# Local Health Department Structure and Financing

Commission Meeting
November 2, 2022

# Study purpose

- Catalog and compare public health services provided by local health departments (LHDs) across the state
- Identify standards used to evaluate the quality of LHDs and identify if LHDs across Virginia are meeting these standards
- Compare Virginia's LHD structure and financing to other states to identify advantages and disadvantages
- Recommend any necessary changes

NOTE: Study mandate approved by the Commission on December 07, 2021.

# Findings in brief

- Code of Virginia does not require all core, public health program areas and some are lacking at LHDs
- There is no system for LHD accountability and performance management
- LHDs need additional support for information technology and workforce
- Current LHD funding allocations do not account for true service costs or community needs

LHD = local health department

# Policy options in brief

- Amend Code of Virginia to include all core public health program areas
- Direct VDH to design an LHD performance management process
- Direct VDH to develop a plan for centralized data infrastructure
- Support recruitment and retention with a student loan repayment program and targeted salary increases for LHD staff
- Increase environmental health inspection fees and establish civil monetary penalties for facilities in violation

LHD = local health department

# Agenda

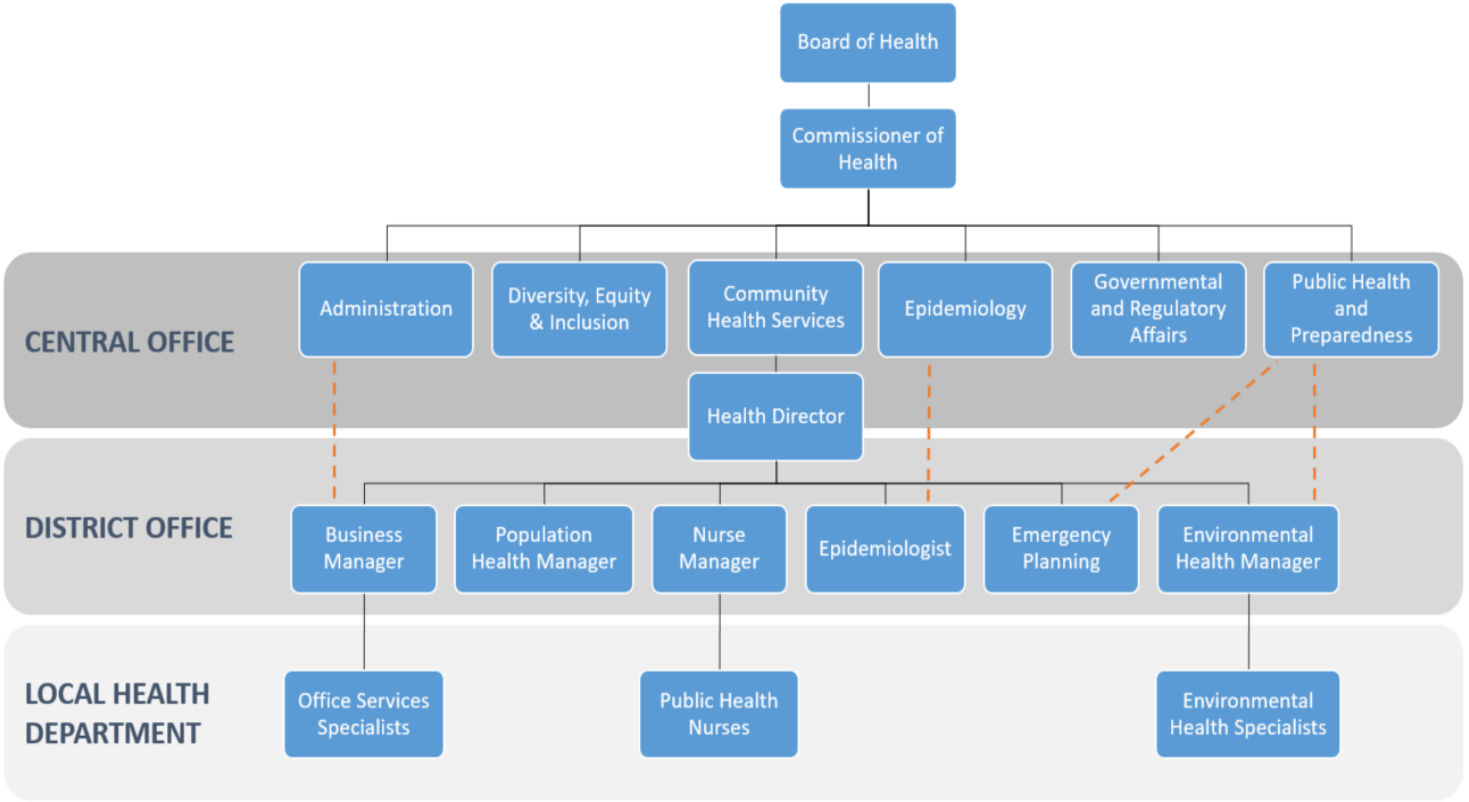
Structure of Virginia's local health departments

