Best Practices Analysis & Operational Assessment Prepared for Skagit County Public Health and Community Services

Communicable Disease Department

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Submitted by:

Slalom, LLC
821 2nd Avenue, Suite 1900
Seattle, WA 98104

Main: (206) 438-5700

Primary Contact:
Clare Pedersen
Managing Director

Phone: (415) 519-2224
Fax: (206) 438-5686
ClareP@slalom.com

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Executive Summary

The state and national public health landscape is in the midst of a major transition in terms of managing and preventing communicable diseases. This transition has led to new Washington State standards for foundational public health services and programs, and has challenged many local health jurisdictions (LHJs) to think critically about the services they provide.

In order to determine the best approach for Skagit County Public Health and Community Services (SCPHCS) to meet the community's needs of preventing and treating communicable diseases, SCPHCS engaged Slalom Consulting (Slalom) to conduct an assessment of the department's communicable disease program. Part of this assessment was to better understand trends in Washington State and to determine how SCPHCS compares to other peer organizations. Slalom interviewed 12 local health jurisdictions similar in population and geography regarding the scope of services of their Communicable Disease Departments. Slalom also interviewed 22 stakeholders, including experts at the Washington State Department of Health, major Skagit County hospitals and provider groups, and internal SCPHCS staff to ensure findings and recommendations are comprehensive and framed within the appropriate context.

Three distinct themes emerged from this study:

1. Overall, LHJs are moving away from providing direct services for communicable disease programs.
2. SCPHCS provides the greatest number of direct services[1] related to Communicable Disease of all surveyed LHJs.
3. There is a strong interest among Skagit community providers for collaboration with the Department of Public Health, specifically in areas of Community Health Assessment and Population Health Surveillance.

The recommendations in this report are based on the federal health care reform's impact on public health services in Washington State, the statewide shift in focus by LHJs, and the results of this evaluation. The Slalom Consulting team suggests that SCPHSC leadership evaluate the impact of these important shifts in public health and consider gradually reorienting its service portfolio to focus on health assessments, surveillance, education, and community engagement rather than on providing direct clinical services. The results of this survey indicate that the majority of LHJ's similar to SCPHSC in

[1] Direct Services within scope of this assessment included: TB screening, Latent TB Disease Management, Direct Observed Therapy, STD Testing, Follow up with Partners, Family Planning Services, Routine Child Immunizations, Routine Adult Immunizations, Travel Clinic, and Seasonal Vaccinations.

size and demographics have already made this shift away from direct communicable disease services, and the change has allowed these LHJ's to focus limited resources more effectively on impacting high-needs clients that are currently underserved, without any detrimental impact to their reportable disease or immunization rates. Moving to a more supervisory and community engagement-based model for public healthcare delivery would serve SCPHSC in achieving its public health goals while also meeting the missions and principles of the County as a whole.[2]

[2] Mission statement and core principles of Skagit County government http://skagitcounty.net/Departments/home/mission.htm

Introduction

Project Background

The Skagit County Public Health and Community Services (SCPHCS) engaged Slalom Consulting (Slalom) to conduct an analysis of health services the county is mandated to provide within the Communicable Disease (CD) Department, as well as provide recommendations on the scope of services the department should provide based on:

1) Recent shifts in national and state health priorities and laws;
2) Best practices from other Local Health Jurisdictions (LHJs) throughout Washington State[3]; and
3) Interviews with key local community providers related to Communicable Disease.

The need for this analysis was driven by a variety of factors, including:

1. Leadership's desire to ensure that all required mandates are being met by LHJ services.
2. The upcoming physical relocation of SCPHCS facilities. Relocation would require a facilities build-out to accommodate clinical services, and leadership wished to ensure the appropriateness of this service offering.
3. Leadership's desire not to duplicate services provided elsewhere in the community by leveraging existing public health services and providing assurance where there are gaps due to changes with national and state priorities and laws.
4. The planned retirement of key personnel and the need to complete succession planning and transition readiness.

Given these drivers, the Slalom team worked closely with the SCPHCS project sponsors to provide a comprehensive and thorough analysis of the SCPHCS's CD department.

Project Scope and Execution

Beginning in July 2014 Slalom conducted 34 interviews over a four week period.[4] Slalom interviewed all parties identified in the original project scope and also met with a number of additional stakeholders from the State and LHJs throughout Washington. Interviews included:

- Leadership at 12 LHJs in Washington State. In addition to the 9 LHJs in scope, Slalom also interviewed Grant, Yakima, and Grays Harbor
- Eight internal SCPHCS stakeholders
- Five stakeholders at the Washington Department of Health

[3] See Appendix "Resources for Skagit"
[4] See Appendix for complete list of interviews.

- Nine community stakeholders in Skagit County representing the following entities: Mt. Baker Planned Parenthood, United General Hospital District 304, Peace Health, Sea Mar, Community Health Centers, Island Hospital, Skagit Regional Health

Project sponsorship and leadership was provided by the Director of Skagit County Public Health and Community Services, with the active participation of key personnel and clinicians. The Slalom team also worked closely with SCPHCS to ensure that the findings and recommendations provided in this report are aligned with the team's expectations.

Document Organization

This document is organized into three distinct sections.

- The first section – *Background: National and State Context to Public Health Reform* – provides the backdrop to the changes impacting and influencing public health agencies in the United States.
- The second section – *Communicable Disease Delivery in Washington State* – provides the findings and analysis from the survey. This section is intended to be shared with peer organizations, as determined appropriate by SCPHCS.
- The third section - *SCPHCS Operational Analysis and Risk Assessment* – presents the analysis and recommendations for introducing changes in SCPHCS's service offering.

Part 1: Background – National and State Context of Public Health

Public health in Washington State is undergoing a major transformation. Changes in funding, policy and incidence of communicable and chronic diseases over the past decade are shifting how local health departments are serving public health needs, and new challenges and opportunities to ensure public health are arising.

National health care reform has impacted the public health system in two ways: first, by reducing Washington's uninsured population which traditionally is served by LHJs, and second by providing new incentives for preventive services like immunizations and screenings to the health system for improved continuity of care. [5] The uninsured rate in Washington is expected to drop from 14.5 percent to 6 percent by 2016 and approximately 805,400 low- and middle-income families will be eligible for free or low-cost health coverage through the state's Exchange.[6]

In 2008, the Washington State Department of Health mandated the development of foundational public health services and programs. The resulting Agenda for Change published in 2013 acknowledges the challenge of severe funding shortages and changing public health needs and concludes that a reformed public health system is necessary. The new core capabilities it outlines for LHJs are Communicable Disease prevention, early detection and swift response to protect Public health, assessment, communications, policy development, community partnerships, emergency preparedness, and modern business practices that cut across all foundational public health programs.[7] The Agenda for Change, along with existing RCWs (Revised Code of Washington) and WACs (Washington Administrative Code), provide a detailed roadmap for public health best practices in Washington State.[8]

As the public health landscape changes, there is a great deal of variation in the degree to which LHJs are providing direct services versus assuring the services are being provided elsewhere in their community. We believe it is important to reflect on the drivers of this transformation and acknowledge both the risks and opportunities it provides for SCPHCS to continue to ensure the best possible public health in Communicable Disease.

