



# PUBLIC HEALTH ADVISORY COMMISSION REPORT

April 2017

Prepared for Governor Rick Snyder

# Letter from Commission Chair

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March 31, 2017

Governor Snyder:

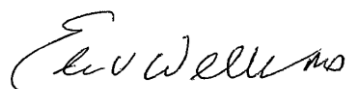
On behalf of the Public Health Advisory Commission, I am pleased to present you the Commission's final report, which arose from an honest assessment of our state and local government's current public health service delivery systems. In order to ensure the protection and promotion of public health in the State of Michigan, we must all work together to move our state forward towards a more equitable and effective future.

The State of Michigan has a strong history of dedicated public health professionals working for the betterment of all residents. The Commission, composed of health care experts, educators, nonprofit leaders, and public servants from throughout the state worked diligently over the last four months to produce these recommendations. The State is committed to public health excellence, recognizing the need for change in order to truly achieve a transformational public health system. This report proposes robust recommendations to advance Michigan's public health system into a citizen responsive, integrated system.

This document is presented with the support of the Commission and their hope that the recommendations will energize a statewide effort towards a more comprehensive, cohesive, accountable and effective public health system. More research, discussions with the public and stakeholders, and expert input will be needed to continue this journey that the Commission has embarked upon.

Please join me, and my fellow Commissioners, in challenging Michigan to ensure the protection and promotion of public health for all residents. The Commission looks forward to working with you on continuing to improve the State's public health service delivery system. Thank you for your leadership in creating this Commission and your commitment to promoting and protecting the health of the people of Michigan.

Sincerely,



Eden Wells, MD, MPH, FACPM  
Chief Medical Executive, Michigan Department of Health and Human Services  
Chair, Public Health Advisory Commission

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# Commission Members

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## GUBERNATORIAL APPOINTEES

- Eden Wells (Chair), State of Michigan Chief Medical Executive
- Kathleen Forzley (Vice Chair), Oakland County Health Division
  - Representing local public health officials
- Cynthia Aaron, Children's Hospital of Michigan Regional Poison Control Center
  - Representing toxicologists
- Eric Adelman, Kadima Mental Health Services
  - Representing general public
- Denise Chrysler, Network for Public Health Law Mid-States Regional Center at University of Michigan
  - Representing schools of public health from higher education institutions
- William Fales, Western Michigan University's Homer Stryker MD School of Medicine
  - Representing a nationally accredited medical school
- Mark Fowler, City of Boyne City
  - Representing local directors of public works
- Debra Furr-Holden, Michigan State University College of Human Medicine
  - Representing epidemiologists
- Robert Gouin, Mid-Michigan District Health Department
  - Representing environmental health experts
- Mona Hanna-Attisha, Hurley Medical Center / Michigan State University
  - Representing physicians
- Joneigh Khaldun, Detroit Health Department
  - Representing local public health officials
- Chris Kolb, Michigan Environmental Council
  - Representing non-profit environmental organizations
- Dianne Malburg, Michigan Pharmacists Association
  - Representing licensed pharmacists
- Bill Manns, Trinity Health/Mercy Health Saint Mary's
  - Representing hospital administrators
- Susie Meshigaud, Hannahville Indian Community
  - Representing general public
- Kristen Schweighoefer, Washtenaw County Public Health
  - Representing food safety experts
- Ann Sheehan, Michigan State University College of Nursing
  - Representing registered nurses
- Michelle Styma, Thunder Bay Community Health Services, Inc.
  - Representing general public
- Melinda Wilkins, College of Veterinary Medicine at Michigan State University
  - Representing veterinarians

# Commission Members and Staff

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## **NONVOTING, EX OFFICIO MEMBERS**

- Jamie Clover Adams, Director, Department of Agriculture and Rural Development
- Shelly Edgerton, Director, Department of Licensing and Regulatory Affairs
- Heidi Grether, Director, Department of Environmental Quality
- Col. Kriste Kibbey Etue, Director, Michigan State Police
- Nick Lyon, Director, Department of Health and Human Services

## **STAFF**

- Therese Empie, Executive Office of the Governor
- Nick Payne, Executive Office of the Governor
- Jamie Zaniewski, Executive Office of the Governor
- Mike Zimmer, Executive Office of the Governor

# Executive Summary

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In September 2016 Governor Rick Snyder announced the creation of a commission focused on assessing and recommending improvements to Michigan's current public health service delivery system. The Public Health Advisory Commission was chaired by Dr. Eden Wells, Michigan's Chief Medical Executive, and included 24 members representing a diverse set of professions and experiences.

