Rider 33: High Priority Performance Measures for Local Health Departments

As Required by

2018-19 General Appropriations Act, Senate Bill 1, 85th Texas Legislature, Regular Session, 2017; Article II, Department of State Health Services, Rider 33

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Health and Human Services

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Executive Summary

The 2018-19 General Appropriations Act, Senate Bill 1, 85th Texas Legislature, Regular Session, 2017; Article II, Department of State Health Services, Rider 33 (Rider 33) directs the Department of State Health Services (DSHS) to coordinate with the Public Health Funding and Policy Committee (PHFPC) and other stakeholders to develop a list of high priority performance measures for local health departments (LHDs) that receive state-funded grants from DSHS. Rider 33 also requires DSHS to submit a report including the performance measures and plans to utilize the performance measures in determination of LHD grant distribution. This report is due to the Governor, Lieutenant Governor, Speaker of the House, Legislative Budget Board, Senate Finance Committee, House Appropriations Committee, and the permanent standing committees in the Senate and the House with primary jurisdiction over health and human services no later than September 1, 2018. This report serves to fulfill the requirements outlined by Rider 33.

DSHS assessed grant funding distributed to LHDs from DSHS, which includes the both general revenue and federal funding. DSHS also examined the mechanisms by which funds are allocated to LHDs, as well as associated monitoring practices and reporting requirements.

DSHS allocates grants to LHDs through a formal contracting process, and funding is based on community need and the LHD's ability to meet that need. Contracts are specific to critical public health services and include performance measures. These performance expectations vary based on the scope of the public health issue being addressed, but are designed to ensure maintenance of standard public health services and activities, or to drive improvement of health outcomes. The state-funded grants provided to LHDs supplement local funding for operations, and are critical in supporting continuity of service availability and delivery at the local level. This funding is a key component to maintenance of the state's public health infrastructure.

Based on the performance evaluation related to Rider 33, DSHS will:

- Regularly evaluate LHD contract measures in collaboration with PHFPC and LHD stakeholders to ensure targets meet local needs and contribute to statewide health improvement objectives, and

- Improve the visibility of LHD performance data through proactive dissemination of key contract measures.

Through these efforts, DSHS will work with LHDs to enhance the critical services they provide every day by ensuring performance measures are being used to evaluate system integrity and promote statewide health improvement, and also help inform resource allocation at both the local and state levels. This improved coordination among the primary public health system service providers will result in the continued ability of LHDs to deliver crucial services at the local level and optimize operations based on performance data.

1. Introduction

The 2018-19 General Appropriations Act, Senate Bill 1, 85th Texas Legislature, Regular Session, 2017; Article II, Department of State Health Services, Rider 33 (Rider 33) directs the Department of State Health Services (DSHS) to coordinate with the Public Health Funding and Policy Committee (PHFPC) and other stakeholders to develop a list of high priority performance measures for local health departments (LHDs) that receive state-funded grants from DSHS. Rider 33 also requires DSHS to submit a report including the performance measures and plans to utilize the performance measures in determination of LHD grant distribution. This report is due to the Governor, Lieutenant Governor, Speaker of the House, Legislative Budget Board, Senate Finance Committee, House Appropriations Committee, and the permanent standing committees in the Senate and the House with primary jurisdiction over health and human services no later than September 1, 2018. This report serves to fulfill the requirements outlined by Rider 33.

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The analysis for this report considers a variety of factors, including:

- The public health system structure in Texas,
- Distribution of funds to local health departments,
- Existing performance measures for local health departments, and
- Stakeholder and PHFPC input.

2. Background

The public health system in Texas is managed through a decentralized structure, and operates according to "home rule", whereby local municipalities determine both the level of local funding invested in public health efforts, as well as what services their local health departments (LHDs) provide.

Approximately 64 LHDs operate within the state, providing coverage in 60 counties – with city health departments providing public health services within their city limits in an additional four counties. Five additional city health departments operate in counties where there is also a county health department.[1]

