible, ensuring that materials and presentations are offered in the language(s) of the residents, and locating meetings in spaces that are familiar and accessible to residents (e.g., churches, community centers, schools and restaurants). Locations should have a wide variety of transportation options and be ADA-accessible.

Some communities the LPHA serves may face challenges to participating. Incentives may make participation easier. Incentives to engage may include free bus tickets, paid stipends and gift cards to grocery stores or other outlets.

Use various communication outlets to broadcast your engagement opportunity and accommodation options, including but not limited to social media, community radio shows and community or culturally specific newspapers. Sometimes word of mouth, such as in-person invitations, may be better.

3. Explore possible cross-jurisdictional collaborations.

Identify opportunities for collaboration with other LPHAs that may be experiencing similar fiscal, programmatic capacity and/or expertise challenges. Identifying opportunities to work together across jurisdictions may provide the simplest solution to some challenges. For example, two jurisdictions may not have enough environmental public health inspection volume to hire a full-time staff person, but together they may have enough volume to support 1.0 FTE.

Opportunities for cross-jurisdictional sharing include but are not limited to:

» Assessment and epidemiology: regional approaches to data collection and analysis

» Environmental health: shared environmental health specialists to prevent, assess and address emerging environmental public health issues

» Emergency preparedness: regional efforts to ensure communities are prepared and able to respond to and recover from public health threats and emergencies.

» Formalized cross-jurisdictional sharing agreements designed and adopted by local governing bodies may include shared capacity with joint oversight or full consolidation of local public health agencies.

Resources for cross-jurisdictional sharing

» Oregon Coalition of Local Health Officials (CLHO) modernization road map: https://orphroadmap.org/

» Center for cross-jurisdictional sharing: http://phsharing.org/

4. **Consult with other partners.**

Consult with other partners that may be interested in innovating with the LPHA. These partners may be identified through the community engagement process in step 2 above. Entities with similar lines of business and/or service populations may be well positioned to expand their services in partnership with the LPHA. For example, federally qualified health centers (FQHCs) often serve similar populations. An FQHC already equipped with community health workers and a registered dietitian that serves a significant number of WIC-eligible families may be interested in providing WIC services through their clinic sites.

5. **Vet potential models.**

Vet potential models with the community partners and members you engaged in step 2. Community partners and public health end users will be most affected by changes in local public health models; their feedback will be valuable in assessing the feasibility and potential effectiveness of proposed changes.

6. **Make a decision.**

Once all feedback has been gathered, the LPHA governing body makes a decision and begins planning for implementation if changes are to be made.

7. **Develop and execute implementation and communications plans.**

To develop a communication plan, you must consider some basic questions:

» Why do you want to communicate with the community? (What's your purpose?)

» To whom do you want to communicate it? (Who's your audience?)

» What do you want to communicate? (What's your message?)

» How do you want to communicate it? (What communication channels will you use?)

» Whom should you contact and what should you do to use those channels? (How will you actually distribute your message?)

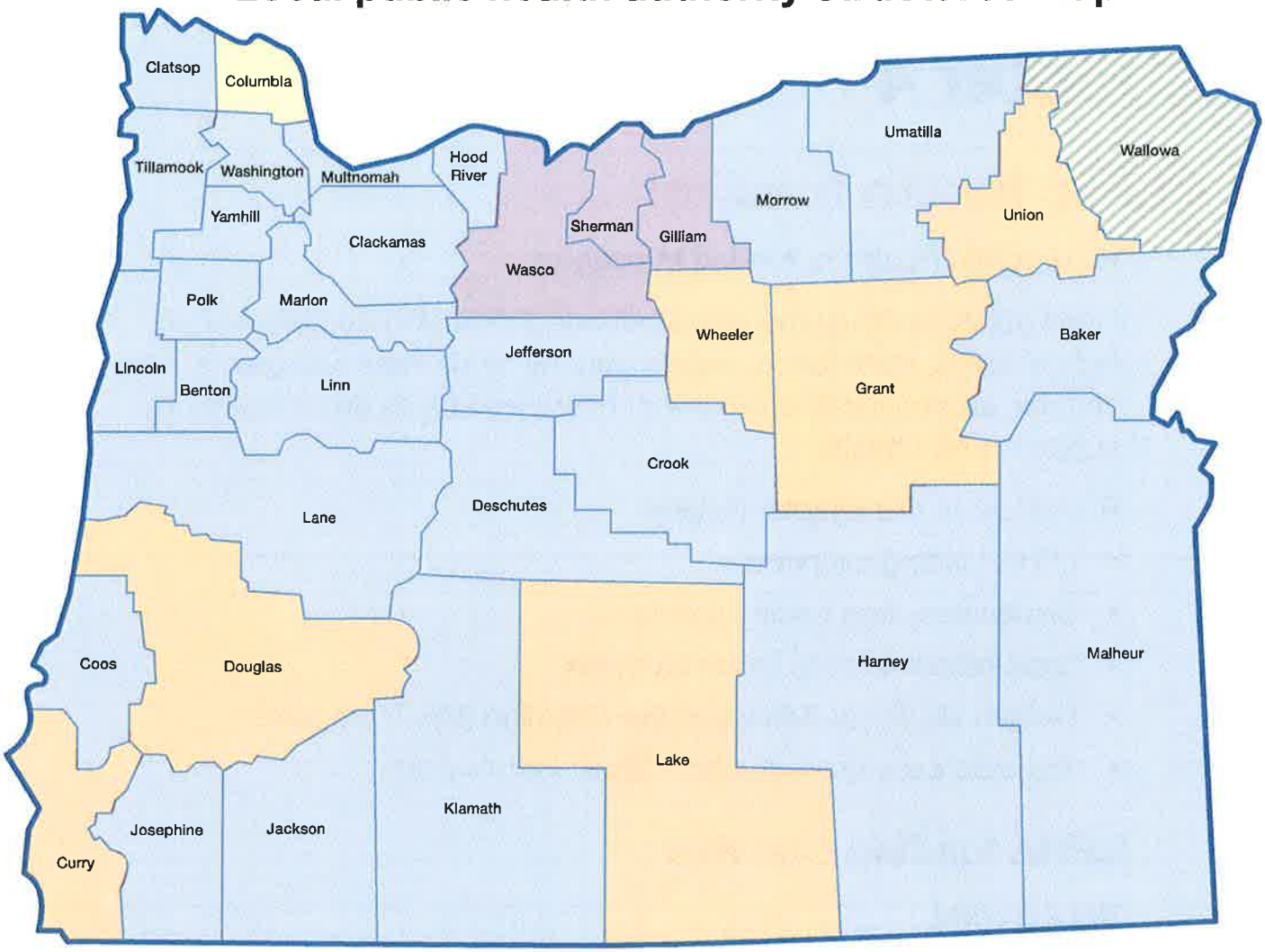
The answers to these questions constitute your action plan — what you need to do to communicate successfully with your audience.