The Commission met regularly throughout a four month period. Commissioners dedicated a substantial amount of time discussing Michigan's current organizational structure of public health services, and deliberating what the optimal organizational structure should be.

The following three proposed reorganization models were actively considered by the Commission, with particular emphasis and time spent contemplating the first two models. Each proposed model represented a different approach to elevating public health's visibility and authority at the state level.

1. The creation of a new and separate State Department of Public Health. The proposed new department would at a minimum include the programs and services provided by the current Michigan Department of Health and Human Services (MDHHS) Population Health Administration.
2. The creation of an independent and autonomous Type 1 Public Health Agency within MDHHS.
3. The creation of a State Health Officer position within MDHHS. The proposed new position would be granted the public health authority provided under the Public Health Code (PHC) PA 368 of 1978, including police powers. Examples of such powers include: declarations of imminent danger, public health emergency orders, isolation, and quarantine.

Despite their sincere efforts and time dedicated to this topic, Commissioners remained divided on which of the three proposed models would best serve the residents of Michigan. The Commission therefore unanimously agreed that further analysis and a more comprehensive review were necessary, prior to recommending one of the proposed models.

Regardless of whether or not changes are made in the future to the state's organizational structure of public health services, commissioners unanimously agreed the State Director of Public Health should:

- Have a strong background in public health practice.
- Serve as the chief strategist for cross-sector and cross-disciplinary work towards executing the vision of public health services, consistent with Public Health 3.0<sup>1</sup>.
- Serve as a member of the Governor's cabinet; regardless of whether or not this position is separated from the Director of MDHHS in the future.

While the Commission did not reach consensus on the optimal organizational structure of state public health services, the overwhelming majority of commissioners did support the 39 recommendations included in this report. The 39 recommendations fall under three themes: **collaboration**, **investment**, and **accreditation**. The following three recommendations are the Commissions highest priorities for consideration:

1. Create a permanent Public Health Advisory Council. In addition to continuing further analysis and implementing the recommendations of this Commission, the new Council would serve as a forum to address emerging state and local public health threats or issues; further, it will provide all state department directors and other public health stakeholders the opportunity to collaborate in real time on public health responses.
2. Ensure all state departments utilize a “Health in all Policies” approach when implementing policies and programs. Included in this report are several department-specific recommendations related to elevating public health, and ensuring that the health of Michigan citizens is considered in all state policy decisions.
3. Commence a comprehensive review of state public health funding. The review should be conducted on a county-by-county basis in order to recognize disparities and unmet needs throughout the state. In addition, and in some cases dependent of this review, the Commission recommends the repurposing of current funding, and calls for increasing investments for Michigan’s public health system.

# **Purpose and Responsibilities**

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Through Executive Order No. 2016-19, the Governor created the Public Health Advisory Commission, to help "...protect and promote public health in Michigan by providing advice and assistance on best practices for the organization of functions and the delivery of public health services by state and local governments." The Commission is temporary and will disband on July 1, 2017.

## **Mission Statement:**

To evaluate and provide recommendations to the Governor as to the optimum organization of governmental public health in Michigan.

## **Vision Statement:**

Improve public health services, assure public health accountability and improve public health efficiency and response.

## **Commission's Responsibilities:**

The Public Health Advisory Commission serves as a resource to the Governor for insight on current and emerging public health issues. The Commission's central charge was to make policy recommendations to the Governor regarding the following three key areas by April 1, 2017:

1. The organization of public health functions within and across Michigan's executive departments.
2. The division of responsibilities between state and local public health authorities.
3. The regulatory framework established by the PHC, as necessary to best protect and promote public health in Michigan.

Lastly, in order to understand opportunities for growth in Michigan in the above mentioned areas, the Commission researched and benchmarked other states throughout the country to identify other state models of public health governance.



# Background

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## Ten Essential Public Health Services

While the amount and level of services vary by state and local public health department (LHD), according to the Centers for Disease Control all public health agencies should provide a minimum amount of services. Developed over twenty years ago, the ten essential public health services that all public health agencies should undertake include the following<sup>2</sup>:

- Monitor health status to identify and solve community health problems,
- Diagnose and investigate health problems and health hazards in the community,
- Inform, educate, and empower people about health issues,
- Mobilize community partnerships and action to identify and solve health problems,
- Develop policies and plans that support individual and community health efforts,
- Enforce laws and regulations that protect health and ensure safety,
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable,
- Assure competent public and personal health care workforce,
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services,
- Research for new insights and innovative solutions to health problems.