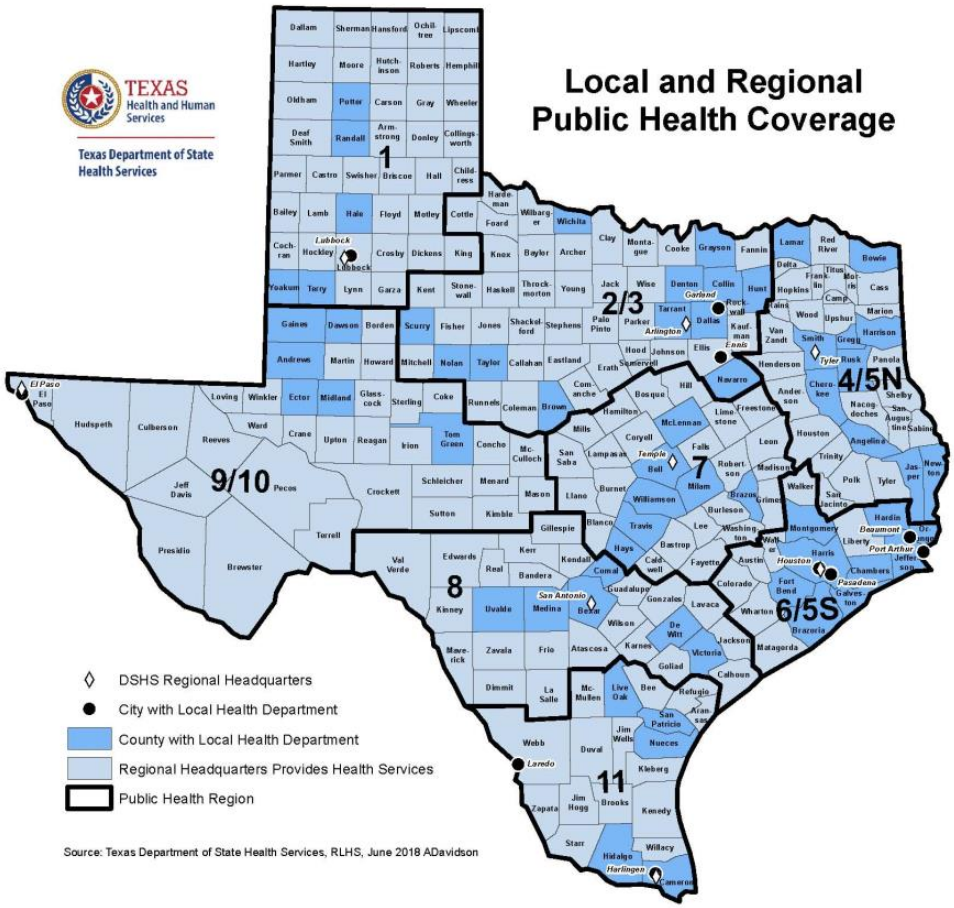
Typically, in areas where a city and county health department both operate, city municipalities provide services within city limits, and the county is responsible for unincorporated areas. In some cases, the city and county may share responsibility and provide distinct services. In areas where no local health department exists, DSHS Public Health Regions (PHRs) are responsible for providing public health services.

Though only accounting for approximately 20 percent of the Texas population, DSHS PHRs are solely responsible for providing public health services in 190 counties. This means that each of the eight Public Health Regions cover expansive geographic areas. The vast area for which DSHS regional staff provide coverage, along with limited staffing and resources, can create challenges in providing robust service delivery in all areas, particularly in rural and remote counties.

Please see the map in Figure 1 for an overview of coverage across the state.

[1] In addition to the 64 local health departments in the state, approximately 95 local environmental health entities operate to provide targeted services, such as mold remediation, animal control, nuisance abatement, etc. Though they contribute to the function of the public health system, DSHS does not contract directly with these entities for routine provision of public health services. Because of DSHS does not provide any state funded grants to these entities, they are not included in the analysis.

Figure 1. Map of Regional and Local Public Health Coverage



In addition to providing services in areas where there is no local health department presence, DSHS PHRs may also assist in the provision of certain critical services in areas covered by city or county health departments if local municipalities do not have the resources or choose not to provide those services. Though the variation among LHDs can create complexity within the system structure, there is great benefit in engaging local municipalities in the provision of public health services. Local health departments have the infrastructure, local presence, and reputation within communities to most effectively and efficiently deliver certain public health services, from both a cost and logistical standpoint.

Because participation in public health service delivery is voluntary at the local level, and there is no minimum threshold for the depth or breadth of services that must be provided, DSHS has a vested interest in providing support to local jurisdictions

that choose to provide public health services. If a local health department reduces or discontinues public health operations because of limited resources or local decision-making, DSHS is responsible for filling those gaps in services. DSHS does not have the capacity to assume increased responsibility and cost to the state to maintain public health services in those jurisdictions.