An implementation plan is the detailed listing of activities, costs, expected difficulties and schedules required to achieve the plan's objectives.

8. **Evaluate the new model and focus on continuous quality improvement.**

   See Chapter 6 for more tips about evaluating the new model and documenting lessons learned.

Local public health authority structures map



LPHA structures

- LPHA operates most public health services within the LPHA governmental structure.
- 100% of non-governance public health services are contracted to other entities.
- LPHA contracts for most clinical public health services and operates some or more most non-clinical core public health services within the LPHA governmental structure.
- Cross-jurisdictional health district.
- LPHA's governing body transferred local public health authority to OHA.

Chapter 4

Public health funding

How public health is funded in oregon

Local public health authorities are funded through a combination of federal funds, state funds, county general funds, fees and grants. This chapter will provide an overview of how these funds are allocated to support public health.

Resources in this chapter include:

- LPHA funding overview
- Discounted drug pricing programs
- Supplemental funds for an outbreak
- Oregon Medicaid Administrative Claiming (MAC) program
- Targeted case management claims submissions

LPHA funding overview

Background

Local public health authorities (LPHAs) are funded through a combination of federal funds, state funds, county general funds, fees and grants. LPHAs are able to bill insurance and Medicaid for some direct clinical services such as family planning, nurse home visiting and vaccines. Funding varies across LPHAs.

The state investment to LPHAs ranks below the national median for per capita funding with Oregon currently ranked 38th in the country with a funding level of $16.08 compared to a median of $27.49. (5)

OHA agreements with LPHAs

1. Intergovernmental Agreement for the Financing of Public Health Services (Public Health IGA). Each local public health authority has a two-year agreement with the Oregon Health Authority (OHA). This is called the Intergovernmental Agreement for Financing Public Health Services (Public Health IGA). The Public Health IGA includes program elements for each funding stream disbursed by OHA's Public Health Division (PHD).

   Program elements are the programmatic and service deliverables in the IGA for Financing of Public Health Services (PH IGA). They describe the services the local public health authorities provide based upon the agreement with the Oregon Health Authority. Each program element is negotiated with the Conference of Local Health Officials.

   The vast majority of dollars that the PHD provides to LPHAs are federal dollars with requirements specific to each funding stream.

2. Intergovernmental Agreement for Environmental Health Services (EH IGA). Through the EH IGA, OHA delegates authority to LPHAs for the licensing and inspection of food, pool, lodging and recreational facilities. Per ORS 524.510, LPHAs collect fees on behalf of OHA to cover the LPHA's and OHA's administration and enforcement costs for licensing programs such as inspection and enforcement activities relating to restaurants, swimming pools and motels. A portion of the fees collected by the LPHA are remitted to OHA on a quarterly basis. Please refer to the EH IGA for more information. Food, pool and lodging program licensing fees by LPHA may be viewed on the OHA Environmental Health website: http://www.oregon.gov/oha/PH/HEALTHYENVIRONMENTS/FOODSAFETY/Documents/lfsr2015.pdf.

3. Other agreements. The Public Health IGA and the EH IGA are the two primary contractual agreements between OHA and LPHAs for public health-related services; however, there may be others. Please consult with the LPHA contracts coordinator to determine if any other contractual agreements should be considered.

County investment

In addition to the Public Health IGA and Environmental Health IGA, counties may invest general fund resources in programs:

- When there is not enough funding to meet the community need and/or
- To provide other prevention interventions when there is no state or other funding to support these activities.

County general fund investment per capita varies greatly across the state with three counties contributing $0 per capita and two counties contributing over $50 per capita. The average county general fund investment in public health is $16.08 per capita. (2)

For many LPHAs, local funding is essential for supporting public health infrastructure and their core capacities.

Public health modernization

The Oregon Legislature has driven efforts to modernize the public health system. In the 2015 and 2017 sessions, the Legislature enacted laws to put in place a public health funding formula for new state funds for modernization. ORS 431.380 requires that, from moneys Oregon Health Authority (OHA) receives for funding foundational capabilities and programs, OHA shall distribute funds to local public health authorities (LPHAs) through a funding formula described in this section of the statute.

Three components to the local public health funding formula:

- Base funds awarded for population, health status, burden of disease and ability of LPHA to invest in local public health, including floor payments (based on five tiers of county size bands)
- Matching funds for county investment in local public health services and activities above the base funding amount
- Incentive funds for achieving accountability metrics.

Discounted drug pricing programs

Background

The 340B Program enables covered entities, including local public health authorities, to stretch scarce federal resources for medications as far as possible, reaching more eligible patients and providing more comprehensive services. The five largest counties in Oregon (Multnomah, Washington, Clackamas, Lane and Marion) maintain their own 340B certification in order to purchase drugs at 340B prices.

The Oregon Health Authority (OHA) provides smaller counties medications for patients infected with sexually transmitted diseases (STDs) or tuberculosis (TB) from the STD or TB medication inventory, purchased through the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) instead of 340B.

Eligibility for subcontractors

MCCAP

If an LPHA contracts with another entity, medications received by an LPHA from OHA will be provided free of charge to the contracted entity unless OHA informs the LPHA in writing that the medications cannot be provided to the contractor. The contractor must comply with all requirements related to such medications. The LPHA must document the medications provided to a contractor.

340B

To be eligible for 340B pricing, an agency must be independently 340B-certified by eligible categories identified in the 340B regulations, by address, authorizing official and identified local contact person. None of the drugs purchased under 340B certification can be transferred to another agency or provided to an individual not fitting the regulatory definition of a "patient."

A subcontractor could independently explore 340B or MMCAP certification or eligibility.

For more information about 340B certification, visit https://www.hrsa.gov/opa/index.html.

For more information about MMCAP eligibility, visit http://www.mmd.admin.state.mn.us/MMCAP/background/Benefits.aspx.

Supplemental funds for an outbreak

Background

Limited supplemental funds (e.g. Tuberculosis Special Needs Funding) are available to local public health authorities (LPHAs) in the event of a TB or STD outbreak or complex case to support the LPHA's investigation and control efforts.

Tuberculosis Special Needs Funding may be used to address acute, non-enduring tuberculosis (TB) control activities such as large contact investigations, increased activities associated with multi-drug resistant TB (MDR TB) cases, legal intervention and outbreaks. Funds are for anticipated future expenses related to the event. The funds may not be used to reimburse past expenses.

HIV and STD Prevention Special Needs Funding may be used to address acute HIV and STD prevention activities including, but not limited to outbreaks and large partner/contact case investigations. Funds are for anticipated future expenses related to the event. They may not be used to reimburse past expenses.