## Public Health 3.0

Public Health 1.0 began in the late 19th century and continued into the 20th century. It was during this time that modern public health became an essential governmental function. This included federal, state and local authorities establishing minimum health standards for necessities such as food and water, while working to better understand disease prevention and treatment.<sup>1</sup>

Public Health 2.0 emerged in the second half of the 20th century, and is recognized as the period of systematic development of public health governmental agency capacity across the U.S.<sup>1</sup> During this time, Michigan solidified its commitment to public health by establishing its own PHC.

Public Health 3.0 is the current initiative being led by the U.S. Department of Health and Human Services and goes beyond the traditional aims of governance. The initiative requires cross-sector collaboration between state, local, and private partners to identify and improve social determinants of health to provide equitable health to all. Public Health 3.0 aims to challenge business and community leaders, state lawmakers, and federal policymakers to incorporate a “health in all policy” approach to governance.<sup>1</sup>

## Organization of U.S. State Health Departments

Under the U.S. Constitution the federal government has limited authority to regulate public health; however, federal policy makers frequently use their spending power through the budget to shape public health policies. Because of the broad flexibility states have regarding public health, no one state health department is like any other in the United States. Currently, there is no universally-accepted best practice for how to organize public health within a state. Rather, accountability models between LHDs and state agencies vary drastically. Per the Association of State and Territorial Health Officials (ASTHO) *Profile of State Public Health Vol. III*, most states can be categorized into one of the following four governance classifications: decentralized, centralized, shared and mixed<sup>3</sup>.

A majority of states (AZ, CA, CO, CT, ID, IL, IN, IA, KS, MA, **MI**, MN, MO, MT, NE, NJ, NV, NY, NC, ND, OH, OR, TX, UT, WA, WV, WI) have what ASTHO considers to be a decentralized governance structure. In this structure, local health units, primarily led by employees of local governments, retain authority over most key decisions.<sup>3</sup> Under this model LHDs primarily operate independently from their state's public health agency.

In centralized governance structures, the state retains almost all public health authority. A centralized structure generally begins with the health agency establishing state-run LHDs, or state-run regional offices which oversee the LHDs. Under this structure state employees make most decisions related to the budget, issuing public health orders, and selecting local health officials.<sup>3</sup> Fourteen states utilize a centralized structure to facilitate public health (AL, AR, DE, DC, HI, LA, MS, NH, NM, RI, SC, SD, VA, VT).

Four states have a shared governance structure (FL, GA, KY, MD). Under this structure LHDs may be led by state employees or local government employees. If local units are led by state employees, the local government has the authority to make key decisions. If local units are led by local employees, the state health department has the authority to make key decisions.<sup>3</sup>

Finally, six states have a mixed governance structure (AK, ME, OK, PA, TN, WY). Under this structure no one entity can claim authority across the entire state. In some areas of the state local health units retain power and authority, and in other parts the power and authority reside within the state department.

## History of Public Health in Michigan

Michigan's historic connection to public health began in 1873, when the State Board of Health was created.<sup>4</sup> Throughout the past 140-plus years, Michigan has remained committed to providing public health services to its residents. Since 1978 public health in Michigan has been primarily governed by the PHC. The PHC has provided Michigan a well-developed state level public health system, while also preserving effective and primarily autonomous LHDs. While there have been numerous amendments to the PHC

since its inception, Michigan has one of the most comprehensive and contemporary codes in the nation.<sup>4</sup>

From 1978 through 1996, Michigan's state public health system consisted of three departments: Department of Public Health, Department of Mental Health, and Department of Social Services. The following five agencies were housed in the Department of Public Health during this time: Public Health, Food Safety, Health Facility Licensing, Occupational Safety and Health Regulation, and the Division of Water Supply. The Department of Social Services housed the Medicaid program during this period.

In 1996, through Executive Orders No. 1996-1<sup>5</sup> and No. 1996-4<sup>6</sup>, Michigan experienced a large restructuring of public health services. Public health services were disseminated into the following five separate departments: Department of Community Health (DCH), Department of Environmental Quality (MDEQ), Department of Commerce, Department of Agriculture, and Department of Human Services (DHS). Public health, mental health and the Medicaid program were housed in DCH. It was also during this restructuring that the Division of Water Supply was moved to MDEQ, Food Safety was shifted to the Department of Agriculture, and Health Facility Licensing and the Michigan Occupational Safety and Health Administration (MIOSHA) were integrated into the Department of Commerce. The state-wide restructuring of public health services in 1996 did not affect LHDs home rule authority.