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[5] ACA: Preventive Care Coverage Requirements. https://complianceadministrators.com/ppaca-preventive-care-coverage-requirements/

[6] Kreidler, M. "Washington's uninsured at 14. http://www.insurance.wa.gov/about-oic/news-media/news-releases/2014/1-30-2014.html 5 percent before start of health reform." Washington State Insurance Commissioner. January 20, 2014.

[7] Agenda for Change: Foundational Public Health Services. Public Health Improvement Partnership. June 5 2013. http://www.doh.wa.gov/Portals/1/Documents/1200/fphs-definitions.pdf

[8] See Appendix for complete listing of RCWs and WACs related to LHJ Communicable Disease responsibilities

Part 2: Communicable Disease Delivery in Washington State

Methodology

Slalom conducted 60-minute structured interviews with leadership at 13 Local Health Jurisdictions (including SCPHCS). LHJs were chosen based on geographic and demographic similarities to SCPHCS.[9] Interview participants varied slightly by LHJ, but generally included the Director of Public Health and the Communicable Disease (CD) Manager, and, on occasion, other key stakeholders involved in CD programs. During these interviews, Slalom assessed the services that each LHJ currently offers under the CD Program and specifically looked at how each entity managed tuberculosis (TB), sexually transmitted diseases (STDs)/family planning, and immunization delivery.

In addition to questions on services offered, Slalom collected information on how and why CD services provided by the LHJ have changed over time by asking the following questions:

- What led to the change in services offered over the last 10-20 years?
- How were successful changes made?
- What resources did the LHJ have on staff, in the community, and at the state to ensure they were assuring the public health to the best of their ability?

Summary of Provided Communicable Disease Services

Slalom identified three categories for survey responses:

- **"Yes"** indicates the LHJ provides the service for the general public.
- **"Limited Scope"** indicates the LHJ does provide the service, but only for certain pre-defined high-risk populations (e.g. HIV-positive clients), and collaborates closely with local providers to serve the general public.
- **"No"** indicates the LHJ no longer provides the service and that the community need is met entirely within the community/health care system.

The results from each of the primary CD programs – Tuberculosis, STD/Family Planning and Immunizations – are provided in the following sections below.

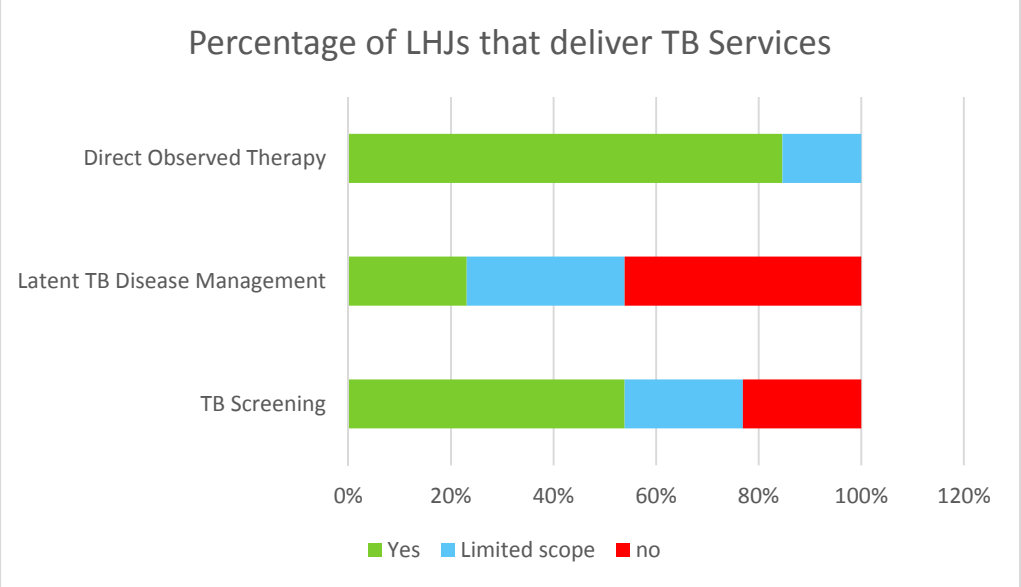
Tuberculosis Program

Direct services assessed include:

[9] LHJs surveyed included Skagit, Chelan-Douglas, Grant, Yakima, Benton-Franklin, Grays Harbor, Clallam, Lewis, Whatcom, Cowlitz, Snohomish, King and Island.

1) Direct Observed Therapy for active Tuberculosis (TB) cases
2) Latent TB Disease Management
3) TB screenings

The chart below illustrates survey results for TB services.



Findings:

- 69% of LHJs surveyed have scaled back their TB services within the past 10 to 15 years, with a specific emphasis in Latent TB (LTBI) Case Management, but 50% still do all TB services.
- For LTBI programs, most LHJs have moved management completely or partially into the provider community, after long periods of training and continued community support, as needed.[10]
- There were often specific exceptions of LHJ managed LTBI cases for high-risk or complex cases, for example for clients with rheumatoid arthritis or high risk migrants.[11]
- Two LHJs surveyed have taken the scaling back of direct TB services a step further by training providers to administer the treatment for Active TB cases. In these cases the LHJ acts as the

[10] This transition to the community took between 3-6 years, depending on things like leadership, relationships between the LHJ and community providers and organizations, capacity of community providers at the outset of the transition and engagement of providers by LHJ leadership and staff. Public Health should maintain capacity to provide expert support, advice, resources and training for related care even when services are transitioned to the community. Chelan-Douglas provided an excellent example of how to transition these services into the provider community over time and would be a good mentor for the process.
[11] LHJs were Clallam and Cowlitz.

prescriber of record and is available for consults; however, the majority of the case management is done by the provider.

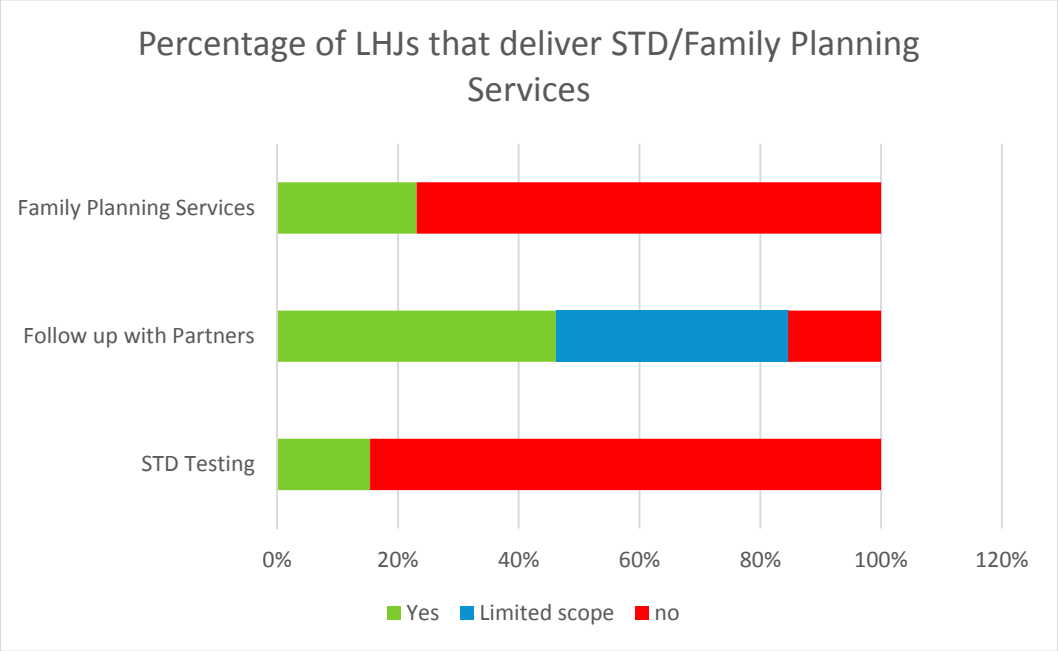
- Irrespective of the balance of TB services offered, it was universally acknowledged that the LHJs must be the primary resource of TB expertise within the community, and ultimately, the LHJ is held responsible for the control of tuberculosis, including case finding, prevention, treatment, and follow up of known cases.[12] Expertise from a physician and nurse perspective were both cited as important.