A key way that the state supports local jurisdictions that have decided to provide public health services is through general revenue or federally-funded grants. These grants not only target critical public health issues, they help LHDs remain operational. State funding is provided to local jurisdictions to:

1) Provide support for necessary statewide public health system activities, and/or

2) Supplement local funding that may not be sufficient to carry out public health activities or services critical to health and safety.

In addition to financial support, DSHS central office and regional staff work with LHDs throughout the state to provide technical expertise and supplemental personnel coverage when necessary to help meet local need. Because diseases addressed through the public health system have no regard for city or county boundaries and are easily spread across communities, DSHS is responsible for statewide oversight with regard to disease burden to ensure protections are in place to maintain the health and safety of all Texans. Grant funding allocated through the DSHS contract process to LHDs is designed to maximize investment in the control of potential threats to health at both the community and statewide level. The methodology for funding allocation through contracts allows DSHS to assess risk at the state level and distribute funds to better leverage local resources and partnerships to best mitigate that risk for the benefit of our entire population. The partnership between DSHS and LHDs is crucial to ensure coordination of limited resources to better meet growing demand in a system that has already reached service capacity in many areas.

3. Performance Measures and Future Improvements

Current Contract Structure

All grant funding from DSHS to local health departments (LHDs) is distributed through a formal contracting process. Grants distributed through contracts focus on high priority public health issues, and funding determinations are made based on need as established through a variety of possible factors, depending on the topic. The type of factors that may be considered during the funding allocation decision making process may include, but are not limited to: disease burden, services area or population size and/or characteristics, capacity to deliver services, ability to expand or leverage existing resources to maximize benefit, geography, potential reach or impact, and level of threat.

DSHS currently contracts with 63 LHDs across the state for the provision of high priority public health services and activities that are critical for health and safety purposes. Contracts with LHDs may use federal funding, state general revenue (GR), or a blend of these two funding sources. DSHS currently has approximately 378 contracts with 63 local health departments. These contracts are detailed in Appendix A. Of the 378 existing contracts:

- 106 contracts in 19 contract categories are fully funded by general revenue (GR)
- 120 contracts in 6 contract categories combine federal funding with GR
- 152 contracts in 17 contract categories are fully federally funded

Contract categories organize funding for the purpose of addressing specific public health needs and priorities, and are focused on distinct objectives. With a few exceptions, standard performance measures are applied to all LHDs who contract within a category and LHDs are accountable for reporting on measures tied to that funding. No single DSHS contract category reaches all 63 LHDs, and the number of LHDs participating in the different contract categories varies. For example, the "Local Public Health Systems" contract category represents the largest number of LHDs participating within any one category, with 58 LHD contracts. Conversely, funding through the "Seafood and Aquatic Life" contract category is only allocated to one LHD.

The performance measures associated with these contracts are tailored to assess progress toward specific outcomes or funding objectives. Through a recent opportunity to engage in a public health service review across the state, in-depth interviews with local health departments on service provision in five major areas of public health have highlighted the variability within local service delivery and underscored that no two LHDs are the same. This variability must be carefully considered when setting funding levels and establishing performance expectations. Due to the decentralized nature of the public health system, flexibility within the contracting structure is beneficial because it provides the ability to be responsive to local need while maximizing state investment. To achieve the flexibility necessary to address the variations within the public health system, DSHS uses contracts to support LHD activities and services in four principle ways:

- Ongoing funding for maintenance of critical public health services. Though these contracts are revisited and adjusted yearly or bi-yearly basis, funding is fairly stable to maintain an acceptable level of service provision to ensure basic public health protections. Examples of these types of contracts include:
    - Funding provided for public health surveillance activities, and
    - The "Local Public Health Systems" funding, allocated to address locally-identified needs of greatest concern.
- Formula-based funding. Formulas are developed based on a variety of local factors, such as disease burden, population, etc., to ensure funding for specific services and activities can address community need. Formulas are populated with the unique data points for each LHD and dictate the level of funding allocated.
    - Contracts for Tuberculosis services are an example of formula-based funding.
- Time-limited funding. This funding, allocated over a set period, is intended to produce an impact on specific public health concerns through the implementation of best practices or innovative approaches.
    - Texas Healthy Communities funding, provided to 15 LHDs over a three-year period to implement environmental and system change to help prevent chronic disease, is an example of this type of contract.

- One-time funding. This type of contract is typically allocated to address unique threats or emerging disease. Examples of this type of contract include:
    - Funding for public health concerns like Zika Virus Disease or disaster recovery.