Eligibility for subcontractors

If an LPHA contracts with another entity to perform required TB and/or STD services, the LPHA would be the entity applying for and negotiating outbreak funding from the Oregon Health Authority Public Health Division (OHA-PHD). If OHA-PHD approves, based on what the funds are used for, the LPHA could transfer the funds to a subcontractor.

All funds will be paid through the standard award PH IGA amendment process to the LPHA.

For more information about the TB Special Needs Fund Request, go to https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/COMMUNICABLEDISEASE/TUBERCULOSIS/Pages/reporting.aspx.

For more information about the STD Special Needs Funds Request, contact Josh Ferrer at JOSHUA.S.FERRER@dhsoha.state.or.us.

Summary of Oregon's Medical Administrative Claiming (MAC) Program

What is Medicaid administrative claiming?

The overarching policy for administrative claiming, referred to in this document as Medicaid administrative claiming (MAC), is that it is a function found necessary for the proper and efficient administration of the state Medicaid Plan. MAC is a method for health authority staff to identify and account for the time spent on administrative activities related to Medicaid-covered services. Local public health authorities (LPHAs) can then be reimbursed, under Title XIX of the Social Security Act, for the cost of performing these activities.

Examples of these activities include:

- Discussing access to health care with a client
- Assisting in early identification of children who could benefit from health services that Medicaid provides
- Contacting pregnant and parenting teens about the availability of Medicaid prenatal and well-baby care programs and services
- Providing referral assistance to families where Medicaid services can be provided.

The Oregon Health Authority (OHA), in concert with the federal Centers for Medicare & Medicaid Services (CMS), created a strategy by which LPHAs can claim costs, not otherwise reimbursed, for providing services that are directly related to the state Medicaid plan. Through a simple time-study instrument that logs activities, and with minimal disruption to the daily

routine, a health department is able to diversify its revenue base by receiving reimbursement for services rendered.

Who can do administrative claiming?

LPHAs that have the authority to tax/levy residents within their jurisdiction (county or district)—in order to ensure that they have a direct source for the non-federal match required by MAC—are elibible to contract with OHA for participation in MAC. Each LPHA will select staff that routinely have contact with children and families, and those who do system development work related to Medicaid-covered services. General categories include community health workers, health educators, administrators, public health nurses, supervisors, interpreters and administrative support staff.

Administrative claiming activities may take place in the department office, in the clinic, on home visits, during counseling sessions or at meetings with other local service providers.

The Medicaid Administrative Claiming Partnership

Medicaid administrative claiming is a process involving key personnel at both state and local levels. The Oregon Health Authority, which administers MAC for the benefit of local public health authorities, has a memorandum of agreement with Multnomah Educational Services District (MESD) to manage web-based data collection services for MAC. Each LPHA participating in MAC contracts with MESD to have MESD's web-based system calculate its quarterly claims. Thus, a partnership of OHA, LPHAs and MESD has developed in order to facilitate MAC activities. Each of these groups has roles and responsibilities that, carried out effectively, lend to MAC's overall cost efficiency.

MAC is a voluntary program: Any LPHA that is eligible to participate (i.e., LPHA is not already using a different mechanism such as a federally qualified health center to reimburse its staff or subcontractors) may opt into the MAC Program by signing an intergovernmental agreement with the state governing terms and conditions of the program. Once an IGA is completed and activated, the LPHA may participate in the MAC claiming process on a quarterly basis.

What is the process leading up to making a MAC claim?

1. An LPHA with an active IGA determines whether it will participate in MAC claiming for an upcoming quarter.
2. Prior to the start of that quarter, the LPHA must ensure it has eligible personnel for completing the required MAC surveys during the quarter. Eligible personnel must have valid "MAC-trained" status by the time the quarter begins. "MAC-trained" status is achieved when an individual designated by the LPHA successfully completes MAC training. The individual then is eligible to take MAC surveys for the next three quarters. The LPHA sends documentation of those who have completed successful MAC training to MESD.
3. The LPHA sends MESD a list of eligible personnel who will be participating in MAC surveys in the upcoming quarter; this is called the LPHA's "cost pool." MESD logs these names into its web-based system.
4. During the course of the quarter, the LPHA's cost pool members log into the MESD system to directly enter information on each of four random survey dates.
5. At the end of the quarter, the LPHA sends the total amount that it paid — in non-federal dollars — to its cost pool in salary and benefits for the quarter. The LPHA also sends an estimated Medicaid-eligible percentage of the portion of its clientele served through MAC-claimable activities during the quarter.
6. MESD's system automatically calculates the LPHA's MAC claim from the data the LPHA provides.

What is the process for approving and paying a MAC claim?

1. With data from the quarter's MAC surveys, the online MESD system calculates the LPHA's claimable amount (its claim) for the quarter. The OHA Public Health MAC specialist reviews each claim and, once approved, documents the claim amount on a dual-purpose invoice. The total claim amount is shown on the invoice, along with the 50 percent

local match amount (from locally sourced, non-federal revenues only) paid to OHA.

2. The LPHA sends a check for the local match amount, along with the invoice (signed by authorizing official), to Receipting & Trust (R&T) at the Office of Financial Services (OFS) in Salem. By signing the invoice and sending it to R&T, the LPHA acknowledges that it agrees with the amount shown as its accurate claim. The invoice originally sent by OHA to the LPHA for payment of the match thus becomes an invoice the LPHA sends to the Office of Financial Services (OFS) for payment of its claim — hence its dual purpose. The LPHA must also fax a copy of the invoice at the same time to the Medicaid administrative claiming specialist. He will note the amount of the claim and match it on the fax to ensure it is the same as the amount in the original form sent in step 1.
3. Once R&T has received the match payment, it will log it into its system and send the match payment to Accounts Receivable in Office of Financial Services (OFS). R&T then sends a copy of the invoice to the Office of Health Services (OHS).
4. OHS approves payment of the claim by sending a payment code to (Contracts) Accounts Payable.
5. A/P sends an Electronic Funds Transfer for the claim to the LPHA.

More information
For more information about MAC, contact:
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Public Health MAC Specialist
971-276-0412
david.v.anderson@state.or.us

Targeted case management claims submissions

Babies First! and CaCoon targeted case management (TCM) services provided to a client enrolled in the Oregon Health Plan (Medicaid) are eligible for reimbursement from the Oregon Health Authority (OHA). The TCM service

provider must enroll as a TCM provider with OHA and must bill according to administrative rules 410-138-0000: http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_138.html. All of this reimbursement and provider enrollment work is done through OHA's Health Systems Division, which runs the state's Medicaid program. The OHA Public Health Division is not involved in reimbursement and provider enrollment. Enrollment information can be found here: http://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx

Prior to receiving reimbursement for a home visit, a local government authority places eligible match dollars in its OHA individual match account. When the service provider has sufficient funds in its match account and submits a claim, OHA draws down the federal portion of the payment, adds the match payment and provides the reimbursement to the local government authority. A match account may hold funds for future claims or for claims already submitted. If the local government authority is not the service provider, the local government authority pays the contracted service provider.

