Polk County

County Public Health Services
Exploratory Report

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Acronyms

BAA – Business Association Agreements

BCCCP – Breast Cancer Cervical Cancer Prevention

CC4C – Care Coordination for Children

CFPT – Child Fatality Prevention Team

CHBINT – Child Health - Breast Cancer and Cervical Cancer Prevention Exams

CHSA – Consolidated Human Services Agency

EH – Environmental Health

FQHC – Federally Qualified Health Center

FTE – Full-Time Equivalent Employee

MOU – Memorandum of Understanding

NC DHHS – North Carolina Department of Health and Human Services

NC DPH – North Carolina Department of Public Health

NCAC – North Carolina Administrative Code

NFP – Nurse Family Partnership

OBCM – Pregnancy Care Management

RPM HD – Rutherford Polk McDowell Health District

STD – Sexually Transmitted Disease/Infection

TB – Tuberculosis

WIC – Women, Infants, and Children Nutritional Services

Staff Analysis of Moving from a Regional Health District to a County Health Department

In the 1970's the Polk County Board of Commissioners chose to implement an opportunity to maximize resources by joining with Rutherford and eventually McDowell counties in a joint Regional Health District (RPM Health District). This decision proved to be successful in supporting quality services provided by the joint venture in a financially sound way for many years. The District operated a home health venture for a number of years and was able to stand alone with little increase in county contribution.

A dynamic shift to improve public health and promotion services in Polk County and increase coordination of in-county whole person health services.

Across the State of North Carolina, county health departments are the service delivery model for a number of required services and the assuring agency for others that promote, protect, and educate the general public. Each public health department across the state operates a unique model based on local needs to address the three essential functions of policy development, assessment, and assurance. To be successful public health agencies effectively engage partners in these core functions to achieve positive health outcomes for the community. Across the State of North Carolina, the county operated health department (Consolidated Human Services Agency or standalone) is the common model.

In 2015 the Polk County Board of Commissioners chose to support a grant that brought a Federally Qualified Health Center (FQHC) to Polk County. Polk Wellness (also known as Blue Ridge Health Center – FQHC) started operations in 2016 and currently serves uninsured and underinsured clients throughout Polk County. Blue Ridge Health Center opened its doors 1960 and has been providing services locally in Polk County for several years. Blue Ridges' mission is to provide quality healthcare that is accessible and affordable for all. Their services consist of family medicine (including maternity and family planning services), pediatric medicine, dentistry, school based health services, behavioral health services, pharmacy, and nutrition services.

Additionally, in 2016 the Polk County Board of Commissioners modified the model of human service delivery to the Consolidated Human Service Agency Model (CHSA). This service delivery model covers all Polk County Human Service Agencies (Social Services, Public Transportation, Senior Services, and Veterans' Services) and is more agile and able to adapt to the real time needs of the human services clients in our community. Our CHSA was designed to provide greater collaboration between partnering organizations and government agencies and to assist and support individuals that live and work in Polk County by developing strategic initiatives that resolve root cause issues.

As a member of the RPM Health District we allocate resources across three distinct counties with varying needs for services. Independently, Polk County has unique needs and assets available to provide similar and more regular services to its citizens. Community input has also driven a desire for solutions to delays and gaps in service, specifically in environmental health.

By forming a district in the 1970's, the Board of Commissioners made an important decision that affected many people. The current Polk County Board of Commissioner's face an equally important decision on the future of Health and Human Services in Polk County. Much like we have done across the charter departments of the CHSA, this model provides opportunities to leverage internal human resources and financial resources to advance aspects of public health. In addition, the creation of a FQHC and the CHSA model in Polk County has created a unique opportunity for us to leverage the best of both models by taking on the public health function within County Government. Some of the functions currently being provided by the Rutherford Polk McDowell Health Department are being duplicated (see attached appendix) by Blue Ridge at the Polk County Office. These duplicated functions could be contracted or assured through Blue Ridge or another entity, allowing a CHSA Public Health Division the ability to focus resources on a local level. Additionally, the State of North Carolina is currently going through a Medicaid Transformation that will completely change the way services are delivered and managed for Medicaid Clients. The CHSA model will allow flexibility, direction, and vision for these changes within our community.

In addition, by reverting oversight to the Polk County CHSA we will be able to respond more effectively and timely to the needs of the community and consumers who utilize our services. This response would be based on the needs of Polk County specifically, not the needs of a region. Strategic planning and decision making would be specific to our County, and we would not need to share resources and etc. with a region.