Because of the variation among local health departments and their community needs, these multiple approaches for quantifying need and mechanisms for distributing funds allow Texas public health funding to be responsive to emerging and changing public health threats. The ability to contract directly with local health departments, as outlined in statute, without the need to post a request for competitive bids allows for distribution of funding into the system where there is need, an existing mechanism for service delivery, and established partnerships with DSHS in place. Distribution of funds in this manner provides assurance that service provision and oversight are carried out within an established and effective network of key public health entities, while allowing for greater administrative efficiency.

Performance Measures

Texas Health and Safety Code, Chapter 121, provides DSHS with the ability to contract with local health departments (LHDs) for the provision of public health services. Within the current DSHS contract structure, a variety of performance measures exist and are regularly reported on by LHDs that receive funding. Texas Health and Safety Code, Chapter 121, underscores the need to use grant funding allocated to LHDs in the support of the ten essential public health services, which were defined by the Centers for Disease Control's Core Public Health Functions Steering Committee in 1994. Performance measures within LHD contracts are designed to address one or more of the ten essential public health services, which include:

- Monitoring the health status of individuals in the community to identify community health problems;
- Diagnosing and investigating community health problems and community health hazards;
- Informing, educating, and empowering the community with respect to health issues;

- Mobilizing community partnerships in identifying and solving community health problems;
- Developing policies and plans that support individual and community efforts to improve health;
- Enforcing laws and rules that protect the public health and ensuring safety in accordance with those laws and rules;
- Linking individuals who have a need for community and personal health services to appropriate community and private providers;
- Ensuring a competent workforce for the provision of essential public health services;
- Researching new insights and innovative solutions to community health problems;
- Evaluating the effectiveness, accessibility, and quality of personal and population-based health services in a community.

Because these functions are recognized as the standard for guiding public health operations at the national level and are outlined in Texas Health and Safety Code as critical components for meeting statewide need, existing performance measures incorporated into LHD contracts are all considered high priority based on their correlation to these essential services and the significant public health benefit they provide.

Performance measures within each contract category are specific to that public health outcome objective and expectations are generally standard across LHD contractors, with a few exceptions based on local factors. For example, all 50 LHDs participating in the Texas Vaccines for Children contract category must complete 100 percent of the DSHS-designated follow up activities related to quality assurance site visits.

Monitoring through the current contracting system assesses both financial and programmatic aspects of an LHD's performance and stated goals and outcomes. Fiscal reviews are conducted onsite to ensure compliance with state and federal law as it relates to each specific contract, and DSHS program staff monitors performance compliance based on a several variables, including the scope and term of the contract, as well as the risk level assigned to the contactor (as determined by

a standard risk assessment within the System of Contract Operation and Reporting). The type of monitoring that is conducted is dependent on these factors, and may result in site reviews, desk reviews, or periodic self-reporting. All data pertaining to programmatic and financial contract operations are submitted to DSHS, which synthesizes the information and reviews invoices on a monthly basis to ensure funds are appropriately expended and performance expectations are met.

DSHS contract reviews are thorough, and sometimes result in providing guidance and/or technical assistance to LHDs to ensure they are able to comply with requirements. Because of the importance of the services being provided and the need to ensure these services are adequately delivered to protect public health, DSHS is motivated to assist LHDs in meeting contract expectations and will expend considerable effort to bring LHDs into compliance before imposing any accelerated monitoring actions or sanctions. LHDs are by and large good performers and continuously demonstrate the willingness and ability to comply with requirements, but there is occasionally the need to resort to accelerated monitoring actions or sanctions when other support efforts have not been successful.

Unrealistic performance measures or overly burdensome reporting requirements included in contracts could cause LHDs to opt out of the provision of certain services or activities. If they cannot deliver the level of service necessary to meet the contractual requirements or reporting elements, they may choose to no longer provide those services – in which case the state would then be responsible for ensuring coverage. There is a risk associated with increasing requirements, as DSHS currently relies on LHDs to provide services at the local level. As opposed to restricting funding, DSHS has found better success when it provides technical assistance to LHDs for performance improvement purposes. In most cases there is no alternative entity that could provide services/activities comparable to the LHD, so it is to everyone's advantage to focus on achieving success as opposed to imposing accelerated monitoring actions, sanctions, or punitive actions.

Penalizing LHDs that are not able to meet performance standards may result in that entity's inability to provide certain necessary basic public health services. This may cause further damage to a local public health delivery system that is already struggling, and has the potential to result in greater risk or worse health outcomes for the population they serve, or necessitate DSHS Public Health Region involvement in filling the gaps in services that LHDs are no longer able to perform.

