



## CLARK COUNTY PUBLIC HEALTH

### FRAMING DOCUMENT – LOOKING AHEAD

MARCH 2010

Public health as a discipline and governmental public health organizations has experienced many changes over the last ten years. This document is (1) for the staff of Clark County Public Health to frame concepts and ideas to guide their current and future work, and, (2) for the Clark County Board of Health to confirm future direction.

The first section reviews our unchanging mission, vision, and values. The next section describes significant influences on public health including publications, legislation, and recent events. Next, we describe the tools, conceptual models, frameworks and methods we will use to communicate our emerging priorities and accomplish our mission. The last section briefly describes our path forward, including ensuring a trained competent workforce.

Our department continues to undergo major changes. We transitioned our clinic to a Federally Qualified Health Center because we thought others could provide services that are more comprehensive to people in need of a medical home. We chose to transition WIC and other programs when the budget forced us to make hard choices. As we have let go of these core elements of our recent past, we must now shift focus to the future.

### What is not changing?

Even in these changing times, there are no changes to our mission, vision, values, or structure.

#### Mission statement:

Our Mission is Your Good Health:

We provide leadership through partnerships to:

- *Prevent* disease and injury
- *Promote* healthier choices
- *Protect* food, water, and air
- *Prepare* for emergencies.

#### Vision statement:

Active, healthy families and people of all ages, abilities, and cultures living, learning, playing, and working in thriving communities.

#### Values:

- Prevention and Promotion
- Data-driven, Science-based Services
- Customer Service and Accountability
- Collaboration
- Social Justice Equity
- Skilled, Innovative and Diverse Employees

Two concepts reflected in our organizational chart ground our department (Appendix 1). First, our organization reflects the public's priorities for governmental public health services. The public expects us to:

- Understand and share our community's health issues;
- Control communicable diseases;
- Protect food, drinking water, and air;
- Ensure that public swimming pools and spas are safe;

- Help families be healthy and help kids get an early start on life;
- Promote conditions that support prevention of chronic conditions so that people can live long, healthy lives;
- Ensure access to medical and dental care;
- Ensure the public's safety and be ready for public health emergencies.

To meet the public's expectations, we must work in teams across our organization when that makes sense and refrain from working in silos. We have made advances in implementing this structure, but we need to strive toward greater integration. Examples of current service units and programs working cross-functionally include:

- Addressing communicable disease prevention (outreach, infectious disease, and environmental public health);
- Increasing access to healthy foods (nutrition and family wellness, outreach, and assessment programs); and,
- Improve access to first trimester prenatal care (parent child health, outreach, and assessment).

These cross-functional work teams have the advantage of bringing together multi-disciplinary teams that share perspectives, expertise, and resources to address a community issue. Taking advantage of service units and programs working cross-functionally provides the opportunity to leverage the natural connections between programs that can increase our overall effectiveness.

Second, governmental public health is only part of a broader public health system that includes non-governmental organizations (Appendices 1 and 2). We need the entire public health system as partners if we are to improve the health of our community. As a governmental public health department, our role in working with our partners will vary depending upon community resources and desires. We have the opportunity to embrace collaborative relationships and provide leadership within the larger public health system. Here are some examples of recent community partnerships that have led to improved health conditions or improved delivery of services.

#### **Collaboration with the Septic System Industry to Improve the On-site Septic Systems (OSS) Program:**

Last fall, a technical advisory committee representing the septic system industry and our OSS staff recommended a Class B waiver policy supported by the local Board of Health. In January, the Washington State Department of Health reviewed the Class B waiver request from Clark County Public Health and supported the site-by-site waiver, which extends the county's septic system operation and maintenance inspection interval for conventional pressure distribution systems (systems meeting Treatment Level E without advanced treatment) from one year to two years. Clark County also committed to track overall performance of the systems and results of the policy change. If failures or other serious problems increase, then the county will reinstate the annual inspections.

#### **Collaboration with Community Planning:**

In 2008, Clark County Public Health responded to a request from the Community Planning Department to carry out a Health Impact Assessment (HIA) for the Highway 99 subarea project. A cross-functional public health team analyzed development alternatives considered in the plan to help area residents and decision makers understand how each alternative could enhance or reduce health outcomes. Health outcomes considered included obesity, safety, traffic injuries, chronic disease rates, and social cohesion. The team included members from Environmental Public Health, the Assessment Unit, HIV and Communicable Disease, Nutrition and Family Wellness, and the Health Officer. The team's report was included in the final Highway 99 Subarea Development Plan and was presented to the Clark County Planning Commission, producing a lively exchange with Commission members and a chance to introduce "public health thinking" into their deliberations. This project created an ongoing relationship with the Community Planning Department, and requests for health impact assessments continue in other settings in Vancouver and Clark County.