Sexually Transmitted Diseases/Family Planning

Direct services assessed include:

1) Family Planning Services
2) Partner Follow up
3) Sexually Transmitted Diseases (STD) Screenings

The chart below illustrates survey results for the STD/Family Planning services.



Findings:

- 85% of LHJs surveyed no longer provide STD clinics.
- 77% of LHJs surveyed do not provide any family planning services.

[12] See Appendix, RCW 70.28-30

- Most LHJs, especially those without community partners like Planned Parenthood, indicated they did not believe the STD/Family Planning needs were being met within their community, and if they could expand their services, this would be their first area of investment.
- The majority of LHJs expressed concern about the rising rates of STDs in their communities and the lack of services to address this need.
- The most common direct service provided was Partner Notification/Follow up, although several LHJs surveyed indicated that follow up was not as comprehensive as they would like due to resource limitations.
- The most successful LHJs identified high-risk clients as their priority for follow up. High risk clients included untreated pregnant women, children under 15, all cases involving STDs, such as syphilis.[13]

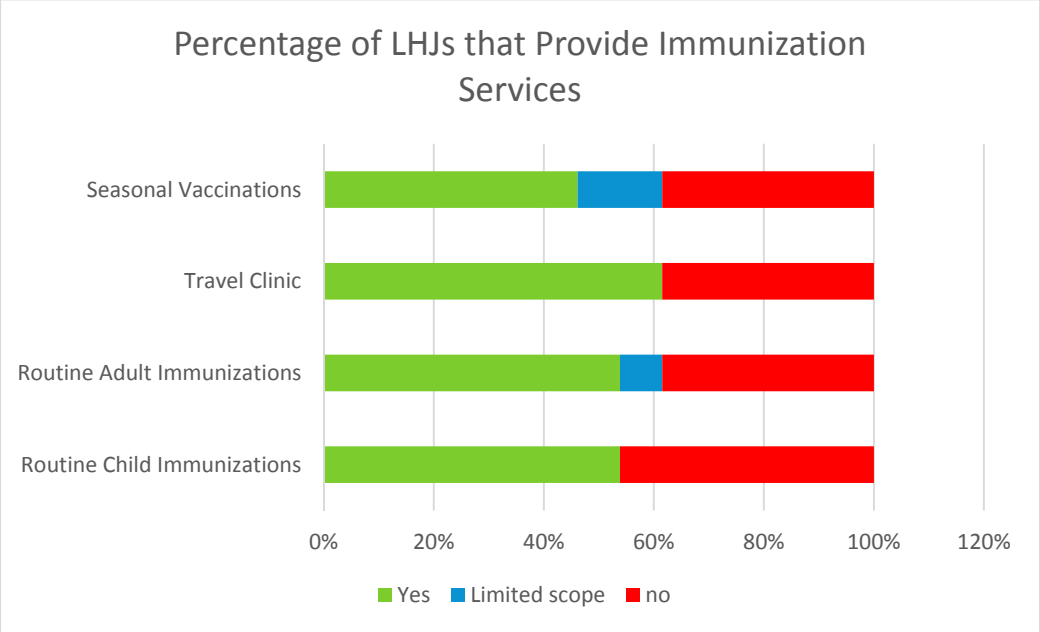
Immunizations

Direct services assessed include:

1) Seasonal Vaccinations
2) Travel Clinic Services
3) Routine Adult Immunizations
4) Routine Child Immunizations

The chart below illustrates survey results for Immunization services.

[13] See Appendix document "CD Operational Changes" in Resources for Skagit



Findings:

- Approximately 50% of LHJs surveyed provide routine immunizations, with slightly lower and higher percentages respectively providing seasonal vaccines and travel clinics.

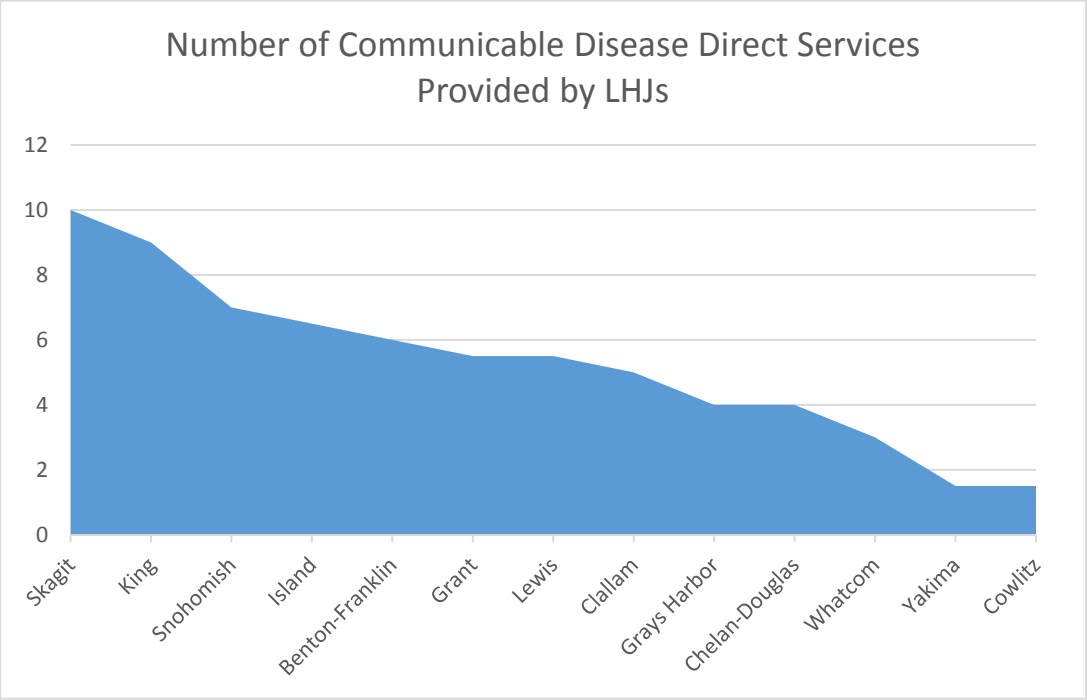
  Two primary reasons LHJs provided for phasing immunizations out include:
  - Increased availability of immunizations in the community (particularly at pharmacies)
  - An intention to improve continuity of care for clients by encouraging them to get preventive care with a primary care provider (medical home providers availability needs to increase in rural communities and there needs to be more commitment from Community health Centers to take the undocumented, uninsured as opposed to ad-hoc at the LHJ).