Stakeholder Input

As directed by Rider 33, DSHS has solicited input on the recommendations for fulfilling this charge through coordination with the Public Health Policy and Funding Committee (PHFPC) and local health departments. Following initial analysis by DSHS staff, a discussion was held with the PHFPC at their June 28, 2018 meeting, and with local health departments during a standing monthly call on July 16, 2018. During these discussions, DSHS had the opportunity to present information related to Rider 33 background research and contract analysis, and seek feedback from stakeholders on an approach for identifying performance measures.

The PHFPC provided the following feedback:

- Given the variability of services and activities at the local level, a "one-size fits all" approach with regard to performance measures in Texas is difficult to achieve. There was expressed interest to move from process measures to outcome measures within contracts, but acknowledgement that short contract periods and lag time in data availability make it difficult to directly link efforts to measurable improvement in the timeframes during which contracts are active. Committee members did feel it was critical that activities and investment within the state are moving in the direction of health outcome improvement, and that we continue to look critically at how contracted services and activities support that improvement.

- There is a need for investment in the public health system to see measurable improvement in health outcomes. Currently local health departments are not resourced to focus on prevention, and the limited resources that are available are often used to react to disease, as opposed to engaging in proactive efforts to prevent disease and produce cost savings in the larger health care system.

- Without increased investment in the public health system, it would be difficult to increase performance expectations or operationalize performance measures outside of the current contracting system. As it is, funding for public health services through DSHS has been level or has decreased over the last decade. The Committee believed that without increased funding, absorbing additional expectations from DSHS would be problematic, particularly given the growing demands associated with population growth.

Improvement Plan

DSHS has recently undergone major changes as a result of Texas Health and Human Services transformation, and with a renewed focus on public and population health, the agency is working to strengthen relationships with local public health department partners. Executive leaders have been working closely with the Public Health Funding and Policy Committee (PHFPC), and have committed to increasing engagement with local health departments to strengthen partnerships and collaboration to achieve common goals. To further public health system improvement efforts, DSHS is currently engaging in a statewide project to assess public health capacity and capability at the local and regional levels. This will allow DSHS to better understand public health system strengths and challenges across the state, and identify opportunities for collective improvement.

Based on examination of current practices and the need to maintain service provision at the local level while driving progress toward system and health outcome improvement across all communities in the state, DSHS plans to implement the following processes for the future:

- Regularly evaluate LHD contract measures in collaboration with PHFPC and LHD stakeholders to ensure targets meet local needs and contribute to statewide health improvement objectives, and
- Improve the visibility of LHD performance data through proactive dissemination of key contract measures.

Through these efforts, DSHS will work with LHDs to enhance the critical services they provide every day by ensuring performance measures are being used to evaluate system integrity and promote statewide health improvement, and also help inform resource allocation at both the local and state levels. This improved coordination among the primary public health system service providers will result in the continued ability of LHDs to deliver crucial services at the local level and optimize operations based on performance data.

4. Conclusion

The sustainability of local health departments (LHDs) is vital to ensure that critical public health services are available and delivered across the state. The decentralized public health system structure in Texas results in local and regional variability, but also creates a unique landscape that allows each local jurisdiction to focus on their communities' needs. Decision making and resource investment at the local level contribute to the determination of the public health services prioritized by local municipalities and the extent to which they are delivered. It is crucial to recognize the singular nature of each local community and work to address local and statewide needs as appropriate, including through public health funding mechanisms.

The current method of funding from DSHS to LHDs reflects the complexity inherent in a decentralized public health system structure, but ensures that taxpayer funds support local need, while ultimately benefitting the entire state. Because funding supports high priority public health services at both the local and state level, LHDs are diligent in their efforts to ensure funds are used in a highly productive manner to benefit their community. Collaboration between LHDs and DSHS is essential in working toward realizing mutual public health goals.

Through greater visibility and thoughtful on-going consideration, DSHS will continue to work closely with the Public Health Funding and Policy Committee and other stakeholders to ensure performance measures in place through contracts are appropriate for maintaining a strong public health infrastructure, contributing to health improvement, and meeting needs at both the local and statewide level.