### **Support for Early Learning and Families (SELF) Community Collaborative:**

The mission of SELF is to launch and lead community partnerships that build an integrated system of support for young children and their families. SELF formed in 2001 in response to a community forum sponsored by public health on early brain development. Since then, SELF has increased communitywide awareness of the importance of early childhood and increased services for families with young children. Partners include Early Head Start (EOCF), Fort Vancouver Regional Library District, Clark College, Washington State University, public school districts, and many others interested in preparing healthy children to learn and thrive.

### **Collaboration with Community Choices to Increase Opportunities for Physical Activity:**

Public Health staff and managers participated and provided leadership through Community Choices for a local walkability coalition to increase physical activity. The coalition developed and distributed a Clark County walking guide that improved knowledge of local trails and increased physical activity. Coalition members included Community Choices, Vancouver-Clark Parks and Recreation, the City of Vancouver, Kaiser Permanente, the Vancouver Housing Authority, and area schools.

## **Significant Influences on Public Health**

As outlined below, academic and research advances, economic pressures, political changes, and global connectedness have influenced public health practice. For more details, see Appendix 3 and visit the public health tool kit on the H drive.

### Publications and programs:

- In 1994, the Core Public Health Functions Steering Committee developed the Ten Essential Services of Public Health.
- The Institute of Medicine issued two major reports on governmental public health:
  - 1998, *The Future of Public Health*, which said governmental public health needed to refocus around three core functions, specifically assessment activities, policy development work, and ensuring services in the broader public health system.
  - 2003, *The Future of the Public's Health in the 21<sup>st</sup> Century*, which said that governmental public health had to be better funded, had to be more accountable, and had to look at the social as well as the behavioral determinants of health.
- Washington State developed Public Health Standards that were assessed beginning in 2000 to address the need for accountability and quality.
- In 2005, the Task Force on Community Preventive Services published the first edition of *The Guide to Community Preventive Services (Community Guide)*.
- In 2005, the National Association of County and City Health Officials (NACCHO) published a booklet entitled the Operational Definition of a Functional Local Public Health Department based on the Ten Essential Services of Public Health.
- National Accreditation for public health departments is scheduled to begin in 2011.
- Professional certification began in 2008 for master of public health trained persons.
- Public Health Code of Ethics was published in 2002.
- In 2008, the World Health Organization released: *Closing the gap in a generation: Health equity through action on the social determinants of health*.
- The Robert Wood Johnson Commission issued *Build a Healthier America* report and recommendations.

### Other driving forces:

- A large body of health and social research began to document the root causes of our alarming socio-economic and racial inequities in health powerfully communicated through the acclaimed PBS documentary series, *Unnatural Causes*, used by thousands of organizations around the country to raise awareness of the relationship of health and social justice.
- Natural and man-made disasters (e.g., Hurricane Katrina and the Haiti earthquake), terrorism (September 11, 2001), bioterrorism (anthrax attacks), and wars caused extensive morbidity, mortality, and population displacement, and heightened public awareness of the importance of the role of public health in preparedness and emergency response.

As we look ahead to the next few years, changes in the economy and in the field of public health will influence our future priorities and work. The current economic downturn, citizen initiatives, legislative initiatives and inflationary pressures will continue to threaten our funding (see Appendix 3). To meet our public health mission, we must lead efforts through partnerships that shape policy and ensure conditions in which all persons can be healthy, and empower vulnerable populations.

### **Implementation Steps**

Clark County Public Health must prioritize and focus our work based on economic, political and social influences. Therefore, we remain committed to our department's top priorities:

- Protect food and drinking water
- Prevent and control communicable diseases
- Ensure conditions where every child has a healthy start
- Prepare for public health emergencies
- Prevent chronic disease and promote health by
  - Increasing our community's healthy nutrition
  - Increasing our community's physical activity
  - Reducing and preventing tobacco use
- Assist people in accessing medical & oral health care

### **Public Health Code of Ethics**

We have adopted the National Public Health Leadership Society code of ethics as a standard by which the community can hold us accountable. The code of ethics includes a list of issues and principles that guide us in addressing public health issues while making our values and ideals explicit.