  Reasons to maintain immunizations included:
  - Desire to provide easy access for community members.
  - Travel vaccines not well covered in most communities, especially communities with no Infectious Disease providers and a few pharmacies
- Several LHJs provide routine vaccinations at syringe clinics, which are seen as servicing high risk populations.
- The most common immunization program service provided is the oversight of the state-run VFC program.

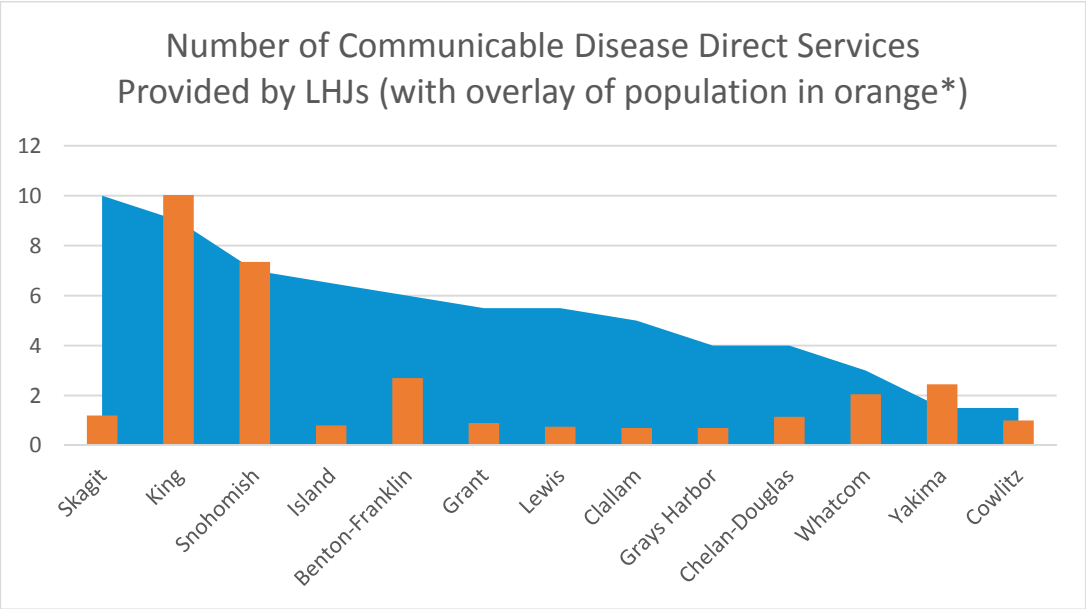
Total Direct Services Provided in Communicable Disease

The graphs below illustrate the scope of direct services offered in the CD programs described above (TB, STD/Family Planning, and Immunizations), but do not include direct services related to Emergency Services.[14] The scale used to calculate results is as follows:

1) Yes, LHJ provides to the general population : 1 point
2) Limited Scope : 0.5 points
3) No, LHJ does not provide this service at this time : 0 points



[14] Services included are TB screening, Latent TB Disease Management, Direct Observed Therapy, STD Testing, Follow up with Partners, Family Planning Services, Routine Child Immunizations, Routine Adult Immunizations, Travel Clinic, and Seasonal Vaccinations.



[15]

*Note the vertical scale for the orange population bars are in factors of 100K, with the exception that King's number is a factor of 200K so that they scale would retain the intended perspective. (e.g. Snohomish's population of roughly 700,000 equates to 7 on the scale whereas King's population of roughly 2,000,000 equates to 10 instead of 20)

Findings:

- Of the 13 LHJs surveyed, SCPHCS has continued to provide the greatest breadth of direct services to its population.
- King and Snohomish are second and third, respectively, in providing direct services, although leadership in both LHJs discussed moving away from being primarily a "provider" of care to an "assurer" of care.
- LHJs providing the smaller breadth of direct services discussed how direct services were gradually transitioned to community-based providers with support and training provided by the LHJ.
- Strategies identified for successful integration into the community included:
    - Taking a nurturing approach; providing personalized care by having LHJ nurses see patients in community clinics.
    - Ensuring frequent communication with providers; creating a feedback mechanism between providers and the LHJ that promotes learning and sharing.
    - Centering efforts at major clinics (i.e. large FQHCs).

[15] The graph represents the breadth of services offered, not the number of clients served.

- Developing trusting relationships with the clinics; developing partnerships with providers who see their role as a part of the process (as opposed to separate from the process).

- While LHJs that have transitioned services to the community expressed an overall sense of satisfaction with their new role, several nurses admitted it was difficult to make the transition.

Emerging Themes

Slalom identified four primary themes as to why LHJs chose to be primarily a 'provider' or 'assurer' of care. In every LHJ more than one of these themes played a role in how they determined their current balance of service.

1) **Philosophy & Strategic Priorities of the Director of Public Health.** This was one of the most significant motivators for changes in services provided by LHJs. Many leaders felt strongly that it was the LHJ's responsibility to transition public health services to reflect changes in public health needs (i.e. chronic illness, ACEs and disparities of care vs. communicable disease direct services) and to provide more population health surveillance, CD investigations, education and assurance than traditional direct service models. Some Directors expressed concern that due to poor availability of services in their community there was still a compelling argument for the LHJ to continue to provide direct services, but these views were the minority.

2) **Availability of Health Care in the Community.** A serious consideration for whether the LHJ was able to transition services to the community was the community's ability to take on those increased responsibilities. If the provider community was already providing the service (i.e. flu shots), it was easier for LHJs to stop the service. Several LHJs discussed how initially their provider community did not have the capacity to provide services (i.e. TB screening), but that ongoing engagement in a structured, intentional manner over the course of three to six years allowed both sides to eventually feel confident that the needs of the population were being met. There were a few cases in which the Director indicated that he/she was concerned about the limited capacity for STD/Family Planning in the community, especially with rising rates of STDs and teen pregnancies.

3) **Budget Reductions.** Most LHJs discussed how their staff has been greatly reduced over the last 10 years, anywhere from a small reduction to 50%. Reduction in State and federal funding sources for direct services resulted in budget cuts at all levels.

4) **Liability.** This was not as prevalent as the previous themes, but a few LHJs cited concern over liability as a motivator for transitioning services. One LHJ was sued for a TB case and despite the fact that the CDC investigation found the LHJ was not responsible for any wrong-doing, the LHJ was advised to settle out of court. The financial and reputational cost in addition to the risk of this

happening again led this LHJ to transition TB care into the community, which it has done successfully.

Patient-Centered Medical Homes

Many LHJs mentioned that the child and adult immunizations, and to a lesser degree LTBI management, were transitioned to the local provider community because of the importance of having a medical home manage all aspects of care, as opposed to having the LHJ provide one-time services that might keep community members from receiving more comprehensive and thorough care.