The financial impact of this transition would be advantageous to the taxpayers of Polk County. The RPM Health District requested that Polk County comply with a plan in FY 16-17 that would build their fund balance. This plan created an increase in funding from Polk County to the RPM Health District from $175,145 in FY 16/17 to $280,840 in FY 21/22, which is a total 60% overall increase over five years. Initially, we would be able to operate the local health department for less than previously budgeted in FY 19/20 ($238,562). There would be transition time and expense if we follow the timeline recommended that would be beyond the regular operating costs (approximately $41,369). This would cover one month of salary and benefits for hiring staff prior to the startup in July 2019. We would also need additional funds for building renovation, which we would be able to quantify accurately when we take possession of the building. If expenses for operations of a new health department stay flat, then we potentially save approximately $63,000 over the next three years. Any further funding could be covered in assets and funds given back to Polk County when and if the RPM Health District is divided.

By consolidating health and human services budgets we will maximize the local dollar (with federal and state funding), while enhancing and locally controlling the integrated health services. We have prepared a budget that considers federal, state, and local funding sources as well as the

expense of running a local department. We consulted with RPM Health District, Blue Ridge Health Services, and community partners regarding the budget process, services functions, and the structure. We also consulted with the North Carolina Department of Health and Human Services – Division of Public Health (NC DPH) on the proposed certification of services by partners in Polk County and functions Polk County would retain. NC DPH has indicated the plan was "solid" and they are committed to working with Polk County should a separation from the district occur.

Finally, we wanted to ensure the Commissioners that our review of data and information was focused on the enhancement of service delivery aspects that include location of services, the scope of services, and the fiscal considerations. We are in no way intending to demonstrate that a regional model is inherently flawed or cannot produce positive outcomes, but rather similar to the 1970's, our consumers, our environment, and our organizational model needs have significantly changed over the past several years.

Appendix A – Impact Analysis

The committee was cognizant of the potential for negative impacts that could occur from changing service oversight from RPM HD to Polk County. To aid in this analysis, the committee requested several items of data and input from RPM HD, NC Division of Public Health, and neighboring like and unlike structured counties. This information was requested to help the committee and potential community partners understand the impact of having a Polk County only Public Health division. The committee reviewed the impact in a number of ways but primarily from a service function and delivery for the consumer and financial perspective.

Data provided by RPM HD indicated that the Polk County walk-in clinic numbers for the past 20 months ranged from an average range of 2.3 to 10.75 per day. During fiscal year 2018 the average numbers of daily appointments were 3 per day (see table 1 pg. 6). The committee also reviewed information on current scheduled clinics of BCCCP[1], CHBINT[2], and Child Health which indicated that clinics offered were not available Monday through Friday but rather twice a month for BCCCP or once a month for CHBINT and child health. CC4C[3] services averaged 20 clients per month. OBCM[4] data was indicated for RPM HD via data received from the NC Department of Public Health (NC DPH) listed past fiscal year Medicaid reimbursement data. Lastly, the committee also received information on current WIC[5] clients which currently ranges from 225-250 for the year and appointments are available Tuesday and Thursday of each week.

The committee also reviewed the mandated services (10A NCAC 46 – Local Standards) each county is either; 1) required to be performed directly by local health department, 2) contracted out for, 3) or certified as available. The committee also accounted for services where there is an expectation that some of those services be provided regardless of ability to pay. These services areas are listed in the appendix section “Services Comparison”.

The committee’s analysis of the various data sets from a service provision view was framed within the concept of providing, contracting or certifying the mandated services in the most efficient, comprehensive, and regular manner possible while maintaining fidelity to the requirements of each mandate and equaling or improving upon the current structure. As noted in the Services Comparison list, some of the services are fragmented among more than one provider or location. The committee felt it was in the best interest of potential consumers of these services to have a

[1] Breast Cancer and Cervical Cancer Prevention Exams
[2] Child Health - Breast Cancer and Cervical Cancer Prevention Exams
[3] Care Coordination for Children
[4] Pregnancy Care Management
[5] Women Infant and Children Nutritional Education and Nutrition Assistance. Also includes working with WIC vendors and there is a Breastfeeding Counselor available as needed.

single point of access, a comprehensive wrap-around approach to services where possible, and utilize existing services in county whenever possible. The committee shared the data points and requirements with the FQHC to determine if they are capable and willing to meet the outlined expectations and we were informed that they are completely willing to meet the needs for services listed and certify them as available. To further assure the community and our state partners that these services would be enhanced, we are proposing that the FQHC relocate their current operations and to co-locate with the Polk Health Division for a one-stop-shop at the current Health Department building.