Public funds may be considered as the state's share (match) in claiming federal financial participation if the public funds meet these conditions:

- The public funds are transferred to OHA from public entities that are units of government.
- The public funds are not federal funds or they are federal funds authorized by federal law to be used to match other federal funds.
- All sources of funds must be allowable under the Social Security Act 42 CFR 433 Subpart B.

The local match prepayment amount is a percentage of the total amount paid for claims submitted. The percentage is determined by the local match rate; the Federal Medical Assistance Percentage (FMAP) rates determine how much the local match rate will be. The current rate, as of Oct. 1, 2017, is 36.38%. The rate is adjusted each year in October and the table of rates can be found here: http://www.oregon.gov/oha/HSD/OHP/Pages/Local-Match.aspx. The Medicaid reimbursement rate for Babies First! and CaCoon is $355, and a 36.38% match would be $129.15.

Prepayment must be submitted using the DMAP 3049 form by 5 p.m. Wednesday of the week that claims are submitted. Otherwise, the claims will be suspended until prepayment is received.

Chapter 5

Subcontracting

Subcontracting requirements

When a local public health authority or its governing body develops a contract with another entity to provide public health services for which OHA contracts with the LPHA to provide, the work performed under the subcontract must comply with all applicable federal and state statutes and rules, local ordinances and other funding requirements as outlined in all applicable agreements between OHA and the LPHA. This chapter describes requirements for contract development, notification to OHA, subcontractor monitoring and other implementation requirements.

Resources in this chapter include:

- Recommendations for contract development
- Contract notification guidance
- Subcontractor monitoring
- Transfer of government/state property and equipment guidance

Recommendations for contract development

Any contract between OHA and the local public health authority shall comply with all applicable federal or state statutes and rules, local ordinances and other funding requirements outlined in all applicable agreements between OHA and the LPHA. These requirements also apply to any subcontracts an LPHA may have with another entity to provide public health services that are funded all or in part by funds the LPHA receives from OHA.

OHA provides the following information based on its understanding of public health laws, rules and contractual agreements, as well as its experiences working with LPHAs seeking to subcontract with other entities for public health services.

This guidance is not legal advice. In addition, it is not OHA's role to determine whether a contract between an LPHA and a subcontractor adheres to all applicable statutes, rules, contracts or agreements. OHA strongly recommends that an LPHA engages its legal counsel and contract administration staff early in the subcontract development process.

Some legal requirements and considerations when subcontracting for public health services:

- The LPHA must follow public contracting rules and regulations as applicable. (ORS 279A — Public contracting — General provisions and ORS 279B — Public contracting — Public procurement)
- The LPHA must provide written notice to OHA at least 75 days before executing a new subcontract or agreement. See the "OAR 333-014-0570(2) Notification of intent to contract for Public Health Services" memo on page 46 of this toolkit for more information.
- The LPHA is ultimately responsible for the subcontract and assuring its compliance with all Oregon Revised Statutes (ORS), Oregon Administrative Rules (OAR) and applicable contractual agreements with OHA, including but not limited to ORS 431.001 to 431.550 and 431.990, and OAR 333-014-0510 through 333-014-0590.
- The subcontract cannot delegate the authority of the LPHA. A sub-contractor can only perform non-governance local public health services and activities. The subcontractor may not perform any governance functions of the LPHA (see OAR 333-014-0580).
- OHA will not approve the assignment of the Intergovernmental Agreement for the Financing of Public Health Services or the Intergovernmental Agreement for Environmental Health Services to another entity due to the complexity of the governmental functions associated with those agreements. Therefore, a subcontract between an LPHA and a

subcontractor must clearly outline the subcontractor's scope of work and the roles of the LPHA and the subcontractor.

- Because the Intergovernmental Agreement for the Financing of Public Health Services and other agreements may contain federal sub-awards, all federal sub-award monitoring requirements are applicable to any sub-awards passed through to a LPHA subcontractor. Please review the applicable provisions in the Intergovernmental Agreement for the Financing of Public Health Services and any other applicable agreements between OHA and the LPHA.
- The subcontract must include any applicable federal or state statutes or rules, or local ordinances that are applicable to the service or activity being provided through the subcontract. The subcontract must note how the LPHA will oversee and monitor the subcontractor or entity with whom the LPHA has an agreement to ensure compliance with all applicable federal or state statutes or rules, local ordinances or other funding requirements as outlined in the applicable contractual agreements between OHA and the LPHA.
- The LPHA and its subcontractor will need to determine the applicability of ORS 236.610 (employee transfer statute) to the subcontracting situation.
- The LPHA should be aware of and take measures to mitigate any actual, potential or perceived conflicts of interest related to the subcontract.
- The subcontract must clearly outline how the LPHA will monitor the fiscal and programmatic performance of the subcontractor. See Subcontractor Monitoring Guidance section starting on p. 49.
- The LPHA must actively monitor the fiscal and programmatic performance of the subcontractor to assure ongoing compliance with all applicable federal, state and other laws, regulations and funding requirements. OHA may request from the LPHA documentation regarding the administration and monitoring of the subcontract as allowable by law and/or the contractual agreements between the OHA and LPHA.
- OHA may request a copy of the subcontract per Oregon Administrative Rule and applicable provisions in any applicable contractual agreements between the OHA and LPHA.

Contract notification guidance

PUBLIC HEALTH DIVISION
Office of the State Public Health Director
Kate Brown, Governor

Oregon Health Authority

800 NE Oregon Street, Suite 930
Portland, OR 97232
Telephone: 971-673-1222
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TTY: 711

M E M O

To: Local Public Health Authorities

From: Danna Drum, Strategic Partnerships Lead

Date: UPDATED October 30, 2018

Re: OAR 333-014-0570(2) Notification of intent to contract for Public Health Services

ORS 431.413(3) states a local public health authority (LPHA) may contract with a person to perform a public health service or activity, or to perform all public health services and activities, with the exception of any LPHA function, duty or power related to governance. Governance functions are described in OAR 333-014-0580.

OAR 333-014-0570(2) requires an LPHA provide written notice to the Oregon Health Authority (OHA) at least 75 days prior to executing a new contract or agreement if the following conditions apply:

- The LPHA plans to enter into a new contract for public health services and activities or amend an existing contract to add new public health services, and
- The public health services or activities for which the LPHA plans to contract with another entity:
  - Are pursuant to a contract or agreement between the LPHA and OHA, and
  - Will have a direct impact on consumers of public health services and activities.

Please note that the 75-day notification provision does not apply if:

- The services for which the LPHA plans to contract:
  - Are administrative services, or
  - Are for specific goods or professional services (e.g. legal services, health officer, registered dietitian), or

    - Do not have a direct impact on consumers of public health services and activities.
- Procurement activities began prior to January 1, 2018.
- In addition, notification is not necessary for contract renewals if the contractor and the scope of work are not changing. Thus, if a new contract is being executed due to expiration of an immediately preceding contract with the same provider for the same scope of work, notification is not necessary.