- Conducting a Community Health Assessment (CHA)
  - Several LHJs discussed the importance of the CHA in shifting the perspective of the community on health priorities.
  - The CHA has typically led to a Community Health Improvement Plan (CHIP); however, the CHIP was usually not focused on issues pertaining to Communicable Disease so the LHJs did not rely on the CHIP process or findings for Communicable Disease programing.
  - Some LHJs used a **Strategic Plan** instead to drive the direction of their public health priorities, including Communicable Disease. Strategic priorities didn't always specifically relate to CD, but included "driving policy change" and "engaging the community."
- Building provider capacity while slowly transitioning out direct services. This was observed to varying degrees in 54% of LHJs surveyed. Yakima is one example:

> *The transition of TB direct services to the local provider community happened in stages, because initially there was not a strong provider community to provide these services. We had our public health RNs go to the local clinics directly to care for TB patients – this allowed us to really focus on training the providers and let them know they weren't at risk. Our nurses initially ordered tests, x-rays, doing all latent TB treatment in their clinics. Over time we started going less and less, and had them do more and more. We would just take the difficult ones. They now refer people to us that they want recommendations on. This process took 5-6 years. In the long run, I think the numbers have worked out: our TB numbers have continued to drop. Having more providers in the community helps. We don't do a lot of training now- it's more the RN staff [in the practices] wanting training (TB 101 basics, ie. Skin tests).*

- Assessing services and prioritizing areas to achieve the greatest impact. Cowlitz was an excellent example (see case study #2 below).
- Helping staff transition roles. Whatcom County is a good example of transitioning people to new roles and being able to make the shift from direct services without changing staff levels.

> *We're moving more towards evidence-based interventions and analysis, [but] if you move away from direct services without context of a new strategic priority, you will be at risk of losing staff/funding. We have always left resources for staff training and development in the budget, even with staff cuts. We dedicate some time in our meetings to do education; our nurses pick their own projects, [Our CD and Epidemiology Manager] provides them with the tools to execute on these projects. They are self-directed learners, if I assign tasks they learn what they need to learn. Infection disease epidemiology is one of the courses I [the Director]*

teach: I am currently teaching my nurses this course. Wherever we see we can make a difference we'll put our efforts there.

- Obtaining funding from unique places. Grant County has built strong relationships with cities and receives annual supplemental funding from them.
- Sharing information to collaborate on reporting notifiable conditions and improve education – Chelan-Douglas provides a valuable example:

> *The Health Department has access to the available EMRs (Skagit needs access to EMRs to increase speed and efficiency of reporting) in our jurisdiction. It benefits both us and the providers. It also streamlines the reporting process for the providers – our Health Department nurses can go into the EMR and collect any missing information needed for reporting purposes. And it also allows our department to identify more education opportunities for community providers, and to be proactive about disseminating information. It took a while to get to this point – cultivating relationships with local providers is really the foundation of a lot of our work.*

- Using a data-first model to orient services, and involving epidemiologist in this analysis (7 out of 13 LHJs have an epidemiologist either on staff on available on contract).

Case Study #1: Transitioning Latent TB Services to Community Partners in Chelan-Douglas

As a result of budget constraints, the Chelan-Douglas Health District went through a large restructuring process in 2008. As a result, **the department clarified its vision and mission, and articulated that its primary responsibility is to perform population based services that cannot be administered by others in the community.** They built a plan to transition latent TB care to the community with the following activities:

- Focus on provider education
- Initiation of high-level talks with leaders of local provider organizations to ensure everyone was on the same page, including timing of transitioning services (i.e., that the LHJ would not discontinue services until providers were ready to intake new clients)
- Contracting with a State TB consultant to offer his expertise to providers for specialized medical questions
- Conducting regular, structured trainings; a registered nurse specializing in TB conducted the nurses trainings while the TB consultant ran the trainings for the doctors
- The overall approach was determined based on the premise that latent TB is a chronic disease that needs to be treated, not a public health emergency.
- The full transition was completed in a year and a half.

Case Study #2: Portrait of an 'Assurer' of Health – Cowlitz County Health Department

A shift in philosophy led Cowlitz County Health Department to embrace their new role as 'assurer' of public health. According to their Nursing Director, "[W]e needed to be the repository of clinical expertise around exotic diseases, and what could be integrated back into the medical home should be."

Leadership at Cowlitz started transitioning services into the community in 2010 first beginning with immunizations, followed by STD services. These two were selected to be first because both were preventive care services that Cowlitz County felt were more appropriate for their clients to receive within the context of a comprehensive health evaluation. Today their direct service offering is specifically invested in high risk patients, for example:

- Anyone who is a confirmed/suspected case of TB is co-managed by the LHJ. The public health nurse goes with the patient to their visits to ensure completion and continuity of care. Nurses are cross-trained, bilingual and bicultural who support other programs including syringe program, immunizations, maternal child health.
- Cowlitz uses a 12 week DOT process, which has allowed them to add back resources, a practice borrowed from Clark County.
- Cowlitz only investigates high risk Chlamydia infections, as defined by specific criteria developed by the public health experts. Nurses spend time only with cases that are considered of high impact. (See Appendix for prioritization)
- They provide a needle exchange program one day a week because this is a niche in the community not currently met. They advise anyone who follows in their footsteps to work closely with the community and ensure that the services shifted to the community will be picked up.
- Instead of providing flu vaccines to everyone, they donate flu vaccines to the local FQHC, their free clinic and their syringe center, to ensure they are providing care to those in highest need.

Quotes from the Field

Leadership at every Local Health Jurisdiction (LHJ) spoke about their work with passion and deep commitment to the community's welfare. Despite challenges of the changing public health infrastructure, many have met the changes in funding, policy, and public health priorities with thoughtful planning resulting in what most described as better care for the population than they provided in the past. Below are some quotes excerpted from our survey interviews:

'Private providers are as good or better at delivery of direct services, but only the health department has knowledge of population-based needs. No private provider has information about everyone in the community.' – Director discussing the niche that the LHJ must fulfill

'If you go back 100 years the three leading causes of death were Communicable Diseases, but the battle against Communicable Diseases has largely been won. Health department attention needs to be selectively moving towards the new leading preventable causes of death. The model going forward is not through direct services but through a health promotion model working in community and neighborhood coalitions. The health department must have competencies in communication and community organizing for these new public health priorities.' – Director describing the orientation that an LHJ needs to have moving forward to battle today's toughest health issues

'As the nature of the work changes, the skills required to do the work change as well. A tension exists between not having a ton of services in the realm of nurses and having the ability to maintain a certain level of nursing capacity when you need it in a time of crises.' – Director talking about the challenges of decreasing direct services and still maintaining capacity

'We have seen a marked decline in usage of our clinics as pharmacies have expanded. Public Health needs to reevaluate what services they provide.' – Director who indicated that the numbers served by the LHJ has decreased over time

'Do we really care who delivers the vaccines as long as the population is immunized? Maybe we become the cheerleaders instead of the providers.' – Director asking a pointed question regarding LHJ's role in immunizations

'Our ability to plan for future investments depend on willingness of our county commissioners to provide support.' – Director talking about the importance of local government buy-in

'Compared to 10 years ago, I think we're doing better. The reason I say this is that the Communicable Disease programs had people who had been doing this forever and the programs weren't being done all that well. In particular, the TB program was a liability/medical nightmare with lots of holes." – Director talking about an LHJ that has successfully transitioned a number of programs away from direct care

'Compared to 10 years ago, we are meeting the needs of our community in a better and more substantial way as a result of our evidence-based approach and the movement towards ensuring people have a medical home. With a medical home, doctors have the full context of the patient, and patients are much more likely to get all services they need versus a one-off service provided by the health department.' – Director describing an LHJ that has successfully transitioned a number of programs away from direct care