Foundational Program Areas in Virginia's local health departments

Foundational Capabilities in Virginia's local health departments

Funding local health departments in Virginia

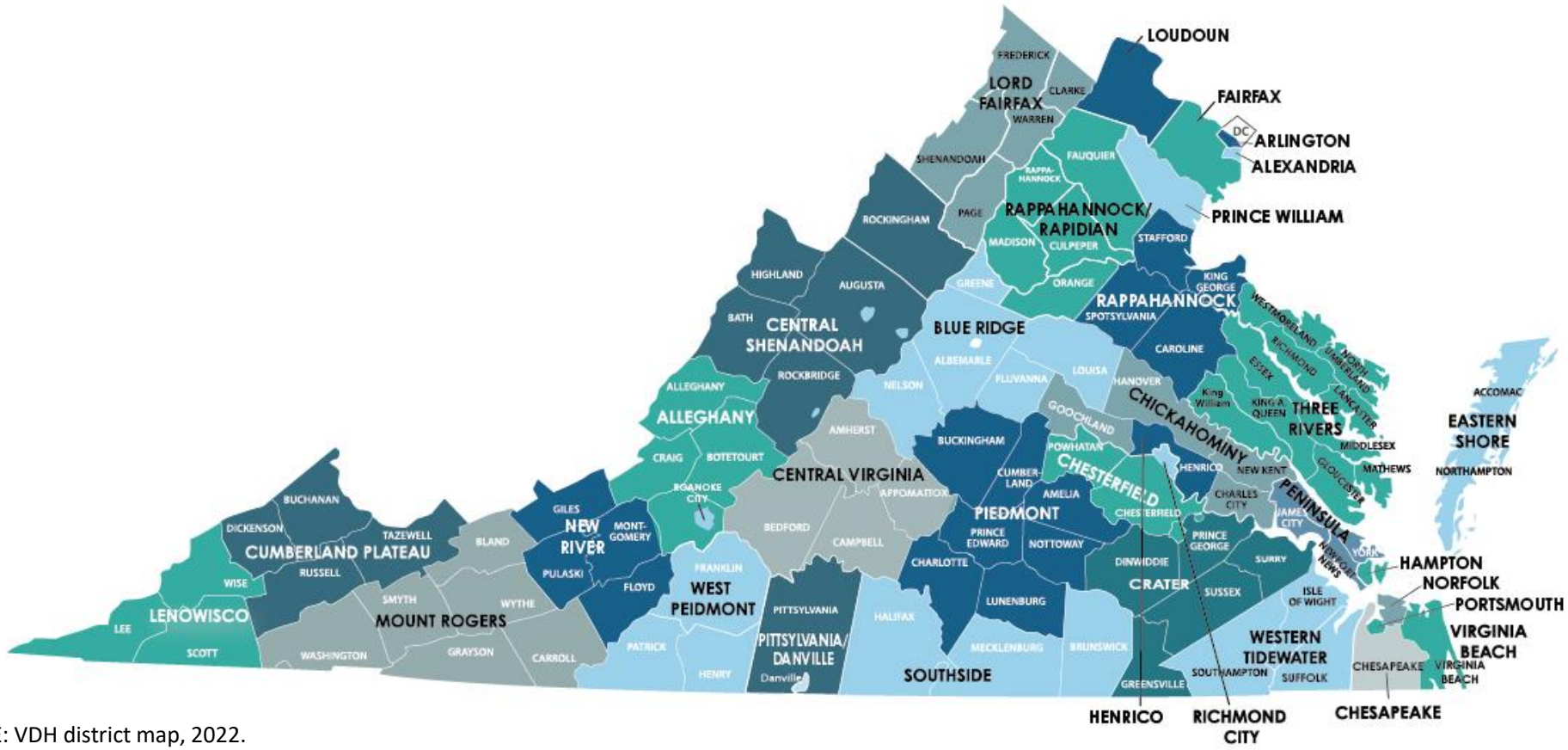
# Virginia has 118 local health departments organized into 35 health districts




**x 35 districts**

**x 118 local health departments**

# Most health districts are multi-jurisdictional and have 2-10 LHDs

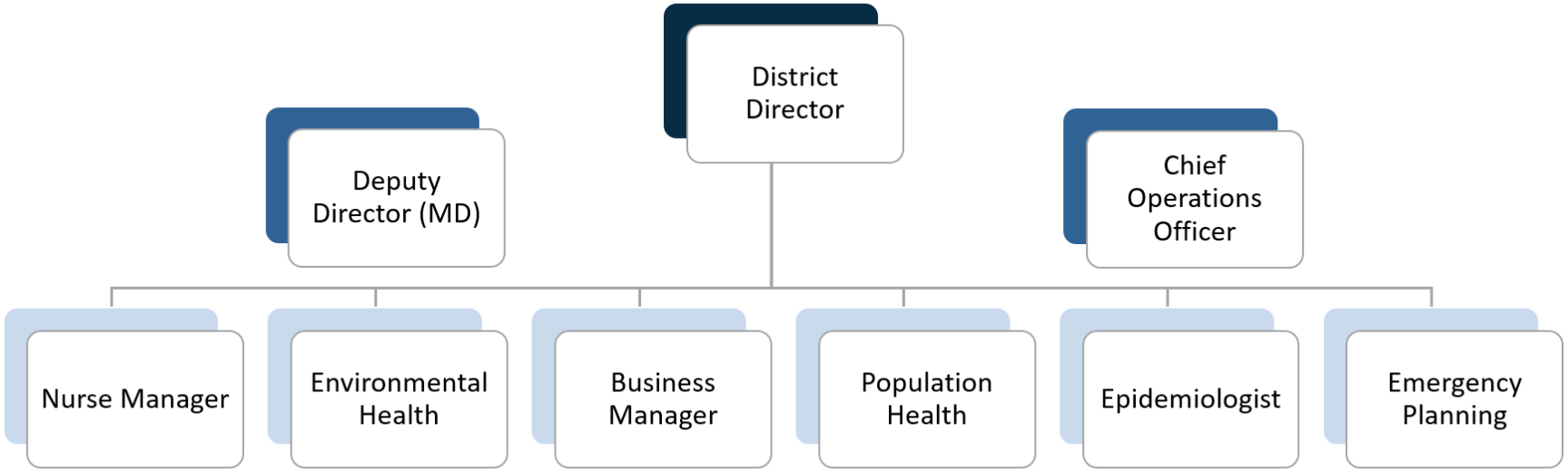



SOURCE: VDH district map, 2022.

# Every local health department has a Local Government Agreement

- The Local Government Agreement (LGA) is a contract between the VDH central office and each locality
- The LGA outlines:
  - State and local funding each locality will receive
  - State-mandated services the LHD will provide
  - Locally-required services the LHD will provide

# Management is shared across local health departments within the district



# Findings

- There is no recognized best practice for structuring local health departments
- There are potential advantages and disadvantages of each structure
- Nationally-recognized frameworks outline best practices for governmental health departments, regardless of structure

# There is no recognized best model for structuring local health departments

| DECENTRALIZED | CENTRALIZED | MIXED | SHARED |
|---|---|---|---|
| • **Leadership:** primarily local government employee<br>• **Public health orders:** primarily local government<br>• **Fiscal authority**: local government | • **Leadership:** primarily state employee<br>• **Public health orders:** primarily state government<br>• **Fiscal authority:** state government | • **Leadership:** some by state employee, some by local government employee<br>• **Public health orders:** sometimes state, sometimes local government<br>• **Fiscal authority:** state or local government | • **Leadership:** state or local government employee<br>• **Public health orders:** if led by state then local government, and vice versa<br>• **Fiscal authority:** if led by state then local government, and vice versa |

SOURCE: CDC, State and Local Health Department Governance Classification Map (September 2020) and ASTHO, Profile of State and Territorial Public Health, Volume Four (2017).