Finally, there are services that by law only county health departments can provide such as environmental health, preparedness, vital records, and communicable disease functions. As an example, the committee believes that relocating Environmental Health to Building Inspections would increase collaboration during the permitting process, leverage existing clerical support, and decrease travel and communication errors for contractors and the general public. In addition, there will be a focus on the permitting process by reducing the turnaround time for information requests for existing systems and improving record keeping to expedite finding information. Further, because Polk County is consolidated we will be leveraging existing structures and staff to enhance prevention outcomes by moving Senior Services as a unit under Public Health, which allows us to leverage existing staff and existing county dollars to support health promotion for all county residents. Lastly, based on the enclosed budget and plans for staffing alignments the committee believes the county would observe a greater return on investment and benefit from a positive impact with this change in service oversight.

Table 1

All Unique Clinic Patient Counts Per Service Per Month from Billing Roster – FY 2018

Program	July	August	September	October	November	December	January	February	March	April	May	June	Grand Total
Child Health	3	5	2	2	3	2		1		2			20
Family Planning	2	1	6	4	4	3	4	8	1	2	4	3	42
Immunizations	16	58	36	128	75	18	31	28	12	19	18	16	455
Maternal Health			1	1	2	1	2	2	3	7	2	3	24
OT	11	4	2	3	6	4	6	4	5	2	9	5	61
STD	1		1	3	4	1	1	4	2	5	2	5	29
TB	14	16	21	15	11	10	8	13	11	17	16	15	167
Grand Total	47	84	69	156	105	39	52	60	34	54	51	47	798

Appendix B – Limitations

While the committee attempted to obtain as much current and relevant data from RPM HD, NC DPH, and other ancillary vendors and data sources we cannot truly know the exact cost to operate a county specific public health department until we have absorbed those functions. The very existence of incoming providers such as the anticipated Urgent Care in Columbus, Medicaid Transformation, the growing services provided by the FQHC and other providers, potential changes in the real estate and trades markets, and the employment market provide variability for which we cannot always account.

Appendix C – Timeline

If the County Commissioners decide to move forward with disengagement from the district the committee would recommend the following 2 phase timeline and fiscal considerations this fiscal year and next fiscal year:

Phase 1 – April 2019

- Preparations
    - Disengagement
    - Notify of NC DHHS of Decision and begin communication with NC DPH Program Consultants and Contacts
    - BAAs/MOUs/Contracts Developed for Physical Health Services
    - Begin review of Environmental Health contracts for scanning, online applications, and online document repository
    - Recruiting and Hiring
        - 15 – 30 days out from July 1, 2019 new staff onboarded
    - Contract Assistance established through December 2019 to assist with the transition: preparing MOU's, policy drafts, etc.
    - May 2019
        - Begin site prep for renovations for FQHC co-location
    - 30 Days out
        - Begin integrating Environmental Health Staff in workflow – Locate at HD
        - Begin patient information sharing and introductions to prevent gaps
        - Establish Usernames/Passcodes for state reporting and billing systems
        - Transfer existing apps to digital platform
        - Notify current patients about change in service providers
        - Inventory Supplies. Order supplies as needed for July 1 go-live
        - Begin landline number porting process
        - Staff begin weekly communications with State Consultants

Phase 2 – July 2019

- Launch
    - July 1
        - Take possession of Polk County Health Department building, equipment, etc.
        - Relocate Environmental Health Staff to Building Inspections
        - Begin scanning of Environmental Health files
        - Go-Live with Environmental Health and EMR software
    - August 1
        - Assess and respond to operationalization efforts and issues respectively

Appendix D – Service Comparisons

Service and Function requirements vary depending on the program. The following key corresponds to the below chart to identify requirements of who can or shall provide designated services or functions.

Level 1 = Health Department Shall Provide; 2 = May Contract or Certify Availability; 3 = Health Department May Contract a Portion of the Services but Maintains Ownership; 4 = Not Required.