'Some of our public health nurses were not thrilled and/or didn't feel comfortable with new roles. It takes time and you really can't do something like that overnight.' – Director that talked about some resistance in staff re-training based on shifting priorities

'In general, I would work with a local provider to provide an STD clinic instead of starting up our own clinical effort if, for example, Planned Parenthood failed. We don't think it's a good idea to open a neurosurgery clinic because there isn't any provider giving these services, so why would we operate this

way with regards to Communicable Disease?" – Director making a comparison and asking why they would consider providing direct STD services when it can be done better through a provider

'We always want everyone to have a health home. There is no reason why a child shouldn't have a doctor. If we are providing 'a la carte' services, we are contributing to the issue. You always need to think of the bigger system.' – Director discussing the importance of the health home model and the danger of 'a la carte' services

'I liked the process (CHIP and CHA) with the community because it helped me work with staff to show them where our focus should be. We had to let some programs go that staff had strong attachment to. It was helpful to show that it was a community process, not just an internal decision of what to prioritize. I haven't heard 'we've always done it this way' as much as I used to"– a Director discussing the CHIP and CHA process and how important that was for overall buy-in to the shifting priorities

'I think that the big thing is to just keep going, keep working with the providers, and don't throw it all on them at once. Possibly consider doing it for them for a while and nurture them along. Make sure they are aware of the risks associated with TB treatment. Start by focusing on a few major providers in the beginning.' – Public Health Nurse talking about the transition of latent TB away from direct service

Part 3: SCPHCS Comprehensive Operational Analysis and Risk Assessment

In order to ensure that SCPHCS is meeting the needs of its constituents, SCPHCS leadership engaged Slalom Consulting to conduct a comprehensive operational review and risk assessment. The fundamental purpose of this study was to ensure that SCPHCS is meeting mandated requirements set by the State of Washington, as well as ensuring that the department is maximizing public funds to meet the most acute community public health needs.

Program level recommendations provided in this report are based on survey results from peer LHJs[16], the Washington State Foundational Public Health Programs and communicable disease mandates, and feedback from local community partners. A wide variety of stakeholders were surveyed in order to provide SCPHCS with a balanced and thorough operational analysis and risk assessment of the current CD programs. Evaluation criteria include:

- Standards outlined in Foundational Public Health Services, RCWs, WACs
- Current needs and services provided in the community (feedback from Skagit County stakeholders)
- Assessment and analysis of services provided across peer LHJs

General findings from each of the three evaluation criteria are as follows:

- *Standards outlined in Foundational Public Health Services, RCWs, WACs*
    - The standards and laws about what an LHJ is required to provide are clear. Some programs and services that SCPHCS provides fall outside of these mandates. While these programs don't necessarily warrant being cut, all programs should be reviewed and determined how they serve the mission of the Department.
    - National and state laws are moving towards more people having health insurance and a medical home. This shift has downstream impacts to LHJs as increasingly they will become an 'assurer' of care versus a 'provider' of care. SCPHSC should embrace the role of 'assurer' as soon as possible.
- *Current needs and services provided in the community*
    - Many of the immunization services SCPHSC provides are duplicated in the community. Although SCPHSC provides many wonderful services, the wide scope of these services limits the staff's capacity to provide education and training to providers, or providing more targeted services to high-risk populations.

[16] LJHs surveyed were chosen by SCPHSC leadership on the basis of geographic and demographic similarities to Skagit County.

- Mt. Baker Planned Parenthood is positioned to potentially take on all STD Clinic services provided currently by SCPHCS. Recommendation is that SCPHCS work on offloading the direct case load and focus on eradicating STDs from a systemic perspective by ensuring that at-risk populations are connected with providers and that the population in general is educated about risky behaviors which could lead to STDs.
- Other LHJs have successfully transitioned the management of latent TB cases into the provider community. Our recommendation is that SCPHCS work with providers and provide a roadmap for this transition.
- Providers, in general, are at capacity, and as more people find medical homes the demand on providers will only increase. Plans to transition direct services need to be conducted in a way that is 1) guided by a Community Health Assessment, 2) has buy-in from all pertinent stakeholders, and 3) gradual and purposeful. SCPHCS needs to prove every step of the way that they are available and a partner to the community.
- There are potential health needs not being met at all within Skagit County that could be uncovered via a Community Health Assessment.

- *Assessment and analysis of services provided across peer LHJs*
  - With few exceptions, LHJs in Washington State are moving away from providing direct services within Communicable Disease. Often the conversation to transition services was triggered by budget cuts; however, most Directors indicated some level of proactive, calculated movement towards becoming an 'assurer' versus a 'provider'. Many Directors indicated they are now able to meet the needs of the population better than 10 years ago, given this new focus. The result has made LHJs stronger, more confident, and more connected within the community, and Slalom expects the same type of result for SCPHCS should they pursue a similar course of action.
  - The specific balance of services that each LHJ is providing is based on 1) where they are at in their transition (whether it is completed or not), 2) specific extenuating factors in their community that dictate whether or not they choose to provide a specific service, and 3) relationship with the provider community and ability of providers to take on a heavier caseload.

Additional Considerations:

SCPHCS has recently undergone changes that include the consolidation of the Community Health Services Department (Substance Abuse, Mental Health, Senior Services and Development Disabilities) and Public Health Department. The departmental integration is intended to provide greater synergies between the departments in order to better serve the needs of the community. A few interviewees have expressed concern about the capacity of SCPHCS given these recent changes but this is speculative in nature.

One of the gaps in this assessment is a full review of assets and liabilities of the supervisor and management staff in relation to current operation and readiness to make system changes. As SCPHCS makes this pivot towards becoming an 'assurer', it is critical that; 1) an asset mapping process be conducted to assess personnel readiness and, 2) that changes are directed toward improving the overall health of all Skagit County residents.

Slalom recommends SCPHCS gradually orient its service portfolio to focus on health assessments, surveillance, education, and community engagement rather than on providing direct clinical services. This recommendation suggests shifting existing staffing models to focus on population-based services that would allow SCPHCS to expand its purview and impact to more high-needs clients that are currently underserved. Shifting to a supervisory and community engagement-based model for public healthcare delivery would serve SCPHCS in achieving both its public health goals, as well meeting the missions and principles of Skagit County as a whole.[17]

SCPHCS Next Steps Priority Matrix

As SCPHCS embarks on a shift to an 'assurer' role in the community, there are many steps and stages that must be clearly outlined. Below is a summary of our recommendations. Please note that 1) specific timing of these events will need to be defined by SCPHSC leadership, and 2) each activity block has a number of sub-activities within it that are not being represented. For example, sub-activities found in 'Transition STD programs' could be as follows:

- Assess number of unique STD services provided monthly including: screenings per month, Partner notifications, counseling.
- Set meeting between Linda McCarthy of Planned Parenthood & Cathy Smith from SCPHCS to determine where overlap in services exists.
- Determine services currently provided to transition and which to share responsibility for. (I.e. Transition STD screenings and treatment, partner notification and follow up and counseling)
- Communicate the change to all providers and patients through web, phone, letter/fax, email and/or in person.
- Discuss additional opportunities for partnership that currently exist in Whatcom with Planned Parenthood. Examples include the following: 1) TOP program 2) Train the teachers for health education 3) Teen Council Program 3) Sharing HPV vaccines through the Vaccines for Children program.