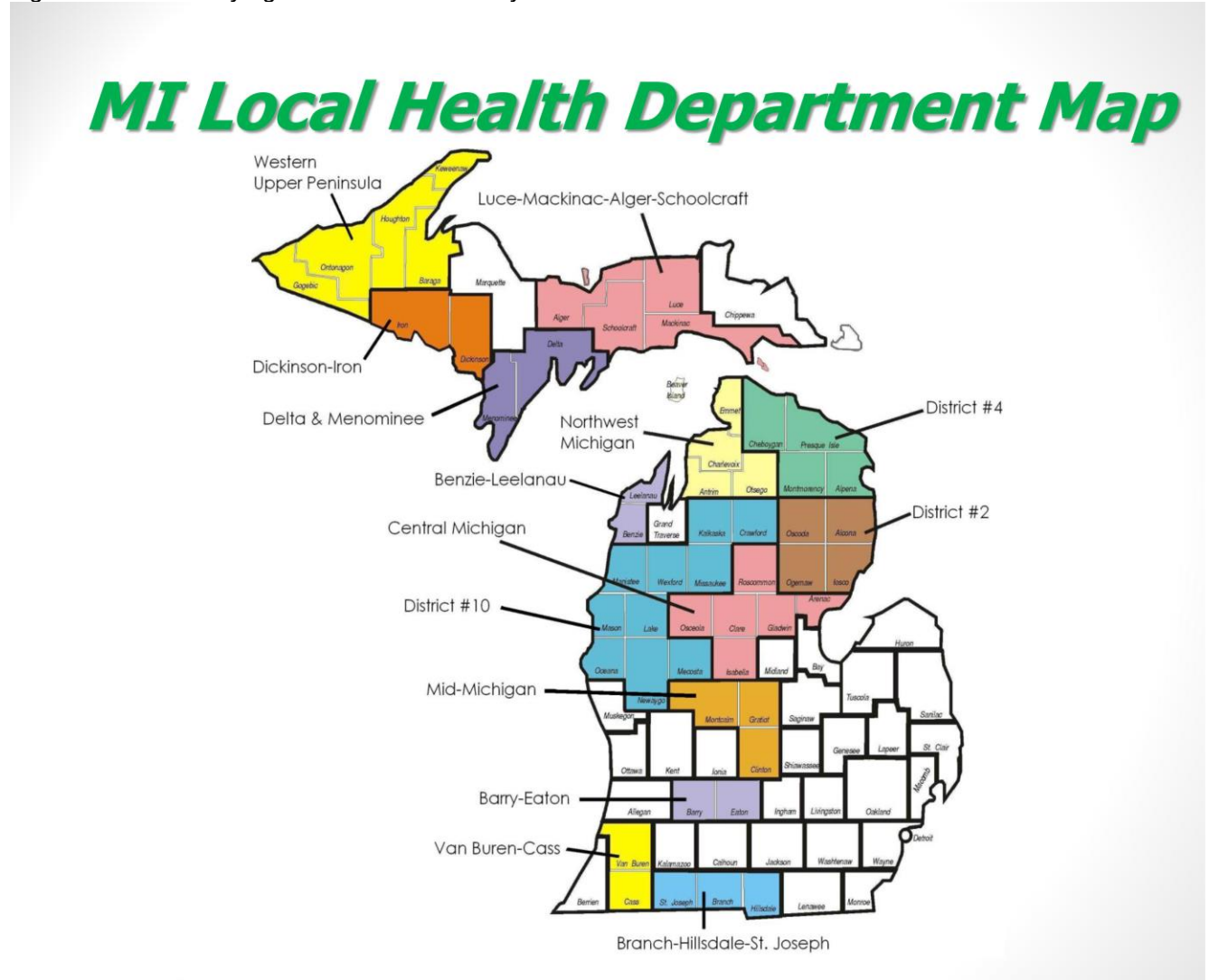
In February 2015, through Executive Order No. 2015-4, Governor Snyder announced the creation of MDHHS.<sup>7</sup> Through this order, all authority and powers of DHS and DCH were transferred to the newly created MDHHS. In addition to departmental transfers, the order created two new agencies to be housed within MDHHS (Michigan Children's Services Agency and Aging and Adult Services Agency) and one new office (Health and Human Services Office of Inspector General). The following public health services remained untouched by the order: Food Safety Services remained within the Department of Agriculture and Rural Development (MDARD), the Division of Water Supply remained within MDEQ, and Licensing and Regulatory Affairs (LARA) continued to house the Bureau of Community and Health Facility Licensing and MIOSHA.