Examples of contracts for which the 75-day notification provision applies:

- An LPHA intends to contract with a health (hospital) district to provide all local public health services and activities, except for governance.
- An LPHA intends to contract with a federally-qualified health center (FQHC) to provide immunizations in the community. The LPHA will no longer directly provide immunizations, but will maintain its assurance and governance roles (e.g.: review of school records and issuance of exclusion orders).
- An LPHA intends to contract with another LPHA or individual environmental health specialist to perform environmental health inspection services (for restaurants, pools, spas, tourist accommodations, etc.).
- An LPHA intends to contract with an FQHC to provide STD screening and treatment services. These services will no longer be provided directly (or will only be available on a very limited basis) by the LPHA, but the LPHA will conduct contact investigations and make referrals for follow up to the FQHC.

Examples of contracts for which the 75-day notification provision would not apply:

- The LPHA has funding through the Intergovernmental Agreement for Financing Public Health Services (Public Health IGA) with OHA for teen pregnancy prevention. The LPHA plans to contract with a local culturally-specific organization to deliver an evidence-based teen pregnancy prevention program to a specific population group in the community. The LPHA remains actively involved in the overall teen pregnancy prevention program and delivers the program to other populations in the community but is utilizing a community partner to more effectively reach a specific population.
- As part of approved public health modernization funded activities, an LPHA plans to contract with a consultant to facilitate a strategic planning meeting with other LPHAs and regional community partners to advance the communicable disease public health modernization planning in its area.
- An LPHA plans to contract with a local physician to act as the local public health officer.

- The LPHA plans to contract with a billing specialist to perform all billing for public health services and activities the LPHA performs.
- An LPHA intends to contract with an FQHC to provide expanded immunization services in the community. The LPHA plans to use only county general funds for the contract with the FQHC and the LPHA will continue providing immunization services as required under the Public Health IGA in the same manner it has been.
- An LPHA has contracted with a local FQHC to provide school-based health center services but the contract expired on June 30, 2018. The LPHA plans to contract with the same FQHC for the same scope of work for school-based health center services as of July 1, 2018.

If an LPHA cannot provide the 75-day notice, because of the need for an emergency procurement or other reasons outside of its control, the LPHA shall provide notice as soon as possible before or after contract execution. OAR 333-014-0570(5).

OAR 333-014-0570(3) states that OHA has the right to request a copy of any subcontract between an LPHA and a contractor that is pursuant to a contract or agreement between an LPHA and OHA. Thus, copies of the subcontracts to which this guidance applies may be requested during the triennial review or at another time deemed necessary by OHA.

If an LPHA has questions about whether the notification provision applies in a specific situation, please contact Danna Drum at (503) 957-8869 or danna.k.drum@state.or.us.

To submit written notification 75 days in advance of a contract being executed, a letter stating the services and/or activities the contractor will perform, the name of the contractor (if available), and the anticipated effective date of the contract must be submitted to:

Danna Drum, Strategic Partnerships Lead
danna.k.drum@state.or.us
(503) 957-8869

If the name of the contractor is not available at the time of notification, please submit the name of the contractor to Danna Drum as soon as the information becomes available.

Please note that any specific contractual requirements related to contracting for services outlined in agreements between the LPHA and OHA also apply. Please review the specific agreement for any additional applicable information.

Subcontractor monitoring

PUBLIC HEALTH DIVISION
Office of the State Public Health Director
Kate Brown, Governor

Oregon Health Authority

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Portland, OR 97232
Voice: 971-673-1222
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TTY: 711

October 30, 2018

Guidance for Local Public Health Authorities on Monitoring of Subcontractors

Issue: Monitoring of Subcontractors when local public health authorities (LPHAs) sub-contract for public health services and activities.

Background:
The Oregon Health Authority (OHA) has a biennial Intergovernmental Agreement for Financing Public Health Services (Public Health IGA) with each of Oregon's LPHAs. The Public Health IGA includes Program Elements for each funding stream disbursed by OHA's Public Health Division (PHD).

ORS 431.413(3) states an LPHA may contract with a person to perform a public health service or activity, or to perform all public health services and activities, with the exception of any LPHA function, duty or power related to governance.

State and federal laws require OHA and its contractors to exercise good stewardship with public funds. Contractor monitoring is an essential component to meeting these standards. Inadequate contract monitoring puts OHA at risk for loss of federal and state funding if Federal Auditors and/or the Secretary of State find deficiencies in the management of state or federal funds. OHA is issuing this guidance to assist LPHAs in better understanding their obligations related to subcontractor monitoring.

For the purposes of this guidance, "subcontractor" refers to any person or entity with whom an LPHA enters into an agreement or contract to provide public health services funded by and described in the Public Health IGA program elements. This guidance does not apply to vendors from whom an LPHA may purchase specific goods or professional services. If the subcontractor is funded by a program for which the LPHA is considered a "subrecipient" by federal standards as indicated on the table of program elements in the Public Health IGA, the subcontractor is also considered to be a subrecipient and additional federal requirements apply to the LPHA for subrecipient monitoring.

Guidance:
When an LPHA or its governing body develops a contract with another entity to provide public health services for which OHA contracts with the LPHA to provide, the work performed under the subcontract must comply with all applicable federal or state statues, rules, local ordinances and other funding requirements. OAR 333-014-0570(4) requires the contract between the LPHA and its subcontractor to state how the LPHA will monitor the contractor for compliance with all applicable laws and funding requirements. OHA expects LPHAs with subcontracts to adopt and use official[1] subcontractor monitoring policies and procedures to assess and correct any fiscal and/or programmatic deficiencies.

[1] Official means the policy and procedure is dated and signed by a LPHA official with signature authority.

Contracts between an LPHA and a contractor funded through Program Elements for which the LPHA is identified in Exhibit A of the Public Health IGA as a Subrecipient (see Program Element table) are subject to federal requirements for subrecipient monitoring (2 CFR 200.331) and require a subrecipient monitoring system, including a:

- ✓ Standardized subrecipient risk analysis;
- ✓ Subrecipient monitoring plan; and
- ✓ Official[1] policies and procedures for monitoring subrecipients.

This federal requirement does not apply to contracts for specific goods and professional services (e.g. legal services).

OHA assesses compliance with these state and federal requirements during the fiscal and administrative Triennial Reviews (TRs) and the WIC biennial review.

Requirements for Subrecipient Monitoring Plan:
As previously stated, when an LPHA contracts with another entity using funds for which federal subrecipient monitoring requirements apply, a subrecipient monitoring plan is required.