# Each structure has potential advantages and disadvantages

| CENTRALIZED | DECENTRALIZED |
| --- | --- |
| • Ability to take advantage of economies of scale<br>• Coordination and sharing of resources across multiple local jurisdictions | • Generate greater local public and political support for public health<br>• Make resource and program decisions in response to community needs |

SOURCE: Mays, G. & Smith, S. Geographic Variation in Public Health Spending: Correlates and Consequences. Health Services Research (September 2009), Volume 44, Issue 5p2, pg.1796-1817. https://doi.org/10.1111/j.1475-6773.2009.01014.x

# There are recognized best practices regardless of structure

| Foundational Program Areas |
| --- |
| • Access to & Linkage with Clinical Care<br>• Chronic Disease & Injury Prevention<br>• Communicable Disease Control<br>• Environmental Public Health<br>• Maternal, Child, & Family Health |

| Foundational Capabilities |
| --- |
| • Accountability & Performance Management<br>• Organizational Administrative Competencies<br>• Communications<br>• Community Partnership Development<br>• Policy Development & Support<br>• Assessment & Surveillance<br>• Equity<br>• Emergency Preparedness & Response |

SOURCE: Public Health National Center for Innovations (PHNCI) at Public Health Accreditation Board (PHAB). Foundational Public Health Services, updated February 2022.

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# Foundational Program Areas should be available in all communities

| | |
|---|---|
| Access to & Linkage with Clinical Care | Provide timely, accurate information on access and linkage to clinical care<br>Increase access to health homes and quality health care |
| Chronic Disease & Injury Prevention | Provide timely, accurate information on chronic disease and injury prevention<br>Prioritize healthy eating, active living, and reduction of tobacco use |
| Communicable Disease Control | Assure treatment of reportable communicable diseases (e.g., TB, STIs, HIV)<br>Disease investigation – contact tracing and notification |
| Environmental Public Health | Lab testing, inspections, and oversight to protect food, recreation sites, and drinking water |
| Maternal, Child, & Family Health | Monitor emerging and ongoing maternal and child health trends<br>Coordinate and integrate maternal, child, and family health programs and services |

# Findings

- Virginia Code does not require access to and linkage with clinical care
- Chronic disease and injury prevention are largely not addressed either by Code or at the LHD level
- LHDs are not consistently doing work in all Program Areas

# Two Program Areas are not required or consistently available in all LHDs

| Program Area | In Code | In LGAs | Available in LHDs |
|---|---|---|---|
| **Access to & Linkage with Clinical Care** | No | Infrequent | Sometimes |
| **Chronic Disease & Injury Prevention** | No | Infrequent | Sometimes |
| **Communicable Disease Control** | Yes | Yes | Yes |
| **Environmental Public Health** | Yes | Yes | Yes |
| **Maternal, Child, & Family Health** | Yes | Yes | Yes |

LGA = Local Government Agreement
SOURCE: JCHC staff analysis of Virginia Code, FY20 Local Government Agreements, JCHC staff interviews with local staff.

# Access to and linkage with clinical care is not required

- **Code**: does not specifically address access to and linkage with clinical care
- **LGAs**: do include some direct clinical services, but do not require referral and linkage services
  - 11% of FY20 LGAs include hypertension screening, counseling, and referral

LGA = Local Government Agreement
SOURCE: JCHC analysis of FY20 LGAs

# Access to and linkage with clinical care is not consistently present in LHDs

- LHDs have been moving away from direct clinical care, toward ensuring access and linkages to other resources
- Staff refer patients to other community providers, including:
  - Local health systems
  - Federally qualified health centers
  - Free clinics
  - Private providers

# Chronic disease and injury prevention are largely not addressed by LHDs

- **Code**: does not specifically address chronic diseases
- **LGAs**: do not require chronic disease or injury prevention programs and services
  - 4 of 133 LGAs include diabetes prevention
  - 8 of 133 LGAs include hypertension screening and counseling
  - All LGAs include community education

LGA = Local Government Agreement
SOURCE: JCHC analysis of FY20 LGAs

# Chronic disease and injury prevention work at the local level is ad hoc

- Many LHDs participate in the infant car seat safety program
- Some LHDs receive grant funding to provide chronic disease programs
- LHDs are not able to provide timely, local data on chronic disease and injury prevention to community stakeholders

# Policy Option 1

**OPTION 1:** The JCHC could introduce legislation to amend the Code of Virginia to require LHDs to ensure the availability of clinical services, either by the LHD or by other providers, facilitate access to and linkage with clinical care, as well as address chronic disease and injury prevention.

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# LHDs do not have all of the necessary Foundational Capabilities

| Foundational Capability | Status |
|---|---|
| **1. Accountability & Performance Management** | Needs attention |
| **2. Organizational Administrative Competencies** | |
| • **Leadership & Governance** | Meets expectations |
| • **Information Technology Services, including Privacy & Security** | Needs attention |
| • **Workforce Development & Human Resources** | Needs attention |
| • **Financial Management, Contract, & Procurement Services, including Facilities and Operations** | Needs support |
| • **Legal Services & Analysis** | Meets expectations |
| **3. Communications** | Needs support |
| **4. Community Partnership Development** | Needs support |
| **5. Policy Development & Support** | Needs support |
| **6. Assessment & Surveillance** | Meets expectations |
| **7. Equity** | Meets expectations |
| **8. Emergency Preparedness & Response** | Meets expectations |

NOTE: Capabilities that need attention are issues that significantly impact LHD effectiveness; capabilities that need support are issues that would further enhance LHD work.

# Findings

- Capabilities that need attention (highest priority):
  - There is no system to manage LHD accountability and performance
  - Siloed and outdated data systems hinder effective service delivery
  - Recruiting and retaining staff is an ongoing challenge

# There is no system to manage LHD accountability and performance

- The Local Government Agreement is not an effective accountability mechanism
- Current LHD metrics are primarily tied to funding requirements or are administrative
- It is difficult to identify which LHDs are doing well and which are struggling

# Locally-administered LHDs do have their own performance plans

Arlington's maternity clinic performance plan outlines:

- Program purpose and program information
- Data on capacity and services (e.g., staffing, total unique clients)
- Data on quality (e.g., on time assessments)
- Client satisfaction
- Data on outcomes (e.g., low birthweight or pre-term delivery)

# Other states have tried different approaches to ensure LHD performance

- **Ohio** required all LHDs to apply for accreditation.
- **Iowa, North Carolina,** and **Michigan** have established their own state accreditation programs.
- **Washington** codified a limited set of core public health services that must be present in every community.