## **Michigan's Current Public Health System (State and Local Level)**

As previously mentioned, Michigan operates under a decentralized public health governance structure. Michigan has forty-five LHDs that are broken out in the following manner (see Figure 1): thirty-two single county departments, twelve district (multi-county) agencies, and one city (Detroit). These forty-five LHDs vary in size from approximately twenty-five staff members to almost five-hundred staff members and provide services for populations ranging from 50,000 to more than 1,000,000 residents. Michigan also has twelve federally acknowledged Indian tribes. These tribes are

sovereign governments that exercise direct jurisdiction over their members and territories. These tribes provide a wide array of services to their members, including health services.

Figure 1: Multi-county agencies are identified by colors



Per the PHC, MDHHS and LHDs have parallel authorities. For example, as outlined in the PHC, the state has delegated much authority to LHDs. Through this “home rule” governance structure, the state has granted local governments the general power to manage their own affairs, including the health and well-being of their residents. That being said, MDHHS requires LHDs to meet certain performance and program criteria in their provision of public health services. For example, under the PHC, LHDs are required to have a Health Officer and a Medical Director; although one person may hold both positions if the Health Officer is also a licensed physician (MCL 333.2428). These positions may or may not report to a Board of Health in addition to their local governing

entities governance structure. LHDs are also required by the PHC to do the following (MCL 333.2433):

- Implement and enforce laws regarding local health,
- Utilize vital and health statistics for the purpose of protecting the public health,
- Make investigations and inquiries as to the causes of disease (especially epidemics), morbidity and mortality,
- Make investigations and inquiries as to the causes, prevention, and control of environmental health hazards, nuisances, and sources of illness,
- Plan, implement and evaluate health education,
- Plan, implement, and evaluate nutritional services.

Thus because of this parallel authority and often shared responsibility, several points must be emphasized regarding state and local public health accountability:

- Local health officers are accountable for public health within their jurisdiction; including rapid communication and response actions with jurisdictional stakeholders and local emergency managers. Local health officers are also accountable for the notification and engagement of relevant state departments; including, but not limited to: MDHHS, LARA, MDEQ, MDARD, and MSP.
- The director of MDHHS is accountable for coordinating public health responses for public health issues impacting multiple local health jurisdictions. This includes assuring uniform comprehensive communications and responses occur from each of the LHD jurisdictions.
- By statute the director of MDHHS shall assign responsibility for the coordination and delivery of public health services and programs to the LHD, unless the LHD is deemed to be unwilling or unable to perform them by the director, the services are specialized or complex, or, other legal constraints preclude assignment of responsibility (MCL 333.2235).

## **Public Health Service Delivery in Michigan**

Many of the programs and funding for public health services are, as expected, administered by MDHHS. Housed within MDHHS, various traditional and essential public health services reside within the Population Health Administration, including, but not limited to: Maternal and Child Health, the Bureau of Health and Wellness, the Bureau of Family Health Services, the Bureau of Epidemiology, the Bureau of Laboratories, the Bureau of Emergency Medical Services (EMS), Trauma, and Preparedness, and the Office of Local Health Services. In addition to administering traditional public health services, MDHHS administers the Medicaid and Healthy Michigan Plan. MDHHS also conducts programs and delivers services for children's health, foster care, behavioral health, crime victims fund, vital records, and seniors; to name a few.

Although MDHHS administers many public health services, multiple state departments oversee various public health programs and/or deliver public health services. In fact,

numerous state departments play a significant role in the overall delivery of public health services to Michigan residents. The following are examples of public health services provided by state departments:

- MDEQ regulates and tests drinking water, environmental toxins and air quality.
- MDARD conducts food safety investigations, along with assuring safe food production in Michigan facilities.
- LARA licenses health professionals and facilities, and has the power to inspect or investigate any concerns in licensed areas.
- Michigan State Police (MSP) assist in the enforcement of laws that effect citizen's safety, implement orders and directives of the Governor in the event of a state emergency or state disaster, and manages the State Emergency Operations Center (SEOC) which is the primary point of direction and control for coordinating state response and recovery resources.

In addition to these examples, the Commission recognized that many state departments, as represented in the Governor's Cabinet, play some part in the overall "Public Health System" of the state.

# Recommendations

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The Commission discussed and evaluated proposed changes to Michigan's current public health service delivery system by analyzing three different structural aspects: horizontal organization of public health at local level, horizontal organization of public health at state level, and the vertical organization of state and local public health. It was through these lenses that the Commission made their recommendations. Although many of the recommendations were individual in nature and specific to the mode of delivery, all recommendations fell under three common themes: **1) collaboration, 2) investment, and 3) accreditation.**

## 1) Continuing and Expanding Collaboration

Throughout the Commission's tenure, one theme continuously arose: collaboration. As highlighted in the Public Health 3.0 White Paper<sup>1</sup>, public health is what all relevant agencies and stakeholders do together, and building healthy communities involves collaboration of all sectors - public and private.<sup>1</sup> Therefore, the more collaboration that takes place, the easier it will be to diminish communication silos and create a stronger Michigan public health service delivery system. The following Commission recommendations require collaboration at local, state and federal levels, across state departments, and throughout the governmental hierarchy.