### **The next two years**

Our central challenge is to create a health department that can influence the conditions that promote health for everyone. Based on our values for social justice and diversity, we will strive to provide all Clark County residents with equitable access to opportunities to be healthy. By doing so, we aim to reduce inequalities in health status. We must position ourselves to take advantage of emerging opportunities that help us meet challenges and ensure sustainability by:

1. Adopting initiatives, strategies and activities that:
  - a. Are based on the socio-ecological model that focuses on the behavioral, social and environmental determinants of health;
  - b. Are evidence-based;
  - c. Use conceptual and theoretical frameworks for behavior change;
  - d. Are innovative and/or promising practice;
  - e. Use multidisciplinary, cross-functional teams;

- f. Demonstrate systems thinking; and
  - g. Are aligned with the central challenge.
2. Clearly describing the Departments goals and objectives.
  3. Developing workforce competencies to meet new opportunities.
  4. Aligning our strategies with our budget.

### **Adopting initiatives and interventions**

The Management Group, working with the Leadership Team, is developing a two-year strategic plan for the Board of Health to adopt by April 2010. The strategic initiatives will reflect our mission, vision, values and the expectations listed above.

### **Clearly describe our Department's goals and objectives**

Marni Storey and Jonnie Hyde will work with their respective staffs to describe the overall purpose of each service unit and identify goals these units hope to achieve over the next two years. This will help to frame the service unit's purpose within the entire public health system and identify the local governmental public health role. Each service unit will:

- Focus on addressing root causes (physical, social, and economic environments) impacting health.
- Study data from the CAPE report, key local public health indicators for Clark County, and the *Community Report Card* to inform the work.
- Consider health disparities and work to achieve equal access to good health.

Once service units have established unit purpose and goals, members will review the literature, including *The Guide to Community Preventive Services (Community Guide)*, to identify what approaches have evidence that support their goals. In some cases, programs have already done this research and may even have developed logic models. We should make use of that work.

### **Developing workforce competencies:**

Developing our workforce requires a leadership team and management group with appropriate competencies to lead staff as we implement the initiatives we develop. The leadership team and the management group will develop a formal training plan that ensures we have the skills and abilities to accomplish our mission. National competencies will help guide us as we assess our current competencies and identify areas for further development (see appendix 4 for a list of the competencies, or visit the following link:

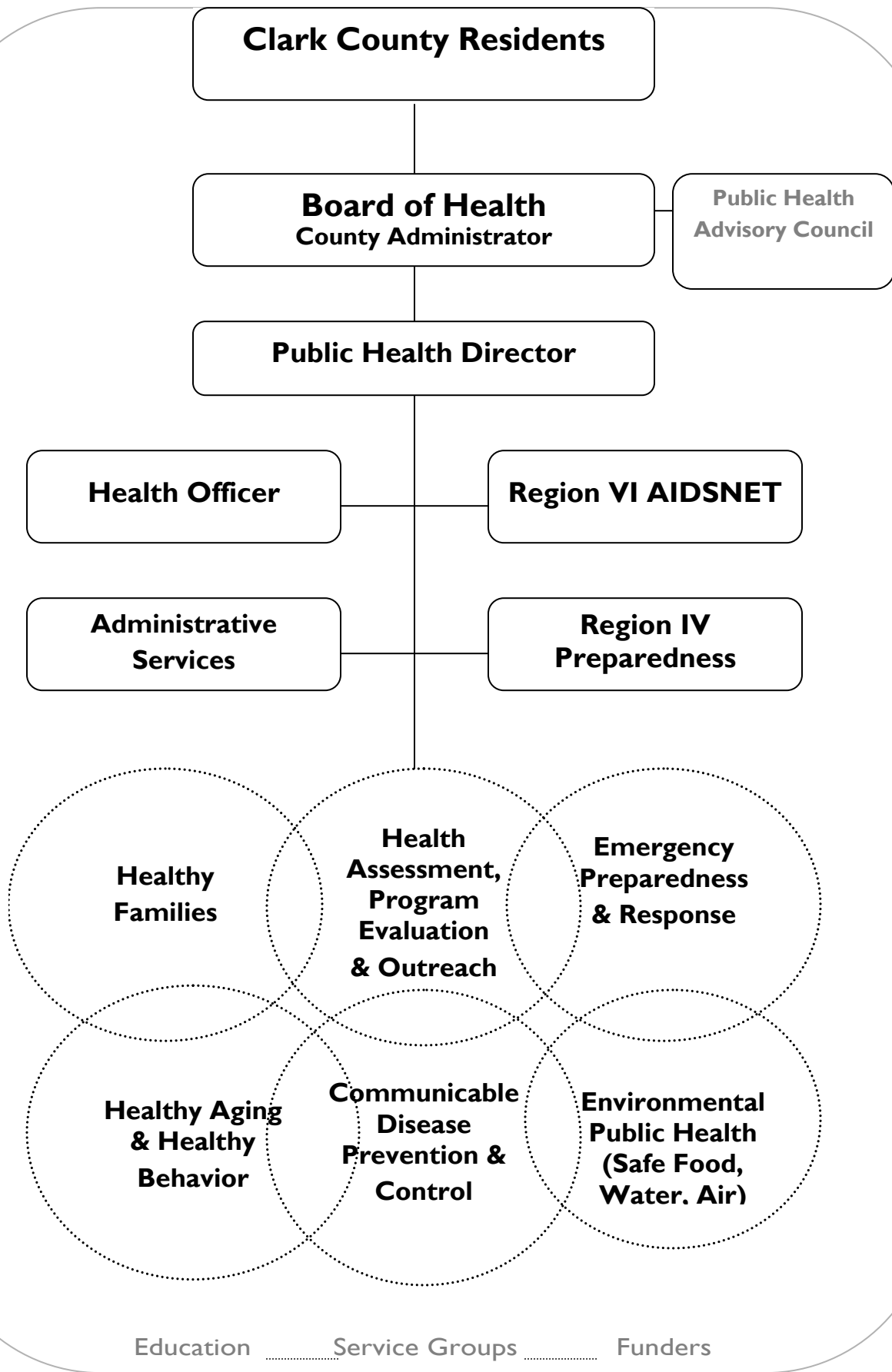
<http://www.phf.org/link/corecompetencies.htm> ).

As a learning organization, we expect managers and staff to read, understand, and incorporate emerging information, tools and concepts into practice. We expect staff to search out the answers—perhaps by doing some outside reading or asking for additional training. We will all have the opportunity and support to engage with this material and own it in our work. Although there is much to learn in the way of new skills and knowledge, all staff managers and the Leadership Team must, at a minimum, become familiar with the concepts listed below:

- Socio-ecological model
- Logic models
- Social and behavioral determinants of health
- Community facilitation using advocacy models & skills

### **Align strategic objectives with the budget:**

As strategically aligned public health interventions are determined, we will complete an analysis of human and financial resources and develop the department's budget plan for the 2011-2012 biennium.



## Appendix 2

### **The governmental role of public health departments and other public health partners.**

#### **Governmental Public Health**

Governmental public health has the legal responsibility for the protection and promotion of the public's health.

The U.S. Constitution does not establish a public health role for the federal government, other than the power to tax and spend and to regulate interstate commerce. Therefore, states have the primary responsibility to provide for the safety of their citizens and to provide for public health services.

In Washington State, the state legislature has delegated the responsibility and authority to enforce public health statutes of the state and rules promulgated by the state board of health and the secretary of health to the local board of health through the health officer or administrative officer (i.e., Director of Public Health) according to RCW 70.05.060. Should the local health jurisdiction fail to act with sufficient promptness or efficiency, or be unable for reasons beyond its control to act, the Secretary of Health shall enforce the laws and bill the local jurisdiction for costs that are then to be paid out of current expense funds of the county (RCW 43.70.130).

The foremost role for our local governmental public health department is to ensure that we implement Washington State public health laws and regulations. The department's responsibility is also to:

- Listen to what the community's priorities and needs are for public health;
- Provide policymakers, organizations, and residents information about their health and evidence-based solutions to health issues so they can make informed decisions;
- Proactively prevent problems, rather than waiting for them to occur;
- Provide leadership by bringing together existing community resources and/or by supporting the development of additional resources to address health issues; and,
- Provide technical assistance, consultation and education to assist our partners as needed.