Service/Function	Minimum Requirement Level	Current Status	Proposed Status	Change	Notes
Care Coordination for Children	2	1	1	Yes	We receive partial FTE currently, proposing 1 FTE
Family Planning	3	3 – Exams are completed in Rutherford	2	Yes	Services will be provided in county by a single entity
Health Education/Preparedness	4/1	1/1 – shared among three counties	1/1	Yes	We receive partial FTE currently, proposing 1 FTE
Maternal Health	2	3 – Services in Rutherford	2	Yes	Services will be provided in county by a single entity
OB Care Management	2	1	1	Yes	We receive partial FTE currently, proposing 1 FTE
On-Site (Wells/Septic)	1	1	1	Yes	Currently 1 FTE, will increase to 1.5 FTE
Women Infant Children	1	1 – Two Days in Polk	1	Yes	We receive partial FTE currently, proposing 1 FTE for 5 days of service
Adult Health	2	2	2	No	
Child Health	2	2	2	No	
Communicable Disease - TB Services - Immunization - Venereal Disease	1	1	1	No	
Dental	2	2	2	No	
Food, Lodging/Inst Sanitation/Public Swimming Pools/Spas, Tattoo Parlors	1	1	1	No	
Home Health	2	2	2	No	
Laboratory	2	3	3	No	
Vital Records	1	1	1	No	
Breast & Cervical Cancer Prevention	2	1	2	Refer to partners	Funding and estimated case load is low. Advised by state consultant to refer potential patients
Nurse Family Partnership	2	1	2	Refer to partners	RPM HD is fiscal operator of the state contract. Polk would refer out as needed to the new contractor.

Appendix E – Proposed Budget

	One-time	Prep FY'19	Total Annual
INCOME			
State & Federal Funds			
EH			$4,232
Clinic			$23,380
General Aid-to-County			$30,580
Healthy Communities/Preparedness			$47,816
CFPT			$402
WIC			$59,258
CC4C			$3,584
CHSA Budget Transfer			
Transfer from main budget			$29,627
Social Services Reimbursement - Foster			$7,045
Revenue			
OBCM Projections			$32,250
CC4C Projections			$27,266
Clinic Revenue			$22,000
EH Fees			$82,500
County Funds	$11,860	$41,369	$236,850
Total	$11,860	$41,369	$606,790
Expenses			
EH			
1FTE Onsite/EH Supervisor		$6,835	$82,014
1FTE Food & Lodging		$5,863	$70,354
Scanning Fee	$2,500		
.5 FTE PRN On-Site			$32,256
Software			$5,000
OFFICE SUPPLIES			$4,000
TRAVEL			$8,500
Cell Phone		$333	$1,080
TELEPHONE			$360
POSTAGE			$1,500
M & R EQUIPMENT			$500
WIC/Breastfeeding Counselor			
1 FTE - WIC		$4,840	$58,078
TELEPHONE			$180
Medical Supplies			$1,500
TRAVEL			$1,000
CC4C/OBCM			
2 FTE - OBCM & CC4C		$9,394	$112,724
TELEPHONE			$360
TRAVEL			$2,000
EDUCATION/PREP/ACCREDITATION			
1 FTE - Public Health Program Manager			$70,354
TRAVEL			$500
Cell Phone			$540
TELEPHONE			$180

CLINIC			
EMR			$5,380
30 Days PRN Nurse			$6,055
1 FTE BSN Enhance Role Nurse		$5,863	$70,354
AIDS Supplies			$814
TRAVEL			$906
PROFESSIONAL SERVICES - MEDICAL			$500
OTHER MEDICAL SUPPLIES			$1,700
OFFICE SUPPLIES			$200
TELEPHONE SERVICE			$180
POSTAGE			$500
M & R - EQUIPMENT			$150
ADMIN			
Office Construction			
1FTE Mgt Support (Vital Records)		$3,342	$40,103
30 Days PRN Mgt Support (Vital Records)			$2,857
Training			$5,000
Support Contractor - Prep/Launch	$9,360	$3,900	
Contract Medical Director		$417	$5,000
TELEPHONE			$360
TRAVEL			$2,000
M & R - BUILDING			$1,000
M & R - EQUIPMENT			$2,000
JANITORIAL SUPPLIES			$1,000
INS - Malpractice		$458	$5,500
INS - PROF. LIAB.		$125	$1,500
DUES & SUBSCRIPTIONS			$750
Total	$11,860	$41,369	$606,790