[17] Mission statement and core principles of Skagit County government http://skagitcounty.net/Departments/home/mission.htm

Urgency →

Complexity ↓

Low Complexity/Low Urgency	High Urgency/Low Complexity
- Find and partner with a 'best in class' LHJ who has gone through similar transitions (Suggestions: Regina Delahunt - Whatcom, Torney Smith - Spokane, Scott Daniels - Kitsap, Jeff Ketchel - Grant) - Explore resources to refer Skagit physicians to such as CDC's STD prevention training in Seattle. - Review and learn Foundational Public Health Services - Reach out to Skagit County pharmacies to discuss immunizations provided and opportunities to improve education.	- Remove X-Ray Machine - Review and update existing policies and procedures and provide new staff training for key CD processes, including Emergency Response System, Pandemic Flu Response, documentation processes and other disease-specific processes as necessary. - Initiate Community Health Assessment process - Consider staffing retraining/augmentation plan based on learnings from CHA (Suggested peer county advisor on this process is Dr. German Gonzalez from Whatcom. Recommended resource by Iva Burke from Clallam is NW Center for Public Health Practice) - As CHA is ongoing, work more closely with providers/partners throughout the community to start to set expectations and build a more collaborative relationship - Create Board Orientation Manual (similar to Kitsap County) - Finalize a project plan which shares the vision for when certain shifts should take place - Assess scope of CD services currently offered in Skagit (i.e. In local pharmacies, providers, planned parenthood, etc.) to inform any changes in SCPHCS services.
High Complexity/Low Urgency	**High Urgency/High Complexity**
- Transitioning completely to Electronic Medical Records - Start orienting focus more towards training and education. - Develop Health Department Strategic Plan (inputs include Foundations Public Health Services, CHA, additional stakeholder feedback on underserved populations, feedback from peer counties such as Whatcom and Cowlitz, etc)	- Start planning STD/Family Planning transition with all providers in community - Begin planning to transition immunization services overall, including travel clinic. Start with transitioning away from flu vaccines, then VFC vaccines, then Adult and travel last. - Begin planning to transition out certain TB services (specifically LTBI) Start with TB skin test screening - Explore ways to orient towards more data driven approach and moving towards analysis of at-risk populations

Detailed Findings

The study is organized by program area – Communicable Disease, Immunizations, STDs/Family Planning, and TB. Each section contains an assessment of the program's strengths, weaknesses, risks, feedback from the community, and opportunities.

Communicable Disease – Strengths, Weaknesses, Risks, Feedback, Opportunities

Strengths

- SCPHCS Nursing staff are respected subject matter experts in the community
- The program has a proven ability to form strong relationships in the community
- General availability and willingness to help community is perceived as a great strength
- Ability to scale up in times of crises and work as a conduit to pass information from state-level to providers. On several occasions the strength of response in outbreaks was noted, including instructional materials provided and availability 24/7

Weaknesses

- Delay in adding new insurance for billing purposes
- High reliance on paper records[18]
- Focus on direct services keeps SCPHCS from being as visible as they could be in the community; constrains key resources
- Current balance of programs and services may not take into consideration the shifting and changing needs of the community
- Duplication of service offering with the community, includes immunizations, flu vaccines, Family Planning services and STD screening and treatment. In qualitative interviews with community stakeholders and nearby LHJs we learned these services are available. We recommend a more quantitative Skagit-specific follow up to assess scope and next steps.

[18] Our comments did not take budgeting into considering. State experts interviewed expressed the importance of keeping EHRs for reasons continuity, tracking and accountability (it is also a part of Meaningful Use standards followed by the private healthcare sector). Although this was not a high priority recommendation (see page 29), we want to point it out to be thorough.

Risks

- Emergency Notification System may need to be reviewed, updated, and tested to ensure the best process is in place.
- Providing services to everyone spreads limited resources thinly and potentially reduces the impact SCPHCS has on high need clients.
- Duplication of direct services[19] diminishes the ability of the staff to provide services that uniquely fit the needs of the community
- Manual processes and the lack of electronic medical records may expose SCPHCS to risk of litigation, according to experts at the Washington Department of Health, if the current process unintentionally allows cases to not be followed up on. Further investigation needed.[20]
- Minimal bandwidth for SCPHCS nurses to provide education for providers, as most of their time is spent on delivery of direct services.
- Health Officer is minimally involved in day-to-day issues (although he is available on an as-needed basis for consultations); numerous competing demands preclude the Health Officer from being more directly involved. The role of a Health Officer as an enforcer, tracker and advocate was described by other counties as a key public health advocate, especially during transition periods.
- Stakeholders from the community have a strong perception that if the SCPHCS does not maintain a safety net no one will be there to provide care for high risk or underserved populations. This underscores the need to evaluate who these populations are and how to care for them by prioritizing limited resources a calculated manner.)
- While convenient for some, providing preventive services outside of the medical home contributes to poor continuity of care for clients.
- In the past decisions have not been made with strong backing of data, putting SCPHCS at risk of spending resources on things like duplicative services.

Feedback and Quotes (Community and Internal)

[19] See STD/Family Planning and Immunization Sections

[20] The assumption made by State representatives was that current processes may have poor communication and documentation practices that put SCPHCS at the risk of unintentionally missing follow up on a case. Because we did not review current policies and procedures in the scope of this report, this is an item requiring further follow up.

- Concerns that if SCPHCS stops providing direct service it would become the primary responsibility of the local hospitals. Hospitals are currently resource constrained and most likely unable to scale to meet the community's needs.
- Feedback that the scope of services of a LHJ is very cut and dry. There is state law (See Appendix) that describes what role an LHJ needs to fulfill; an LHJ should start with this; everything else is up to their discretion.

Opportunities/Mitigation Strategies

- Continue to review and update Emergency Notification System to ensure a clear process is in place.
- Consider taking a lead role in a Community Health Assessment. In fact, others in the community see that as a critical role for SCPHCS to play, and there was some acknowledgement from Skagit Regional Health (for example) that they and other similar entities would need to provide funding towards this.
- Lead with a more data-driven approach and develop a new vision for the department. Potential areas for consideration include hiring or contracting with an epidemiologist, prioritizing programs based on data rather than on individual knowledge. Examples include Whatcom County.
- Move towards providing fewer direct services (where appropriate) and focus on community awareness, education and impacting high-need populations.
- Develop a technology strategy for adopting electronic medical records (if direct services continue).
- Focus on being an 'assurer' versus a 'provider' of public health care, as outlined in the Agenda for Change.[21] The transition will be difficult as initially there may not be enough physicians to meet the needs of the population; however, there are examples in other LHJs of how to tackle this successfully and sustainably (i.e. Yakima or Chelan-Douglas)
- Consider engaging the Health Officer or another respected, clinical expert as an SCPHCS representative in discussions with community providers if SCPHCS choses to transition away from direct services and towards more population health surveillance. In several other LHJs, the Health Officer worked in tandem with the administrator to engage local providers around taking on greater clinical responsibility for managing certain CD populations (i.e. TB).