# Policy Option 2

**OPTION 2:** The JCHC could introduce a Section 1 bill directing VDH to design a state performance management process for each LHD, with the goals of assessing the ability of each LHD to meet minimum capacity requirements, assisting in continuous quality improvement, and providing a transparent accountability mechanism to ensure public health functions are being met.

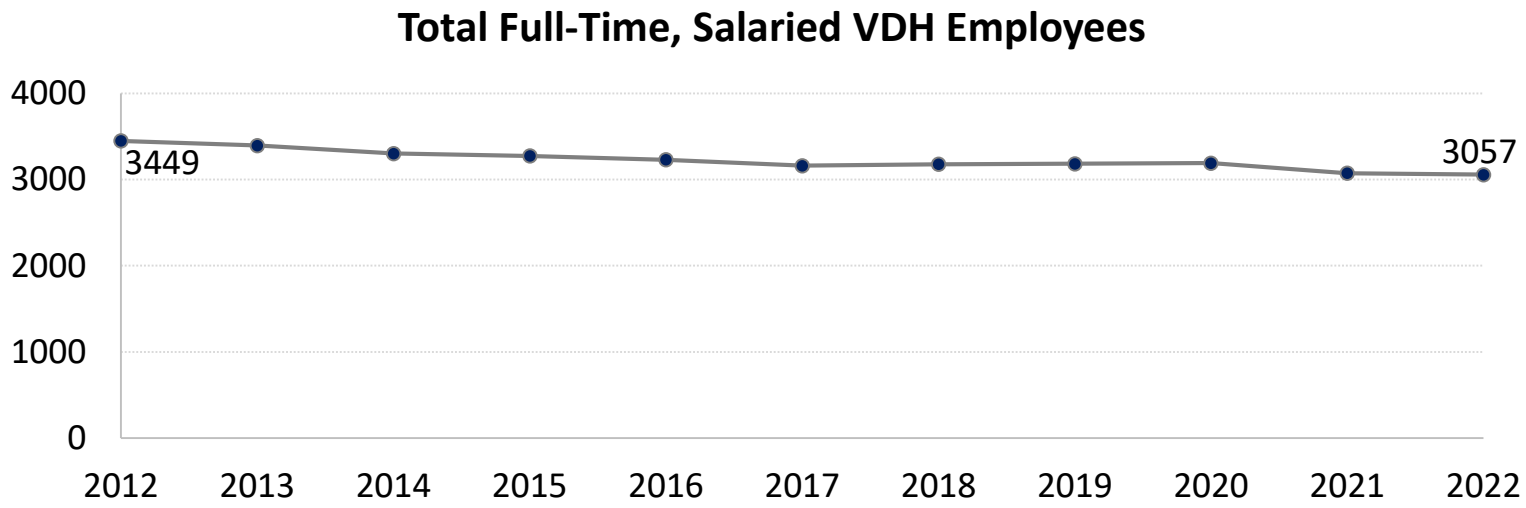
# Siloed and outdated LHD data systems hinder effective service delivery

- Medical records are still on paper at LHDs
- Environmental health data systems are improving
- Internet access is still a barrier in some rural localities
- The VDH central office cannot easily access centralized data from all localities and program areas

# Policy Option 3

**OPTION 3:** The JCHC could introduce a Section 1 bill directing VDH to develop and submit a plan by November 1, 2023 for the development of a centralized data system that will enable VDH to access necessary data from all LHDs across departments to support LHD assessment and performance management, as well as enable greater data sharing with stakeholders and the public.

# There has been an 11% decline in VDH employees in the last decade




- In contrast, the national public health workforce increased since 2016

SOURCE: Department of Human Resource Management, VDH Population data, 2012-20122.
NOTE: The chart numbers do not include contract or part-time employees.

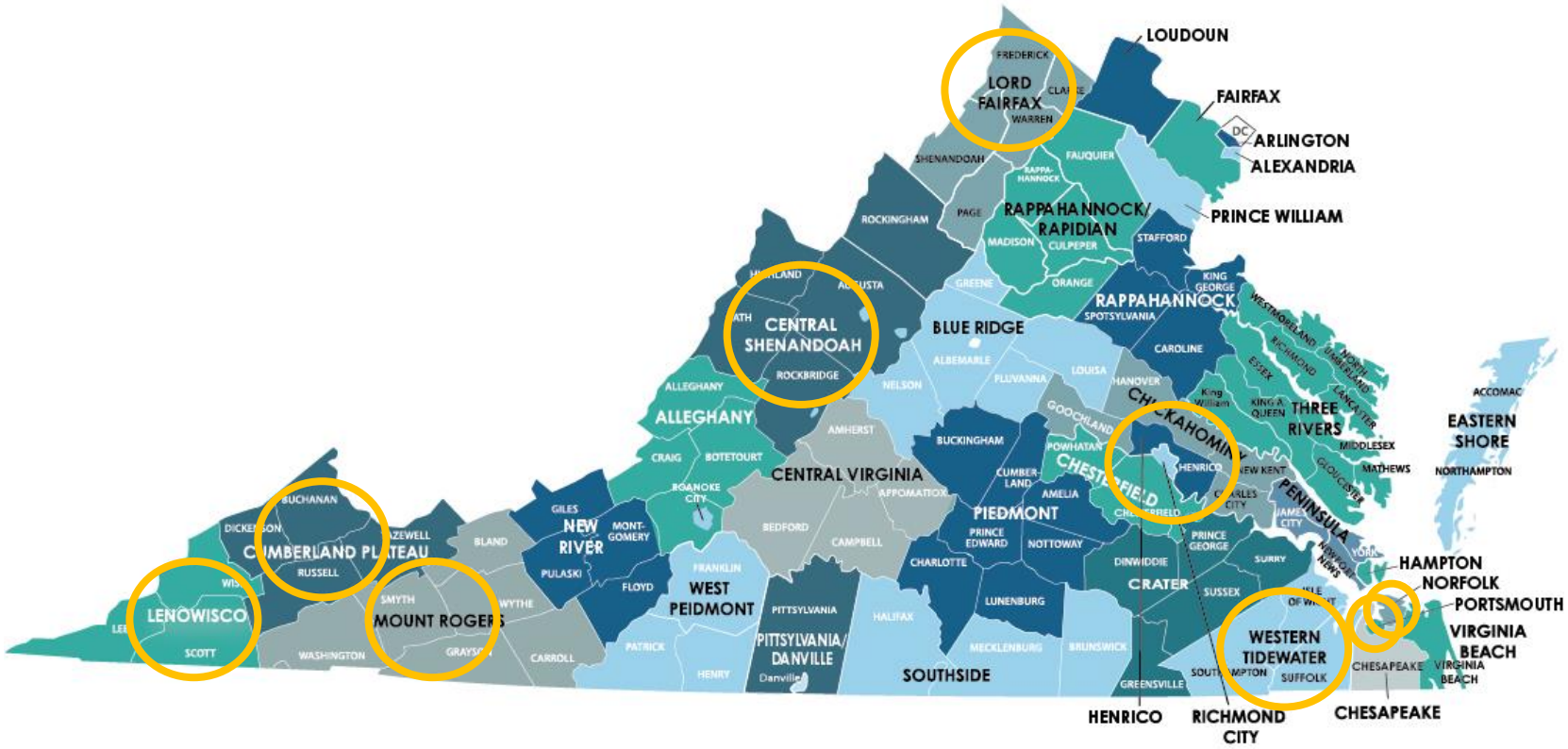
# Recruiting and retaining a sufficient workforce is a significant challenge