### **State and Local Collaboration:**

#### ***Public Health Advisory Council***

Create a permanent Public Health Advisory Council to be housed in a principle state health department. In addition to continuing the work and implementing the recommendations of this commission, the new council would serve as a forum to address emerging state and local public health threats or issues, and provide all state department directors and other public health stakeholders the opportunity to collaborate in real time on public health responses.

#### ***Regional Collaboration***

LHDs should continue and expand collaboration with each other, the state, and tribal entities to build and formalize regional structures that share public health resources where appropriate.

#### ***Incentivize Consolidation***

The State should incentivize LHDs to consolidate into multi-county public health districts; where and when appropriate. For example, such incentives could include flexible funding models, templates for the sharing of resources or sharing of subject matter expertise across county lines.

### ***Coordination of Multi-Jurisdictional Public Health Response***

Create a public health response system when multiple agencies are required to respond to a non-emergency situation. This system would replicate the system utilized by the State Emergency Operations Center (SEOC). The system would allow public health officials to more appropriately and expeditiously respond to emerging public health threats or response needs involving multiple state and local agencies.

### ***Develop Local Response Teams***

Develop local public health response teams. The teams would provide multi-disciplinary public health expertise, including, but not limited to: capacity-building, mentorship and general assistance to peer agencies. Teams will be formed through collaborative efforts of appropriate State agencies and the Michigan Association for Local Public Health (MALPH).

### ***Leverage Collective Buying Power***

The State should inventory and share any appropriate state contracts that LHDs could choose to utilize, and also collaborate with each other on new opportunities for leveraging collective buying power. For example, in order to eliminate duplicative negotiations and contracts for each LHD to purchase vaccines for private pay clients, the State could negotiate a single contract that all LHD could utilize.

### ***State and Local Public Health Leadership Continued Teamwork***

State public health leaders should continue to meet, and actively engage with, MALPH and the Michigan Association of Local Environmental Health Administrators (MALEHA) leadership on a regular basis to determine model program elements, communication items, etc.

### ***Ensure LHD Involvement***

Public health programs and services conducted by any state department at the local level should ensure that LHDs participate in the delivery and coordination of those programs and services; or, assess whether the programs and services be administered by the LHD, where possible. This includes, but is not limited to: food inspection programs conducted by MDARD at the local level, issuance of public health orders by the MDHHS pertaining to local issues, and collaboration with local partners to identify or investigate public health hazards with the MDEQ.

### ***Survey LHDs***

LHDs and their stakeholders should be surveyed by the State to determine and compare local public health structures, in order to identify and share best practices of high-performing organizations.



### ***Create Public Health Hotline***

Create a state public health hotline. The hotline would provide the general public and nongovernmental staff with one phone number for public health services inquiries, regardless of which state department the service may reside in. This single point of access would allow individuals to ask questions, express concerns, receive direction, and obtain contact information for where to go for appropriate assistance at both the state and local level.

### ***Increase Statewide Information Sharing***

Improve and support statewide information sharing by connecting Michigan health information systems and databases to enhance health officer's capabilities at the state and local level.

## **Collaboration between State Departments**

### ***Ensure Health in all Policies***

The Governor and his cabinet should ensure all state departments utilize a "Health in all Policies" approach when implementing policies and programs. The following are mechanisms to achieving this:

#### ***Public Health Impact Statements***

Require public health impact statements and assessments be developed and reviewed by state decision-makers and stakeholders. At a minimum, state transportation and infrastructure decisions should require a public health impact statement and assessment.

#### ***State Departments Conduct Public Health Assessment***

Each state department should conduct an assessment of the services they provide that impact public health. The assessment would help departments identify gaps and/or challenges in their delivery of public health services.

#### ***State Department Mission***

All state departments' mission statements should include the prioritization and safeguarding of public health, and they should maintain special consideration for vulnerable populations.

#### ***Environmental Justice***

State departments and LHDs should embrace awareness of environmental justice and its impact on vulnerable populations.

### ***State Director of Public Health***

The State Director of Public Health should serve as the chief strategist for cross-sector and cross-discipline work toward implementing the vision of Public Health 3.0<sup>1</sup> and achieving the Commission's goal of health in all policies.