#### **The role of other public health partners**

The diversity of our public health partners can be illustrated through a single health issue: prevention of chronic disease by directly or indirectly addressing the obesity epidemic. The organizations listed below demonstrate the diverse nature of public health partners:

- National organizations such as the American Heart Association, the Diabetes Association, and the National Association for Health and Fitness provide education and advocacy to promote the health benefits of physical activity;
- State organizations such as the Washington State Association of Local Public Health Officials and the Washington State Nurses Association work with public officials and professionals to communicate the necessity of a coordinated public health effort to combat obesity;
- County and municipal departments such as parks and recreation and local educational institutions promote environments and activities that create opportunities for youth and families to be physically active;
- Local non-profits and advocacy groups such as the Bicycle Transportation Alliance and Community Choices publicize the need for active transportation, publish route maps, and participate in planning processes that will help ensure that our community is both walkable and bikeable;
- Neighborhood associations identify safety needs (such as stop signs or traffic lights) and supporting healthy communities through actions such as volunteering to participate as part of a "walking school bus" so children can get physical activity as part of their daily routine.
- Both national and local foundations, from the Robert Wood Johnson Foundation to the Clark County Community Foundation, provide the financial support to research and/or implement health solutions,

## **Appendix 3**

### **Influences on Public Health**

#### **Lessons from the Past**

Since the first Board of Health was formed in 1793, the field of public health has evolved against a backdrop of external crises threatening the public's health on massive scales: communicable diseases such as smallpox in the 1700's, environmental contamination leading to cholera epidemics in the 1800s, early deaths of women and children living in extreme poverty during the industrial revolution, the arrival and spread of HIV in the 1900's, and natural or man-made catastrophes such as Katrina or the September 11 terrorist attack in this century. Each emerging crisis has added to public health's scope of responsibility and pushed us to develop new tools. To stop the spread of smallpox, it was essential that vaccines be delivered to and accepted by the community - so skills in outreach, home nursing and health education evolved. To stop the cholera epidemic, it was essential that once the source was identified as contaminated water, health workers and city planners collaborate to re-design wastewater systems - so skills in sanitation and urban planning became integral to our success. To improve the health of women and children living in extreme poverty during the industrial revolution, it was essential to not only provide home services but to work with municipalities, housing authorities and advocates to improve the conditions of daily life. As with any catastrophic event, public health was needed to minimize the loss of life and property and to help rebuild the infrastructure.

In the late 1900s, as funding streams became more prescriptive and as government infrastructure became more robust, the role of public health and its boards shifted. We moved from comprehensive disease prevention planning, promotion of community health policy, and a commitment to social justice, to a narrower role involving the delivery of categorical services and regulatory oversight. We became siloed, and we began to under-utilize many of the community-based approaches that had been integral to our early success, e.g., partnerships that shape policy, collaborations with planners, assurance of conditions in which all persons can be healthy, and empowerment of vulnerable populations.

#### **Recent Influences on Public Health**

##### *Economic Factors*

##### **Current economic downturn**

The current economic downturn affects our future through two mechanisms.

*First*, declining sales tax revenues mean that county and state government loses the major source of funding. Growth has slowed and new building has almost stopped, meaning that Clark County no longer benefits from increased property tax revenues in excess of the 1% per year allowable in a measure passed by citizens in 2007 (I-747). These declines in income mean that the government can no longer afford the services it once provided. Along with the state, Clark and other counties have drastically cut expenses in order to pass balanced budgets.

*Second*, our elected officials are trying to mitigate these impacts by using one-time federal stimulus dollars and reallocating existing revenue sources and fund balances for one-time fixes (for example, road funds have been shifted to support sheriff patrols). However, this cannot go on forever because stimulus funds will end, and we can only postpone the repair and maintenance of our roads for so long.

The reality is that programs like public health, human services, parks and recreation, etc., are not going to recover as quickly as programs such as law enforcement and roads. Bottom line: we have to prepare for more lean years.