List of Acronyms

Acronym	Full Name
DSHS	Department of State Health Services
LHD	Local Health Department
PHFPC	Public Health Funding and Policy Committee
PHR	Public Health Region

Appendix A. Contracts with Local Health Departments

	Contract	# LHDs	Contract Period	Total Contract Amount
General Revenue	ID Surveillance and Epidemiology Activities	31	(9/1/17–8/31/19)	7,462,189.00
	Tuberculosis Prevention and Control	29	(9/1/17–8/31/18)	4,510,135.00
	HIV Prevention Services	7	(9/1/15–12/31/18)	6,300,519.00
	HIV Services	2	(9/1/17–8/31/18)	3,880,838.00
	Community Diabetes Education Program	3	(9/1/15–8/31/18)	1,936,839.00
	Tuberculosis State African American Project – Harmony House	1	(9/1/17–8/31/18)	1,777,509.00
	Tuberculosis State African American Project	1	(9/1/17–8/31/18)	1,345,532.00
	Tobacco Community Coalitions	1	(9/1/15–8/31/18)	823,533.00
	Lactation Support Center Services	2	(9/1/16–8/31/18)	550,000.00
	Laboratory Analyses of Milk & Dairy Samples	5	(9/1/17–8/31/19)	508,473.75
	HIV Surveillance	4	(9/1/17–8/31/18)	420,130.00
	Healthy Texas Babies	3	(9/1/17–8/31/18)	202,500.00
	Texas Heart Disease/Stroke Program Community Clinical Linkages	2	(12/10/15–8/31/18)	96,000.00
	Influenza Surveillance Clinical Specimens Testing	6	(9/1/17–8/31/19)	60,000.00
	Health Service Region 2/3 Tuberculosis	1	(1/1/16–12/31/18)	58,088.00
	Seafood & Aquatic Life	1	(9/1/16–8/31/18)	56,000.00
	Health Service Region 7 TB Prevention and Control	1	(12/1/15–11/30/19)	53,328.00
	Health Promotion Restaurant Menu Labeling	1	(10/1/16–8/31/18)	33,350.00

	Influenza Surveillance Activities Using the Right Size Guidance	5	(9/1/17–8/31/18)	25,000.00
	Contract	# LHDs	Contract Period	Total Contract Amount
Federally Funded	Public Health Emergency Preparedness	45	(7/1/17–6/30/19)	31,327,874.00
	Zika Virus Surveillance and Control	17	(3/1/17–7/31/19)	10,616,943.00
	Cities Readiness Initiative	13	(7/1/17–6/30/19)	5,354,590.00
	Tuberculosis Prevention and Control	30	(1/1/18–12/31/18)	4,602,246.00
	HIV Prevention Services	4	(1/1/16–12/31/18)	4,580,887.00
	Zika Virus Surveillance and Control – LRN	5	(4/10/17–7/31/19)	3,682,105.00
	Texas Healthy Communities	15	(10/1/15 – 9/30/18)	2,810,000.00
	Laboratory Response Network (LRN)	6	(7/1/17–6/30/19)	2,732,340.00
	TB DSRIP 1115 Waiver Project	1	(1/1/18–9/30/19)	1,826,997.00
	HIV Surveillance - Federal Core	2	(1/1/16–12/31/18)	1,490,821.00
	Routine HIV Screening Services	2	(1/1/16 – 12/31/18)	1,266,496.00
	Health Promotion Primary Prevention	3	(4/1/17–9/30/19)	1,187,499.00
	Texas Healthy Adolescent Initiative	2	(9/1/15–8/31/18)	858,600.00
	Texas Healthy Adolescent Initiative - Clinic-Based Program	2	(9/1/16–8/31/18)	800,000.00
	HIV Housing Opportunity for People with AIDS	2	(2/1/17–1/31/19)	264,127.00
	Hansen's Disease Services and Patient Case Management	2	(1/1/18–12/31/18)	135,000.00
	HSR 2/3 Public Health Emergency Preparedness	1	(7/1/17–6/30/19)	98,000.00

	Contract	# LHDs	Contract Period	Total Contract Amount
Blended (GR and Federal)	STD/HIV Prevention Services	8	(1/1/16–12/31/18)	25,678,602.00
	Immunization Services - LHDs	50	(9/1/17–8/31/18)	15,277,142.00
	Local Public Health Systems	58	(9/1/17–8/31/19)	11,997,800.00
	HIV Ryan White	2	(4/1/17–3/31/18)	10,669,734.00
	Children with Special Health Care Needs	1	(9/1/15–8/31/18)	311,991.00
	Zoonosis Arbovirus Associated Surveillance	1	(9/1/16–7/31/19)	270,300.00