To comply, the LPHA must demonstrate implementation of its subrecipient monitoring plan, including completion of a risk analysis and application of its official[1] subrecipient monitoring policies and procedures. The methods and frequency of monitoring activities included in the plan should be determined through a standardized risk analysis completed internally or by the subrecipient. The monitoring plan should include strategies to mitigate potential risk of non-compliance.

A subrecipient monitoring plan must include the following components:

1. Programmatic review to ensure performance goals (scope of work or specific aims) are achieved.

   Programmatic compliance can be achieved by:
   - Programmatic reviews of each Subcontractor and the programs they have been contracted to provide. This may include reviews of benchmarks, goals and objectives, performance data, workplans and/or reports developed for OHA programs. The frequency of the reviews should be consistent with the risk identified in the risk analysis.
   - For programs that have an on-site review with the subcontractor during the TR, LPHA should participate with OHA representatives in the TR process and monitor compliance with TR findings in addition to the LPHA's programmatic reviews.

   Best practices include:
   - LPHA participation with OHA program representatives in monitoring of workplans and budgets (e.g. progress reporting interviews between state and local program staff);
   - LPHA use of TR program tools with the Subcontractor during the two years between each TR;
   - Subcontractor development of improvement plan(s) based on issues discovered through the LPHA programmatic monitoring processes and TR to ensure achievement of the improvement plan(s).

2. Fiscal review to ensure effective stewardship of federal funds. This includes expenditure testing to assess the legitimacy of costs charged against the contract.

Fiscal compliance can be achieved by:

- Regular review of financial reports;
- On-site financial review of expenses submitted and payroll allocation by Program Element. This may be completed by using a standardized fiscal monitoring tool with the Subcontractor. The TR fiscal tool may be used by the LPHA, if desired. The frequency of the reviews should be consistent with the risk identified in the risk analysis.

Best practices include:

- Quarterly review of financial reports with general ledger detail.

A fiscal review is not an audit, which is an official inspection of an individual's or organization's accounts, typically by an independent body.

3. Regulatory monitoring system to ensure compliance with all federal laws, regulations, and executive orders applicable to the Public Health IGA or to the delivery of Program Element Services.

Regulatory compliance can be achieved by:

- Development and use of a template to track Subcontractor's compliance with all federal laws, regulations, and executive orders applicable to the Public Health IGA or to the delivery of Program Element Services. LPHA may use OHA triennial review tools, if desired.

Effective April 1, 2019, LPHAs must comply with the subcontractor and subrecipient monitoring requirements outlined in this guidance document. Triennial reviews conducted before April 2019 will identify when the LPHA does not meet the requirements. If areas identified as out of compliance are not resolved by March 31, 2019, they will become official compliance findings. If you have specific questions, please contact the Public Health Systems Consultant assigned to your LPHA, Andrew Epstein or Kimberly La Croix.

Transfer of government/state property and equipment guidance

Background

The Oregon Health Authority, Public Health Division (OHA-PHD) has developed guidance for transferring Government/State property* and equipment† to subcontractors of local public health authorities (LPHAs) and subcontractors' management and use of government property; and reporting, redistributing and disposing of subcontractor inventory.

This guidance is being made as some LPHA assets (that the LPHA wishes to transfer to the subcontractor), were purchased with funding OHA-PHD has provided through the Public Health Financial Assistance Agreement (PH FAA). This guidance applies to the transfer of all capital assets,†† except IT equipment, that exceeds a depreciated value of $5,000. For assets that do not exceed the capital reporting threshold, the LPHA may transfer the items to its subcontractors, and shall retain records of the transfers.

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* "Government property" means all property owned or leased by the government. Government property includes both government-furnished property and contractor-acquired property. Government property includes material, equipment, special tooling, special test equipment and real property. Government property does not include intellectual property and software.

† "Equipment" means a tangible item that is functionally complete for its intended purpose, durable, nonexpendable, and needed for the performance of a contract. Equipment is not intended for sale, and does not ordinarily lose its identity or become a component part of another article when put into use. Equipment does not include material, real property, special test equipment or special tooling.

†† "Capital assets" means tangible or intangible assets used in operations having a useful life of more than one year which are capitalized in accordance with GAAP. Capital assets include:

(a) Land, buildings (facilities), equipment, and intellectual property (including software) whether acquired by purchase, construction, manufacture, lease-purchase, exchange, or through capital leases; and

(b) Additions, improvements, modifications, replacements, rearrangements, reinstallations, renovations or alterations to capital assets that materially increase their value or useful life (not ordinary repairs and maintenance).

The guidance applies to all equipment that qualifies under the Federal Acquisition Regulation (FAR) disposition process for depreciated items* that have been purchased with funds under the current and past PH FAA.

Guidance

The LPHA and the OHA-PHD must reach an agreement, based on the terms in PH FAA,† on whether the title/equipment for property or equipment 1) may be transferred to subcontractors or 2) it shall stay with the LPHA or 3) be transferred to the OHA-PHD.

If OHA-PHD, as the contract administrator, concurs with the proposed use of the property or equipment by the LPHA, then OHA-PHD may allow the transference of the property's or equipment's accountability to the subcontractor. For example, a proposed use may be for the subcontractor to use the property for the same provision of services (e.g., examination table). The decision on whether the property/equipment may be transferred to a subcontractor ultimately rests with the contract administrator (OHA), not the Contractor (LPHA) or the subcontractor (another entity).

OHA-PHD will take into consideration the proposed use and apply the inventory of equipment/property maintained by the LPHA, which documents the straight-line depreciation process and accounts for the property disposition, to determine if the LPHA may:

- Transfer property/equipment to the new provider/subcontractor, with written approval from OHA, or
- Transfer the property/equipment back to OHA. OHA, in turn, assigns the property to the new contract recipient.

Standards for use

The following standards should be applied to ensure proper use of government/state property and equipment.

* Disposition process for depreciated items: FAR 31.205-11: https://www.acquisition.gov/browse/far/31/2?&searchTerms=depreciated,

† Section 14 of Exhibit E of the PH FAA

LPHAs shall:

- Allow and encourage subcontractors to use voluntary consensus standards (see FAR 11.101(b)) and industry-leading practices and standards to manage government/state property in their possession
- Ensure maximum practical reutilization of contractor inventory for government purposes
- Require contractors to use government/state property already in their possession to the maximum extent practical in performing government/ state contracts
- Charge appropriate rentals when the property is authorized for use on other than a rent-free basis and
- Require contractors to justify retaining government/state property not needed for contract performance and to declare property as excess when no longer needed for contract performance.

Additionally, to the maximum practical extent, any competitive advantage a prospective contractor may have by using government/state property should be eliminated.

Contractors' property management system compliance

The LPHA shall conduct an analysis of the subcontractor's property management policies, procedures, practices and systems. This analysis shall be accomplished as frequently as conditions warrant, in accordance with agency procedures.