- The FY22 vacancy rate across the state was 18.6% (701 positions)
- Within districts, FY20 vacancy rates ranged from 4.6% in Piedmont to 35.2% in Southside
- Staffing challenges put pressure on remaining staff

# LHDs are struggling to fill empty health director positions

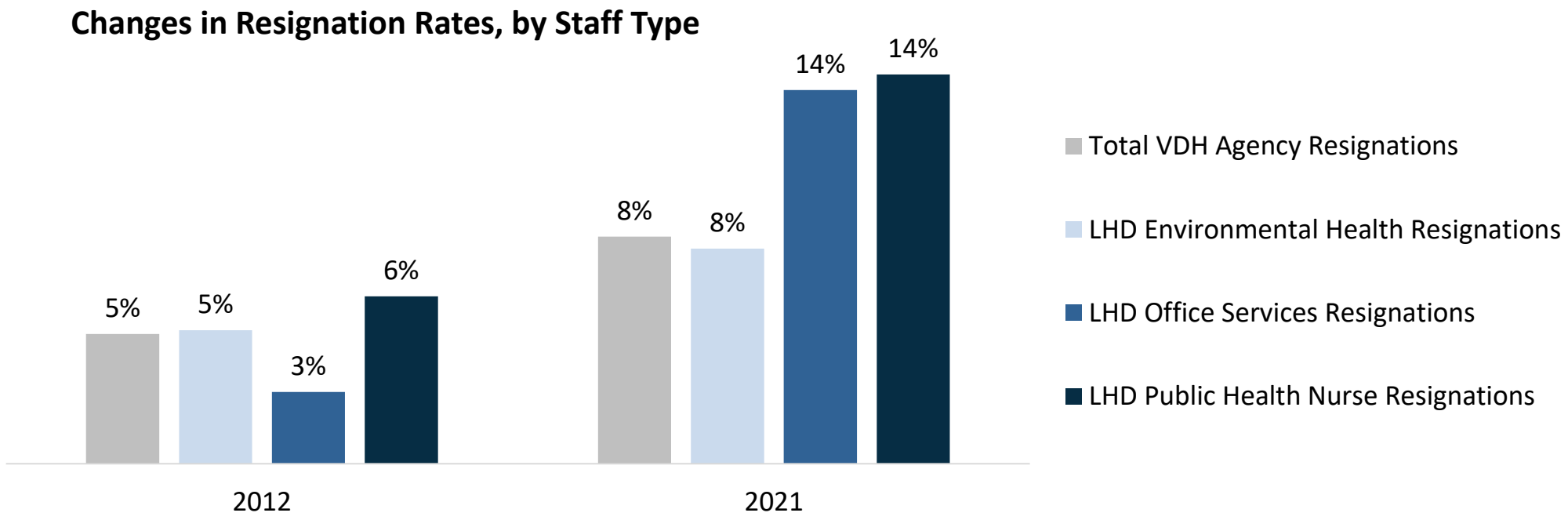
- Districts with long-term, experienced directors benefit from leadership stability, established community relationships, and institutional knowledge
- SB192 (2022) expands the qualifications of local health directors
- As of Summer 2022, there were 10 multi-jurisdictional health districts (35 LHDs) with acting health directors