[21] Agenda for Change: Foundational Public Health Services. Public Health Improvement Partnership. June 5 2013. http://www.doh.wa.gov/Portals/1/Documents/1200/fphs-definitions.pdf

- Develop a staffing model that 'right fits' tasks to staff; consider whether lower paid resources can complete tasks now being performed by highly paid staff. For example, data entry can be provided by non-nurse staff and the Washington Department of Health (DOH) has a training program for non-nurse staff to perform these tasks).
- If leadership intends to cut back on services provided by SCPHSC, ensure that decisions are made with expertise of experienced and qualified division managers, advisors, as well as a neutral quantitative assessment of community need and capacity to inform the decision making process.
- Orient overall health programs and initiatives towards the leading causes of mortality, which may or may not be Communicable Disease.[22] Any shift in service offerings requires strong leadership, education, and communication provided by the Director and key people managers to explain the business case for the transition.
- Create/Update Board Orientation Manual for the Board of Health (similar to Kitsap County).

Immunizations – Strengths, Weaknesses, Risks, Feedback, Opportunities

Strengths

- Nurses are respected subject matter experts in the community and have strong relationships with schools and hospitals.
- The 'walk-in' model has worked well for internal staff, removing administrative burdens around scheduling appointments.
- Nurses ensure immunization visits are educational, when applicable. For example, they spend 30 or 40 minutes when someone is travelling to an exotic country to discuss potential risks, etc. associated with immunization.

Weaknesses

[22] Center for Disease Control (CDC), "Potentially Preventable Deaths from the Five Leading Causes of Death — United States, 2008–2010" available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6317a1.htm.

- SCPHSC staff feels pride in doing a better and more thorough job than the community. This can be seen as a weakness, as it potentially leads to a perception that SCPHSC is only able to provide the services, rather than expecting an equally high level of care from community providers.
- Due to focus on direct services, SCPHSC staff has limited time to educate community providers and their staff.
- There is a duplication of immunization services with community providers at comparable costs and availability, particularly for seasonal and routine adult and child immunizations.

Risks:

- Due to staffing constraints, a systemic outbreak (similar to H1N1) would be extremely difficult for SCPHSC to respond to.
- Due to staffing constraints, overburdened staff may be more prone to making crucial mistakes.
- Focus on direct service detracts from SCPHSC focusing on providing necessary trainings and oversight of community clinics.
- Offsite immunization clinics offered by SCPHSC have operated with minimal management oversight, raising safety concerns. No other LHJs surveyed provided offsite clinics.
- The pandemic flu response plan should be reviewed and re-evaluated in light of the current Ebola outbreak. Review should include community stakeholders (see State Law in Appendix).

Feedback and Quotes (Community and Internal)

- *'If we had H1N1 today it would be terrible'* – internal immunization staff indicating that even though SCPHCS has met past challenges, budget and staffing cuts mean that it will be much more challenging during the next outbreak
- *'The clinic is unsafe because we don't have enough staff. It's inappropriate – you can't just go to lunch when you are providing help to a patient.'*
- *'Every day I deal with half a dozen phone calls from one of the 32 clinics that make my mouth fall open'* – internal Immunization staff discussing concerns about some of the questions clinics ask that hint at a lack of understanding about how to administer immunizations.

Opportunities/Mitigation Strategies

- Review and reassess the pandemic flu response. See Appendix RCW 70.26 for details on requirements and performance standards for LHJ Pandemic Flu Response.

- Phase out immunization services already provided in the community. Current providers include: Sea Mar, pharmacies, 32 clinics. Sea Mar, for example, could provide their own storage and give more vaccinations (note that Sea Mar indicated that previous issues with storage are no longer a concern).
- Evaluate who the high need/underserved populations in the community are and develop strategies to prioritize immunizations (i.e. partnering with current providers to reach these populations).
- Leverage SCPHCS's strong internal expertise among public health nurses and increase focus on provider education.

Tuberculosis – Strengths, Weaknesses, Risks, Feedback, Opportunities

Strengths

- Staff own the complete tracking and care of active and latent cases. The County as a whole acknowledges and appreciates this due diligence.

Weaknesses

- Community relies almost completely on SCPHCS; therefore, there is little ongoing training that is given to providers.

Risks

- X-Ray machine is costly, and this service exists and can be met by the community. Additionally, no other LHJ we interviewed owns and operates an x-ray machine.
- Concerns were raised by some at the State level that current TB case management cases needed greater physician oversight.

Feedback and Quotes (Community, State, and Internal)

- According to a state TB expert, the way SCPHCS has operated their TB program in the past with limited physician oversight has created some liability concerns.
- Recommendations of moving the optional services to the community (like LTBI monitoring).
- The state TB expert also recommended looking at creative models to monitor the active TB cases. There are ways to partner with the community in this as well so that the LHJ is not on their own.

Opportunities

- Decommission x-ray machine and transition to a contract with a local hospital.
- Increase education and knowledge sharing with the provider community and transition TB service offering to the community over time.
- Transition SCPHCS's role in latent TB cases to one of 'assurer' or 'advocate'. This would need to transition slowly with a specific process and timelines outlined.
- When the current CD Manager retires, recommendation is to replace her with an RN that has an MPH or add another BSN and an Epidemiologist. The current staff are more skilled in providing direct services so it would be beneficial to hire a resource with experience in population-based programs.

STD/Family Planning – Strengths, Weaknesses, Risks, Feedback, Opportunities

Strengths

- STD nurse is respected as a skilled and knowledgeable expert in the community.
- Strong collaboration with schools.

Weaknesses

- STD clinic sees very few patients, particularly in the eastside of Skagit County. Clinic operates regardless of the number of people requesting service (some days only 1-2 seek care), resulting in wasted resources.

Risks

- Duplication of STD and Family Planning services with community providers, including Planned Parenthood. Planned Parenthood has a larger reach, but has had trouble partnering with SCPHCS in the past. Planned Parenthood did express interest in a firmer partnership moving forward.
- Current programs directly impact a small number of people and use valuable SCPHCS resources.
- Little to no training or oversight is being provided of STD screening and treatment among community providers, although several interviewees expressed concern about provider capabilities to provide these services.

Feedback and Quotes (Community, State, and Internal)

- *"Providers are trying to provide more STD services but often need to be taught what they should be doing. They need to be given information about who the right people are to screen, how to take a complete sexual history, etc."*
- *Linda McCarthy for Planned Parenthood is very positive about future partnership and engagement with* SCPHCS*. She mentioned that she would strongly consider expanding Planned Parenthood to the eastern side of the county in order to fill the gap if* SCPHCS *ceased providing clinics to that part of the county.*

Opportunities

- Partner with Planned Parenthood to gradually transition STD/Family Planning services currently provided in the SCPHCS clinic (including clinics in eastern part of Skagit County).
- Partner with providers throughout the county for training and education, and leverage community resources. Sea Mar, for example, has an HIV expert.
- Refer physicians in Skagit County to the CDC prevention training center in Seattle.
- If transitioning away from direct services, there is an opportunity for SCPHCS to analyze and ensure that all at-risk populations are being reached, and then work with community clinics and partners to ensure there are outreach efforts in place.
- Partner with an LHJ who has run a successful STD/Family Planning program (Spokane County was mentioned as a strong model).