The subcontractor is not required to establish property management systems that are separate from a contractor's established procedures, practices and systems used to account for and manage contractorowned property.

The LPHA shall notify the subcontractor in writing when the contractor's property management system does not comply with contractual requirements, shall request prompt correction of deficiencies, and shall request from the contractor a corrective action plan, including a schedule for correction of the deficiencies.

If the contractor does not correct the deficiencies in accordance with the schedule, the contracting officer shall notify the contractor, in writing, that failure to take the required corrective action(s) may result in:

- Revocation of the government's/state's assumption of risk for loss of government/state property and/or
- The exercise of other rights or remedies available to the contracting officer.

If the subcontractor fails to take the required corrective action(s) in response to the notification provided by the LPHA, the contracting officer shall notify the contractor in writing of any government/state decision to apply the remedies described above.

Making a request to transfer property or equipment

If an LPHA seeks to transfer property or equipment that was purchased with funds provided to the LPHA through the PH FAA, the local public health administrator must submit a written request to the OHA-PHD strategic partnerships lead (Danna Drum) that includes the following:

- The property/equipment to be transferred, including description, serial number, where equipment was purchased, acquisition cost and date, and current location, use and condition of the equipment
- Name of entity to which the property/equipment would be transferred
- A description of the how the property/equipment would be used upon transfer and
- A current inventory list of property/equipment purchased using funds provided to the LPHA through the PH FAA (per the PH FAA, Exhibit E 14c).

The LPHA should take into consideration the guidance provided within this document when making the request. OHA will respond to the initial written request within 30 calendar days of its receipt. A written agreement must be reached between OHA and the LPHA before any applicable property/ equipment can be transferred to a subcontractor.

If an LPHA plans to include property/equipment available for subcontractor use in a request for proposals (RFP), the LPHA should plan the RFP timeline

accordingly so that a tentative written agreement is reached with OHA regarding transfer of any property/equipment. If the LPHA does not know the name of the entity to which the property/equipment would be transferred due to a pending RFP, the LPHA may still submit the request; any tentative agreement between OHA and the LPHA would be contingent on the LPHA providing the name of the entity as soon as it was available for OHA to consider the request for final approval.

The LPHA shall work with the state program staff to complete any inventory records specific to the program, if requested.

Chapter 6

Evaluation and lessons learned

Identifying key questions and documenting lessons learned

This chapter will provide tips for assessing the success of the intervention in meeting its goals and lessons learned from local officials who are currently involved in, or have recently been involved in, the restructuring of public health services in their LPHA jurisdiction.

Resources in this chapter include:

- Key evaluation questions
- Documenting lessons learned

Evaluating the new public health delivery model

It is important to identify the impact, cost and/or cost savings of interventions on intended outcomes to make decisions about future public health activities and interventions. LPHAs may consider a formal evaluation (e.g., process or outcome evaluation) or a less formal mechanism (survey or facilitated discussion) to evaluate how the new model is working and next steps. Monitoring outcome data such as number of clients served or client satisfaction can contribute to an evaluation of the intervention.

Key evaluation questions

- How are the programs being implemented under the new structure?
- Are public health outcomes improving, staying the same or worsening?
- Are the programs being implemented correctly?
- Are participants being reached as intended?
- How satisfied are program clients?
- Has the intervention been cost-effective (compared to alternatives)?

Evaluators recommend thinking about evaluation questions before a project or intervention begins.

Washington County Public Health: Clinic Transition Evaluation

The Rede Group collaborated with Washington County Public Health to conduct an evaluation of the clinical preventive services transitions (immunizations and reproductive health), which took place in Washington County during 2014–2016.

While it is important to be thoughtful about what may be the best approach for each specific LPHA, the following are general recommendations outlined in the evaluation report that may apply to other LPHAs considering transitions.

Timing

- Engage the community early (optimally 1–1.5 years) before making final decisions.
- Carefully structure request for proposal (RFP) processes and plan for nine months to one year for the process. Other recommendations for an optimal RFP process include:
  - » Well-crafted RFP documents (reviewed by peers or Oregon Health Authority Public Health Division)
  - » Controlled communication (e.g., structured Q&A)
  - » Bidders' conferences to provide time for discussion and questions
  - » 100-day RFP response times (minimum).

Communication

- Develop a written strategic communication framework and detailed plan for the following audiences:
  - » LPHA staff
  - » Clients
  - » Providers
  - » Community-based organizations, community at large

- » Oregon Health Authority Public Health Division
- » Media.

- Budget dollars for communications planning.
- Consider contracting with strategic communications professionals and local community-based organizations and partners for communications planning and implementation.

Staff and training

- Plan for staff turnover and consider options to best deal with loss of staff if it occurs before transition is completed.
- Create a formal, tailored start-up plan for each provider with requirements for collaboration among providers.

Contact Tricia Mortell, Washington County public health administrator, at Tricia_Mortell@co.washington.or.us for more information.

Documenting lessons learned

Lessons learned include documented information reflecting both the positive and negative experiences of an intervention. They represent the LPHA's commitment to excellence and the LPHA's opportunity to learn from the actual experiences of others.

Oregon Health Authority Public Health Division (OHA-PHD) asked local public health officials who are currently involved, or have recently been involved, in the restructuring of public health services in their jurisdiction to share lessons learned from their experience.

Here is what they had to say:

- Bob Dannenhoffer, MD, is Douglas County's public health administrator and health officer. He also serves as the executive director of the Douglas Public Health Network, a nonprofit organization providing communicable disease, emergency preparedness and public health modernization services and activities. Dr. Dannenhoffer may be reached at rldannen@co.douglas.or.us.

In 2015, Douglas County public health leaders decentralized most public health services to nonprofit organizations. The following entities provide public health services in Douglas County:

» Douglas Public Health Network
Public health information and education
Public health community planning
Communicable disease reporting and investigations
Emergency preparedness

» Umpqua Community Health Center
Immunizations
Reproductive health (family planning)
Sexually transmitted disease (STD) testing and treatment

» United Community Action Network
WIC: Women, Infant and Children's
Maternal, Child and Adolescent Health
(Babies First, maternity case management)

» ADAPT
Tobacco Prevention and Education Program

» Douglas County Planning Department
Environmental health programs (licensing and inspections of restaurants, recreation parks, pools/spas, lodging, camps)
Drinking Water Services Program
Animal Bites and Exposures
Food handler training
Illness investigations and complaints

» Douglas County Clerk's Office
Vital records (birth and death certificates)

Dr. Dannenhoffer shared the following lessons learned about public health restructuring in his jurisdiction:

Community energy and community support are critical to developing and implementing a new model. Douglas County was able to create a successful model because of the dedication and enthusiasm from

not-for-profit organizations in the community who were equipped and ready to take on new roles and responsibilities. For example, when Douglas County contracted immunization services to Umpqua Community Health Center (UCHC), UCHC smoothly integrated public health immunization services and activities into their existing system. The result was expanded hours and locations for all Douglas County residents receiving immunizations.