### ***One Health Approach***

State to review multiagency efforts that support a One Health approach (human health/animal health interface) in order to reduce duplication of effort and facilities by involved agencies. For example, currently MDARD and MDHHS have two separate laboratories for testing infectious diseases that affect animals and humans.

### ***Unified State Communication Strategy***

In order to limit duplication of efforts and resources, state departments should coordinate a unified communication strategy when addressing local public health concerns.

### ***Orientation of State Staff to Understand Powers Provided by the PHC***

The state, in partnership with the MALPH and MALEHA, should provide orientation, education, and training programs for the Director of MDHHS, Medical Directors, Environmental Health Directors, state level public health leadership and emergency management coordinators to assure understanding of state and local public health powers provided by the PHC.

## **State and Federal Collaboration**

### ***Alignment of Community Needs Assessment***

State should collaborate with the federal government to allow for the alignment of the hospital system community health needs assessment requirements with those conducted and required by Michigan LHDs. This would allow for both entities to be on the same timeline and encourage collaboration when conducting community health assessments.

## **2) Investing in Michigan's Public Health**

As state and local governments have faced fiscal challenges throughout the past two decades, public health spending has also continued to decrease. For example, in a 2015 study published in the American Journal of Public Health, it was determined that national public health expenditures had decreased by 17 percent from 2014 compared to 2002.<sup>8</sup> Not only state and local governments have decreased spending; the federal government continued to decrease funding throughout this same time period. In a recent report published by the Robert Wood Johnson Foundation, it was determined that federal funding for the Centers for Disease Control and Prevention (CDC), the agency that primarily supports public health services and programs for states, had decreased by more than \$1 billion (15 percent) between fiscal year 2005 to 2013.<sup>9</sup> Despite declining funding, the science and field of public health has broadened to include critical issues such as poverty, racism, food insecurity and adverse childhood experiences (ACE).

Because preventing diseases, reducing health care costs and preparing for emergencies is vital to all Michiganders health and well-being, the Commission

recommended the following, pertaining to the State's investment in its' public health delivery system:

***Comprehensive Review of State Public Health Funding***

Commence a comprehensive review of state public health funding. The review should evaluate funding on a county-by-county basis, in order to recognize disparities and unmet needs throughout the state. The review would help ensure provided funding be based on program and service needs.

In addition, and in some cases dependent of such a review, the Commission made the following recommendations related to the repurposing of current funding and increasing investments towards Michigan's public health system:

***Support LHDs Efforts towards Accomplishing a Public Health 3.0 Vision***

State should promote and support LHDs to complete community health assessments, community health improvement plans, programs such as Project Public Health Ready, and national voluntary retail standards, consistent with Public Health 3.0.

***Complete review of State Equitable Cost Sharing***

State should complete a review of state equitable cost sharing for local public health operations, and identify opportunities for developing a sustainable funding formula.

***Blend Funding Streams***

State should review the use and flexibility of block grants to LHDs. The State should explore opportunities to blend funding streams to support local and state public health needs.

***Ensure Flexibility of LHD Funding***

State should review funding allocations and work with MALPH towards maximizing LHD funding flexibility. Currently, due to varying sources of state and federal funding, LHDs are not able to move certain funds from one area to another to address needed public health service delivery.

***Additional State Appropriations Geared at Accreditation Compliance***

State should work with MALPH towards achieving additional unrestricted state appropriations for LHDs, to be used towards compliance with current and enhanced accreditation standards.

***Establish Minimum Emergency Response Standards***

State should work with MALPH to establish minimum emergency response standards for all LHDs and allocate additional funding to support implementation and maintenance of these standards. Support should include minimum staffing, training, planning and exercise requirements.

***Review LHDs Funding for Regional Emergency Response Training***

State should continue to review the need for additional state funding for MDHHS and LHDs to be used towards required regional emergency preparedness planning, training, and response exercises in collaboration with local and state emergency management and public health agencies.

***State Training of LHD Staff to Understand Powers Provided by the PHC***

State should provide orientation, education, and training programs for local public health officers, medical directors, environmental health directors, local emergency management coordinators and health care system leadership to understand, and effectively use, local public health powers provided through the PHC.

***Expand Office of Local Health Services***

State should provide additional resources to support expanded functions and additional staff to the Office of Local Health Services. This office is currently staffed by one MDHHS employee. With expanded function and additional staff, this office will have opportunity to engage with LHDs more frequently.

***Increase Public Health Workforce***

Increase funding and field staff for state and local employees actively working in public health related activities.