# As of Summer 2022, there were 10 health districts with temporary leadership



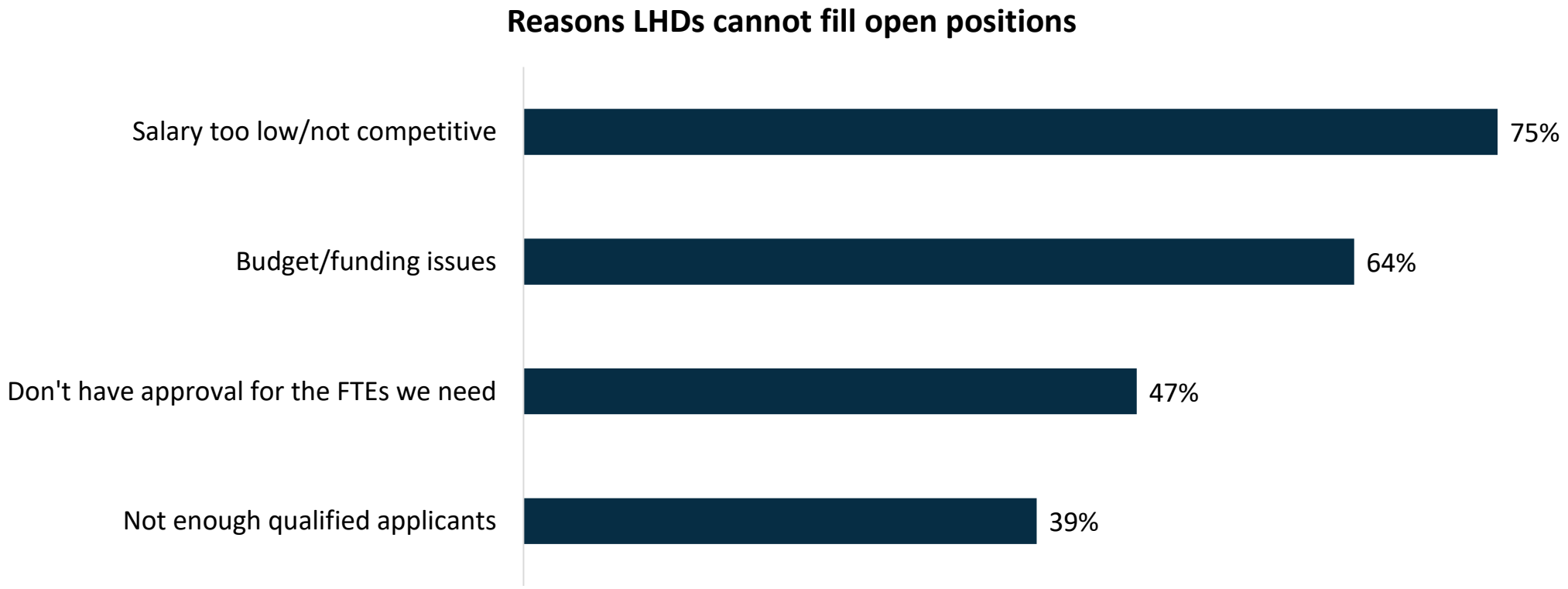

SOURCE: VDH district map and health director vacancies as of May 2022.

# Resignation rates have increased and are highest for nurses and admin




SOURCE: Department of Human Resource Management, VDH Population and Transaction data, 2012-2021.
NOTE: Rates were rounded to the nearest whole percentage, but are visualized in the chart based on true numbers.

# Staff cite salary as a primary reason they cannot fill open positions




SOURCE: JCHC survey of local health departments, 2022.

# Specific barriers differ for each position type, but always come back to pay

- LHDs have difficulty competing with other health care providers for nurses
- Environmental health specialists require specialized training, making high turnover a significant challenge
- Office services staff are responsible for multiple, critical administrative responsibilities

# Local health departments are struggling to meet staff salary expectations

## Increasing base salaries for local health department staff would help with both recruitment and retention

| Position | Median State Salary | Industry Average Salary |
|---|---|---|
| Office services assistants, specialists, and supervisors | $34,700 | $49,133 - $61,725 |
| Environmental health specialists, supervisors, and managers | $53,180 | Not available |
| Public health nurses, supervisors, and managers | $65,296 | $66,277 - $83,000 |

SOURCE: Department of Human Resource Management, VDH Population data as of January 2022 and Mercer Healthcare industry data.
NOTE: Average annual rates are from the Mercer Healthcare survey. Ranges show differences in average salary based on position level/experience. Mercer data did not have comparable industry salaries for EHS staff.

# Student loan repayment programs could support workforce retention

- Research shows that student loan repayment programs have higher retention and satisfaction than scholarship programs
- Repayment amounts can be tied to specific service contracts (e.g., $5,000 for one year of full-time employment at a local health department)

# Policy Options 4 & 5

- **OPTION 4:** The JCHC could introduce a budget amendment to provide additional funding to VDH for loan repayment programs for LHD staff.
- **OPTION 5:** The JCHC could introduce a budget amendment to fund targeted increases for LHD staff base salaries to align with current industry salary benchmarks.

# Findings

- Capabilities that need support (lower priority):
  - LHDs need greater support for facilities and operations
  - LHD relationships with community partners are inconsistent across the state
  - LHDs do not usually have capacity for dedicated communications staff

# LHDs need greater support for facilities and operations

- LHD physical facilities vary drastically and some are substandard
  - Identification of active mold
  - Ceiling fell in on staff
  - Five years to add a necessary check-in window at a clinic
- LHDs' facility issues are addressed by the locality, the VDH central office, and Department of General Services

# Policy Option 6

**OPTION 6:** The JCHC could introduce a budget amendment directing VDH to create regional operations and facilities management positions to assist LHDs, and providing funding for these staff.

# Community partnerships across LHDs vary

- There is a process for community health assessment (CHA) and improvement planning (CHIP), but LHDs are not required to participate
  - Some do participate in their local health system's Community Health Needs Assessment (CHNA)
- Local governments reported varying relationships with their health district and LHD

# Policy Option 7

**OPTION 7:** The JCHC could introduce a Section 1 bill directing VDH to require all health districts to participate in the CHA/CHIP process, in coordination with the state health assessment process and local health system Community Health Needs Assessments.

# LHDs do not usually have dedicated communications capacity

- LHDs are not always sure if or when they will receive communications guidance from the central office on significant public health issues
- Staff cite concerns that locality residents do not know all of the programs and services available at the LHD

# Policy Option 8

**OPTION 8:** The JCHC could introduce a Section 1 bill directing VDH to determine the funding necessary to provide sufficient communications capacity across all health districts. VDH should submit the funding estimate to the Chairs of the House Appropriations Committee and Senate Finance and Appropriations Committee by August 1, 2023.