Another key lesson is to have sufficient time and resources devoted to planning for the new model. When Douglas County transitioned mental health services to Umpqua Health Alliance, Douglas County did not have adequate time to plan and set up supportive systems to make the transition as effective as possible. Douglas County Public Health learned from the experiences of the mental health transition and intentionally devoted more time to planning and transitioning services to non-profit organizations that were natural fits for public health programs.

One of the challenges of implementing a decentralized local public health system is the accounting complexity. For example, state and local governments use municipal accounting methods and non-profits use accrual accounting. These different methods contributed to cash flow challenges, specifically related to accounting for payment after services were rendered and staff benefits for vacation accrual.

- Tricia Mortell is the Public Health Division manager for Washington County Department of Health and Human Services. She also serves as the chair of the Oregon Conference of Local Health Officials and is a member of the Public Health Advisory Board, a subcommittee of the Oregon Health Policy Board. She can be reached at Tricia_Mortell@co.washington.or.us.

  In 2014, Washington County Public Health, under the direction of the Washington County Board of Commissioners, undertook a process to restructure the provision of direct clinical preventive services for uninsured Washington County residents. Before the restructure, Washington County was providing limited, direct preventive service including immunizations, family planning and STI screening and treatment through clinics owned

and operated by the county government. As a result of the restructure, the county provides general funds to support local (non-government) health care providers to provide improved access to primary care and clinical preventive services for immunizations and screening for and treating sexually transmitted diseases. They also subcontracted Title X funding for family planning services.

Tricia Mortell shared the following lessons learned about public health restructuring in her jurisdiction:

> *Our process was about making decisions regarding what role local public health should play and what role community organizations should play in access to care and health care services. As health care transformation improved options and opportunities for accessing services outside of the local health department, we determined that clinical services are better served through the medical setting rather than through the county. Our interest was not in eliminating all direct service programs such as WIC or nurse home visiting. For example, WIC is a direct service program, but it's also an engagement opportunity for public health prevention due to the number of contacts the program provides. Overall, it's important to be thoughtful in determining the best approach for community members to get the best services possible. Every county is different and every community is different; there's not a one-size-fits-all approach to determine which services are best for the county to lead vs. others to lead. Local public health administrators need to be thoughtful and look at resources within county government and within the community before making decisions.*
>
> *It's important to engage the community at the appropriate time. People wanted to know why the county was already on track towards a plan before the community was allowed to have input. In Washington County, the Board of Commissioners (BOC) as the policy decisionmakers provide policy direction. When engaging with the community, be clear on what you can or can't do within that direction from the BOC, and then do what you can to address community*

concerns. It can be a problem if the process takes too long, as the length of time before changes are implemented impacts staff; find the balance between opportunity for community input and not making the process too long to where staff may decide to leave.

A lesson learned in Washington County was that it's important to broaden community engagement by not only reaching out to local partners, but also engaging with regional and statewide stakeholders such as advocacy groups that may have an interest in the process. It's important to consider historical trauma and the depth of distrust of government that may exist. Washington County had originally stated that funding would be driven to open more primary care for community members to access. The county heard feedback from the community that they wouldn't be able to afford to access those services even with county assistance. Washington County modified plans to provide funding for places that would have an open door for accessing STI and immunization services.

It is critical to take care of staff and engage the Human Resources Department throughout the process. Staff were told what options they had including other positions within Public Health or options for opportunities in the county department that incudes Public Health (Department of Health and Human Services) as well as opportunities with community partners. It was very important to us to find options for all staff. Only one person was laid off and she took a position with one of the safety net clinics. Most staff were very satisfied with the process, which was meaningful to staff and management, including new opportunities for growth and promotion that people had not previously thought they had.

- Mike Weber is the public health administrator for Josephine County. He developed the request for proposal (RFP) for public health services for Josephine County. He may be reached at MWeber@co.josephine.or.us.

  In 2017, the Josephine County Board of Commissioners started having community conversations about improving access to, and quality of, health care services, removing disparities in health across social and

socioeconomic lines, reducing the cost burden for taxpayers, and improving the overall health for all citizens. To accomplish these goals, Josephine County developed an RFP to give all public, private and not-for-profit organizations an opportunity to propose new models under which specific public health services can be provided. Ultimately, no community-based organizations (CBOs) applied for the RFP. The most common reason cited by CBOs for not applying was the lack of funding of the public health services included in the RFP.

Mike Weber shared the following lessons about public health restructuring in his jurisdiction:

> *My advice is to consider the timing of the changes you want to make. When Josephine County was developing a request for proposal (RFP) for public health services there were a lot of changes happening in the public health system. All the program elements (PEs) were undergoing revisions, there were new administrative rules and the public health accountability metrics were being developed. All these moving parts had different timelines and the potential to impact how we structured the RFP.*

Appendix

Public Health Modernization Manual and applicable rules, statutes and program elements

Public Health Modernization Manual, September 2017

The Public Health Modernization Manual provides detailed definitions for each foundational capability and program for governmental public health.

The Public Health Modernization Manual is intended to guide administrators and staff of state and local public health authorities in implementing each foundational capability and program. This manual defines how these apply specifically to state and local public health authorities, who in turn work closely with community members and partners to implement them. The manual provides a roadmap for Oregon's public health system's day-to-day work.

OAR 333-014: Standards for State and Local Public Health Authorities

These rules implement House Bill 3100 (Oregon Laws 2015, chapter 736) and House Bill 2310 (Oregon Laws 2017, chapter 627) and establish the rules and procedures for implementing public health modernization.

Rulemaking Summary, January 2018

The summary is a matrix that includes a summary of each rule component.

Program elements and service deliverables

The Financial Assistance Contract with local public health authorities includes program elements. These program elements are the programmatic and service deliverables. They describe the services local public health authorities provide based upon the agreement with the Oregon Health

Authority. Each program element is negotiated with the Conference of Local Health Officials.

There are periodic amendments to the program elements.

Local public health authority reviews

A comprehensive review of local public health authorities (LPHAs) is conducted every three years for most programs.

This webpage includes the triennial review tools that are used to assess compliance activities of LPHAs, evaluate overall program effectiveness and recommend modification to programs when requested.

The results of the review — including commendations, compliance findings and recommendations — are communicated to the governing body of the LPHA and the county health administrator.

Oregon Public Health Modernization Roadmap (Roadmap)

The roadmap was developed by the Coalition of Local Health Officials and provides a step-by-step structure for local health authorities to use when working on public health modernization efforts. It is designed to be useful no matter what step in the process you are taking.

Understand and Consider Different Service Delivery Models section of the Roadmap reviews possible delivery systems and models (e.g., cross-jurisdictional sharing, cross-sector sharing, contracting, in-house models).

Endnotes

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