## Impact of citizen initiatives

Three initiatives have greatly affected the economics of public health:

- I-695, passed by voters in 1999 repealed Motor Vehicle Excise Taxes (MVET). 1999. Despite being ruled unconstitutional by the State Supreme Court in 2000, it was quickly re-instated by a vote of the legislature at the governor's request. These actions eliminated public health's largest, most flexible, and sustainable funding source. While the legislature restored 90% of local public health funding, it was a cut of 10% and has not since been adjusted for inflation.
- I-747, which was passed by voters in 2001. It limited property tax growth to the lesser of 1% or inflation (minus new building property taxes in the year they are added to the tax rolls). This initiative, ruled unconstitutional by the State Supreme Court in 2007, was quickly re-instated by a vote of the legislature at the governor's request. These actions limit counties' revenues and require new property development to fully fund all existing services. This means that counties are strapped for funding to continue existing services, and that financial stability for counties is inextricably tied to new development.
- I-960 was passed by voters in 2007. It reaffirmed state law requiring a two-thirds vote of the legislature to increase taxes and required that all new fees or fee increases be passed by the legislature (e.g., driver license fee, nursing license fee, etc.). In addition, it requires a non-binding public advisory vote on tax increases not sent to the voters for approval. These actions set a high bar for the state legislature and governor to raise additional revenue, limiting options for increasing public health and other funding.

## Inflationary Pressures

Expenses in county government are driven mostly by salaries and benefits, which accounted for 42% of actual expenses for Clark County between the years of 2004 and 2008. Countywide wages (cost of living, step increases, and merit pay) per FTE increased by 19% between 2004 and 2008. In addition, countywide benefits have increased by 35% over that same time. Due to the limitations on developing new revenue sources described above, and with growth all but stopped due to the current recession, there is no way the county can continue its current level of expenditures.

## FIELD OF PUBLIC HEALTH

*NOTE: For an in-depth examination of these influences and to read the full documents refer to the Public Health toolkit located on the H drive.*

- In 1994, the Core Public Health Functions Steering Committee developed the Ten Essential Services of Public Health. The steering committee included representatives from national public health service agencies and other major public health organizations, including the National Association of County and City Health Officials (NACCHO). The ten essential services are: monitor health status; diagnose and investigate health problems; inform, educate, and empower people about health issues; mobilize community partnerships; develop policies and plans; enforce laws and regulations; link people to needed personal health services and ensure the provision of health care when otherwise unavailable; ensure competent workforce; evaluate effectiveness; and research.
- The Institute of Medicine issued two major reports on governmental public health:
  - 1998, *The Future of Public Health*, which said we needed to refocus around three core functions, specifically assessment activities, policy development work, and ensuring services in the broader public health system.

- 2003, *The Future of the Public's Health in the 21<sup>st</sup> Century*, which said that governmental public health had to be better funded, had to be more accountable, and had to look at the social as well as the behavioral determinants of health.
- In 2000, state and local public health officials developed the Washington State Public Health Standards, against which each local health department, the state Department of Health, and the state Board of Health are evaluated every three years. These standards, revised in 2005, serve as one component of accountability.
- In 2005, the Task Force on Community Preventive Services published the first edition of *The Guide to Community Preventive Services (Community Guide)*. The Task Force is an independent, volunteer body of public health and prevention experts, whose members are appointed by the Director of the Centers for Disease Control (CDC). The guide describes which community public health interventions have an evidence base for their effectiveness and is another component of accountability.
- In 2005, the National Association of County and City Health Officials (NACCHO) published a booklet entitled the Operational Definition of a Functional Local Public Health Department based on the Ten Essential Services of Public Health.
- In 2005, the CDC and the Robert Wood Johnson Foundation launched the Exploring Accreditation Project (EAP), a fourteen-month exploration process to determine if it was feasible and desirable to implement a national voluntary accreditation program. The EAP Steering Committee and four workgroups included public health practitioners from local, state and federal government and members of academia. In the winter of 2006-07, the EAP recommended moving forward with establishing a national voluntary accreditation program for public health agencies. Beta testing of the standards will begin in the spring of 2010.
- In 2007, the Washington State Key Health Indicators Committee, including state and local health officials and academic partners, established and released data for the first set of statewide Local Public Health Indicators. The indicators include measures in the areas of communicable disease, prevention and health promotion, maternal and child health, and access to care. Public health officials can use these indicators to inform and stimulate state and community discussion, develop policies, and implement programs to improve community health outcomes.
- In 2008, the National Board of Public Health Examiners implemented the Certification in Public Health (CPH) exam, which allows persons who have graduated from approved public health schools/programs to demonstrate their competencies in public health. This credential will include maintenance of certification process that will elevate the recognition of public health trained professionals and ensure ongoing education of these persons to maintain knowledge and competency in the field.