# Agenda

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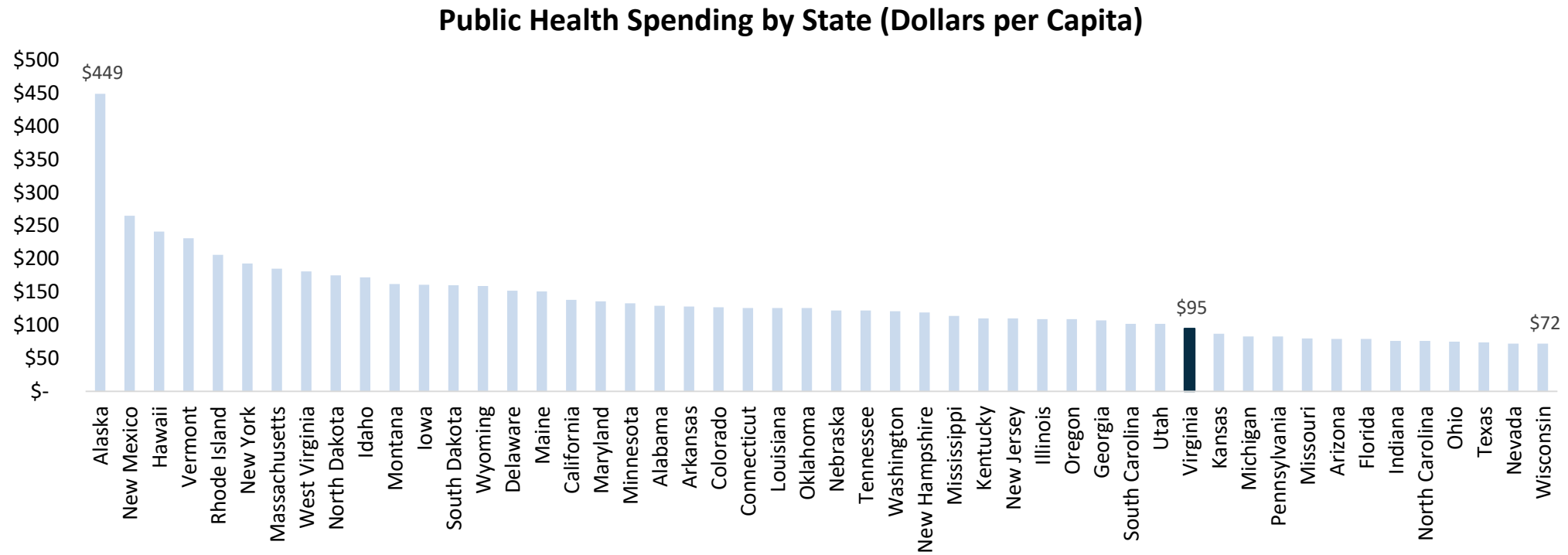
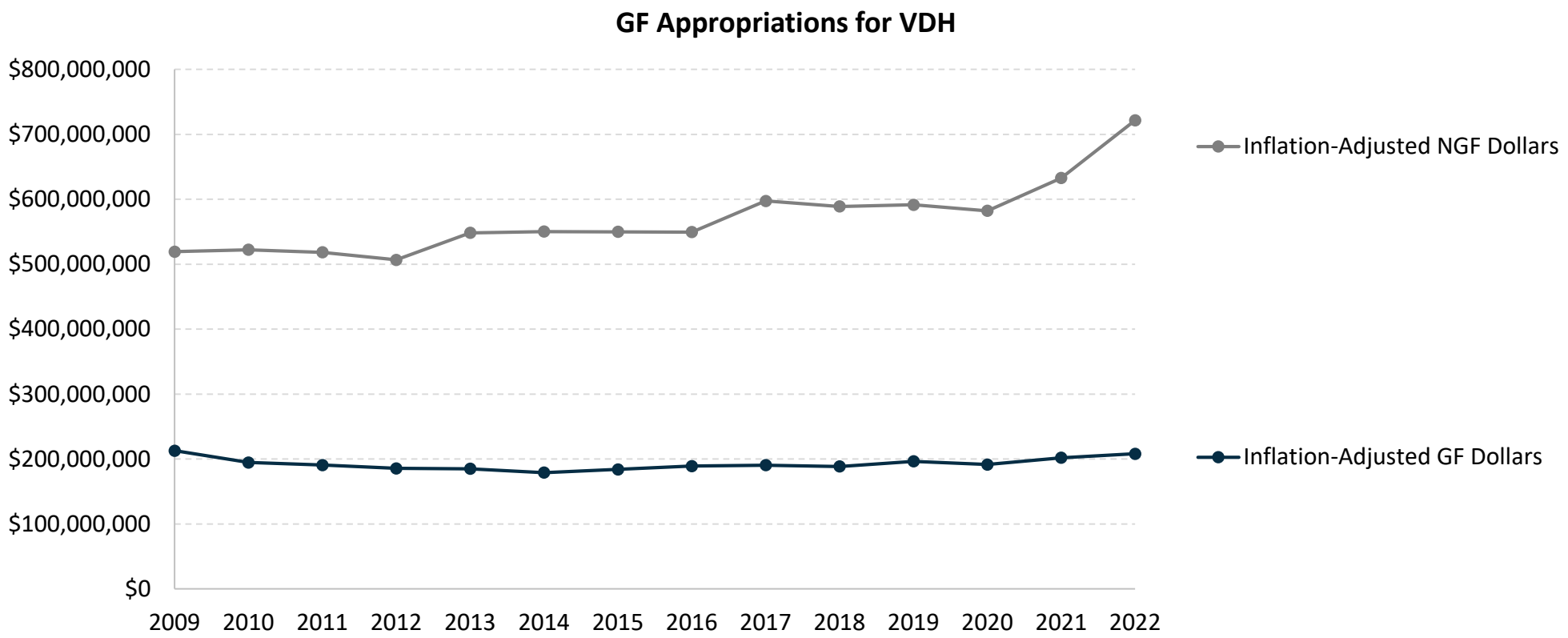
# Virginia ranks 38th nationally in public health spending per capita




SOURCE: America's Health Rankings, Public Health Funding by State (2021). Data from CDC, HRSA, and Trust for America's Health.