### **3) Changes to Accreditation Process (State and Local)**

The Michigan Local Public Health Accreditation Program identifies and promotes the implementation of public health standards for LHDs and evaluates and accredits LHDs based upon their ability to meet these standards.<sup>10</sup> LHD accreditation began in Michigan in 1998 and is now conducted by several state departments. On a regular cycle, LHD accreditation by the state occurs every three years. The program is a collaborative effort between the Michigan Public Health Institute, MDARD, MDEQ, MDHHS, MALPH, and Michigan's 45 LHDs. MDHHS provides oversight and funding for the program.

The Commission makes the following recommendations related to the state accreditation process for LHDs:

***LHD State Accreditation to Reflect Public Health 3.0 Initiatives***

Working through the Michigan Local Public Health Accreditation Program, the state should amend the accreditation process for all LHDs to reflect and encompass national accreditation standards consistent with Public Health 3.0 initiatives.

***LHD State Accreditation to Reflect Performance & Outcome Based Assessments***

The Michigan Local Public Health Accreditation Program should review and revise local public health accreditation standards, in alignment with national standards, to reflect performance and outcome-based assessments, quality improvement processes, and the powers and duties explicitly required by the Michigan PHC.

***LHD Accreditation Review Findings Made Public***

LHD accreditation review findings should be summarized, scored and made available to the public.

***Review of State Intervention Procedures***

State intervention protocols and procedures that take place if LHDs fail to meet state accreditation minimum standards should be reviewed by the Director of MDHHS. The Michigan Local Public Health Accreditation Program should be included in the review and necessary revisions.

***Include Local Governing Entities in LHD Accreditation Process***

Amend the state's LHD accreditation process to require the state meet with local governing entities of each community during the accreditation process.

Just as LHDs are accredited by the state, MDHHS should also receive accreditation. The Commission recommends the following in regards to MDHHS pursuing national accreditation:

***State to Pursue National Accreditation***

MDHHS should pursue national accreditation through the Public Health Accreditation Board (PHAB).

***MDHHS Accreditation Process***

MDHHS' accreditation process, once initiated, should reflect national accreditation standards consistent with Public Health 3.0 initiatives, similar to the recommendation for LHDs.

# Evaluation of Proposed Organizational Changes to Public Health at State Level

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The Commission included an accomplished and diverse group of stakeholders and state department representation. Commissioners dedicated a substantial amount of time discussing Michigan's current organizational structure of public health services, and deliberating what the optimal organizational structure should be. Commissioners supported structural solutions to address fragmentation of public health programming at the state level. It was thought that a structural change would assist in defining clear authority over public health program implementation across multiple departments and decisions that impact human health.

Three proposed reorganization models were strongly considered by the Commission; with particular emphasis and time spent deliberating model 1 and model 2. Each of the three models (described below) call for differing levels of reorganization of public health functions at the state department level, with varying impacts on agreed upon attributes.

In their efforts to determine the optimal model of state public health service delivery, Commissioners measured the impact that each of the proposed models would have on the following sub-attributes:

- Credibility of public health
- Alignment of public health responses and communications
- Accountability between state and locals clearly defined
- Visibility of public health
- Funding impacts

Despite their sincere efforts and time dedicated to examining the state's public health service delivery system, Commissioners were unable to reach consensus on which of the three proposed models would best serve the residents of Michigan. Therefore, the Commission unanimously agreed that additional time was required to pursue an objective, measured, and comprehensive analysis of the optimal model for Michigan's organizational structure of public health services.

While the Commission did not reach consensus on which model for structural change should be recommended, Commissioners unanimously agreed that the State's Director of Public Health, regardless of whether or not changes are made in the future to the state's organization structures of public health services, should be responsible for advancing state public health priorities and serve as a member of the Governor's cabinet.

The following three proposed reorganization models were actively considered by the Commission:

***Model 1***

Create a new and separate State Department of Public Health. The proposed new department would at a minimum include the programs and services provided by current MDHHS Population Health Administration. The Commission recommends that future consideration of this model includes a review of all public health services provided by the state, and the consideration of combining public health services provided by state departments other than MDHHS. The proposed new department should be led by a Governor appointed, cabinet level director, who should also serve as the State's Health Officer.

***Model 2***

Create an independent and autonomous Type 1 Public Health Agency within MDHHS. The proposed new agency should be led by a Governor appointed, cabinet level director, who should also serve as the State's Health Officer.

***Model 3***

Create a State Health Officer position within MDHHS. The proposed new position would be granted the public health authority provided under the PHC; including police powers. Examples of such powers include: declarations of imminent danger, public health emergency orders, isolation, and quarantine. Amongst other responsibilities, this position would be responsible for implementing the Public Health 3.0 vision, including consideration of health in all policies, cross-agency coordination of state and local public health service responses, and lead strategic planning for Michigan public health.

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