# Federal funding increasingly makes up the majority of public health funding

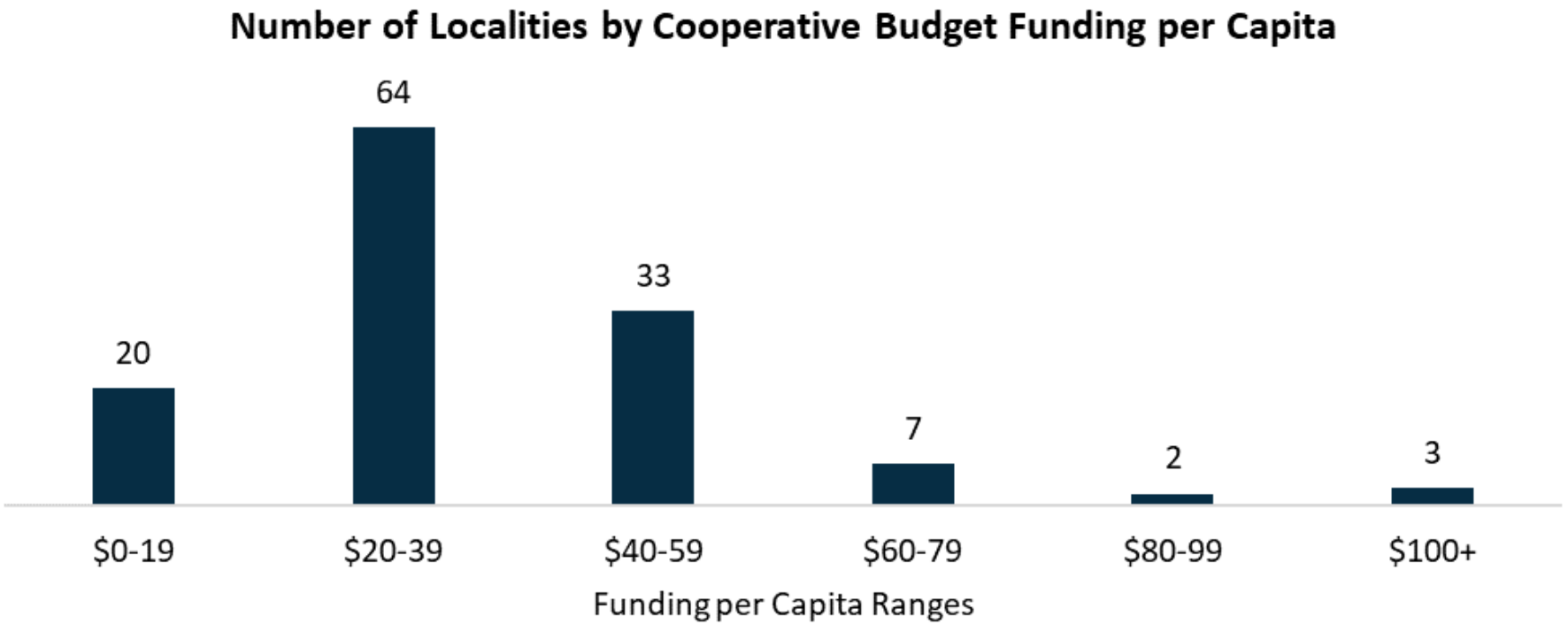



SOURCE: Virginia Department of Planning and Budget, Budget Appropriations Database.

# Findings

- Current LHD allocations do not account for true service costs or community needs
- There are opportunities to generate additional revenue to support LHDs
- Additional authority could improve capacity of environmental health staff

# Funding per capita varies widely across local health departments




SOURCE: JCHC analysis of VDH FY20 Budget and Year Ending Data, and population estimates from U.S. Census Bureau, 2019 American Community Survey (ACS).
NOTE: Chart outlines per capita funding for 129 localities. Data were not available for Fairfax and Arlington counties, which have locally-administered LHDs.

# Funding variations may be due to differences across localities

There are a few key factors that likely affect LHD funding:

- Differences in the size of localities
- Localities' ability to provide local matching funds
- Community needs and availability of other providers

# Current LHD allocations do not account for true costs or need

- There is no standard system for assessing needs
  - This would be improved by regular community health assessments
- Community needs vary by locality
  - Geography, availability of other community providers, and locality resources all influence what the LHD should provide
- Gaps and needs are hard to quantify

# Policy Option 9

**OPTION 9:** The JCHC could introduce a Section 1 bill directing that VDH track cooperative budget funding per capita, compare that funding to the identified needs of each LHD, and make appropriate adjustments as additional funding is made available.

# LHDs generate revenue to support their operations

Local health department revenues come from:

- Vital records requests from residents
- Long-Term Services and Supports (LTSS) screenings paid by Medicaid
- Fees and permits from regulated industries (e.g., restaurant inspections)
- Insurance reimbursement from Medicaid and commercial insurance for clinical services

# Fees do not always cover the actual cost of providing services

- Current permit fees do not account for different types of establishments
- A restaurant/food establishment annual permit costs $40
  - In 2010, the permit fee was raised from $100 to $285
  - In 2011, the permit fee was dropped to $40

# Additional authority could improve environmental health capacity

- Fees are flat, regardless of how many repeat inspections are required
- Repeated follow-up inspections create additional burden
- Civil monetary penalties may help cover the cost of additional follow-up inspections, and act as a disincentive for facilities that are slow to correct violations

# Policy Option 10

**OPTION 10:** The JCHC could introduce a Section 1 bill directing VDH to update state regulations for environmental health services to increase inspection fees and adjust them based on the type of establishment being inspected, to account for the typical time it takes to conduct the inspection.

# Policy Option 11

**OPTION 11:** The JCHC could introduce a Section 1 bill directing VDH to update the Administrative Code with a system of civil monetary penalties on facilities in violation of state environmental health regulations.

# Policy options about LHD performance

## Accountability and performance management

- **Option 2.** Direct VDH to design an LHD performance management process

## Clarify LHD roles and expectations

- **Option 1.** Amend the Code to include responsibility for access to and linkage with clinical care, as well as chronic disease and injury prevention
- **Option 7.** Require all health districts to participate in the CHA/CHIP process

# Policy options to build capacity

## IT and Data Systems

- **Option 3.** Direct VDH to develop a plan for a centralized data system

## Workforce Development

- **Option 4.** Provide funding for a student loan repayment program
- **Option 5.** Provide targeted, one-time increases for LHD staff salaries

## Provide additional support to LHDs

- **Option 6**. Create regional operations and facilities management staff
- **Option 8.** Determine funding necessary to provide sufficient communications capacity in all health districts

# Policy options related to funding

## Funding

- **Option 9.** Track cooperative funding per capita, identify needs and differences, and adjust as appropriate
- **Option 10.** Increase environmental health inspection fees and adjust by establishment type
- **Option 11** Design tiered system of civil monetary penalties on facilities in violation of state environmental health regulations

# Opportunity for public comment

Submit written public comments by close of business on Friday, November 18th

Email: jchcpubliccomments@jchc.virginia.gov

Mail: 411 E. Franklin Street, Suite 505
Richmond, VA 23219

NOTE: All public comments are subject to FOIA and must be released upon request.

# Joint Commission on Health Care

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