



OREGON

MARION COUNTY HEALTH & HUMAN SERVICES
PUBLIC HEALTH DIVISION

EQUITABLE ACCESS TO PUBLIC HEALTH SERVICES ASSESSMENT REPORT

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ACKNOWLEDGMENTS

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INTRODUCTION

INTRODUCTION

On behalf of Marion County Health and Human Services - Public Health Division (MCHHS - PHD), Rede Group, an Oregon based consulting firm, conducted this assessment to assist MCHHS - PHD in evaluating how to focus organizational resources to increase health equity and exert the greatest impact on population health.

Like all governmental public health departments in Oregon, MCHHS - PHD experiences a lack of resources to fully implement the foundational public health services.¹ At the same time, significant changes in the landscape of public health over the past decade require local governmental health organizations to rigorously examine their programmatic and business models to ensure that: (1) adequate resources are devoted to preventing disease through policy, systems, and environmental changes that have the greatest potential to effect the largest number of people² and (2) the entire local health system has the preparation and capacity to address and reverse health inequities.

CLINICAL PREVENTIVE SERVICES

This assessment examines MCHHS - PHD's provision of clinical preventive services:

- + Family Planning (including Reproductive Health Programs),
- + Sexually Transmitted Infections,
- + Immunizations Services, and
- + Tuberculosis Program

Governmental public health's role in providing clinical preventive services is often tethered to historical norms that continue to inform attitudes and beliefs about how local health departments should function within a local health system. For example, beliefs that local governmental health must provide direct clinical preventive services to individuals who are experiencing poverty or are uninsured are still held by some people. In addition, since public health departments often offer convenient, respectful, culturally agile services, they may be preferred by some community members. However, in 2017, Oregon public health leaders clarified and codified core governmental functions related to clinical preventive services in a modern public health system.³

- a. Ensure ongoing planning with health care system partners, community members, and organizations that represent members of priority populations to:
 - i. Identify barriers to access and gaps in services;

notes:

1. BERK. (2016). *State of Oregon Public Health Modernization Assessment Report*. Retrieved from: <https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/PHModernizationReportwithAppendices.pdf>
2. Frieden, Thomas R. (2009). *A Framework for Public Health Action: The Health Impact Pyramid*. Retrieved from: <https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2009.185652>
3. Oregon Health Authority. (2017). *Public Health Modernization Manual*. Retrieved from: https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf

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- ii. Develop and implement strategic plans to address these gaps and barriers to care;
 - iii. Ensure access to effective clinical preventive services;
 - iv. Identify opportunities to work together to improve population health.
- b. Ensure access to clinical preventive services through provision or linkage to clinical preventive services to priority populations that may include youth and young adults, those not covered under federal programs because of citizenship status, and those who are historically not well-served by the healthcare system.
 - c. Recommend implementation of evidence-based clinical and community interventions for disease prevention, early detection, and self-management.

Similarly, National Public Health Accreditation Standards⁴ are explicit in clarifying that local public health departments are to ensure but not necessarily provide clinical preventive services.

STUDY QUESTIONS

Under the direction of MCHHS - PHD, the Rede Group developed this assessment to examine:

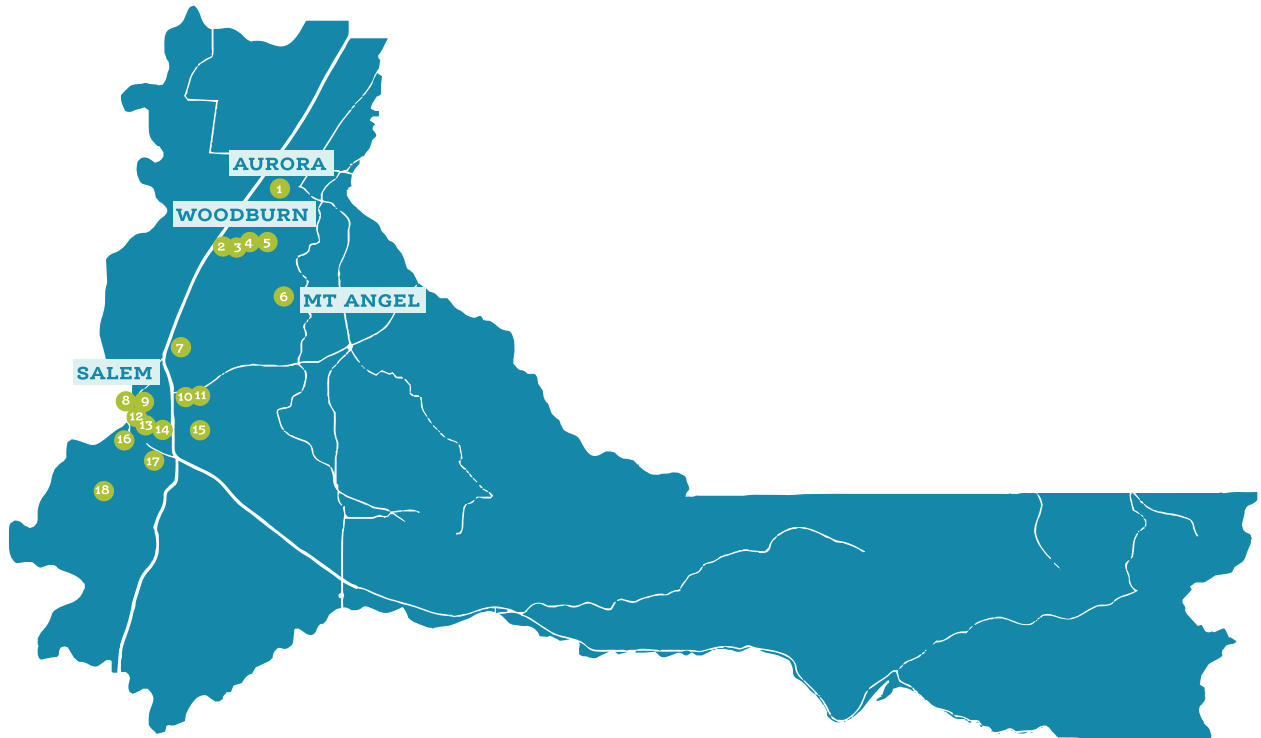
1. What is the long term stability and health equity impact of MCHHS - PHD's clinical preventive service programs?
2. What shifts in clinical preventive service programs should be undertaken to promote health equity?
3. If changes to clinical preventive service programs are necessary, how can transitions be managed to effectively support community members to find new methods of receiving clinical preventive services?

notes:

4. Public Health Accreditation Board. (2013). *Standards & Measures*. Retrieved from: <http://www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-2014.docx.pdf>

INTRODUCTION

Figure I: MCHHS - PHD safety net clinics



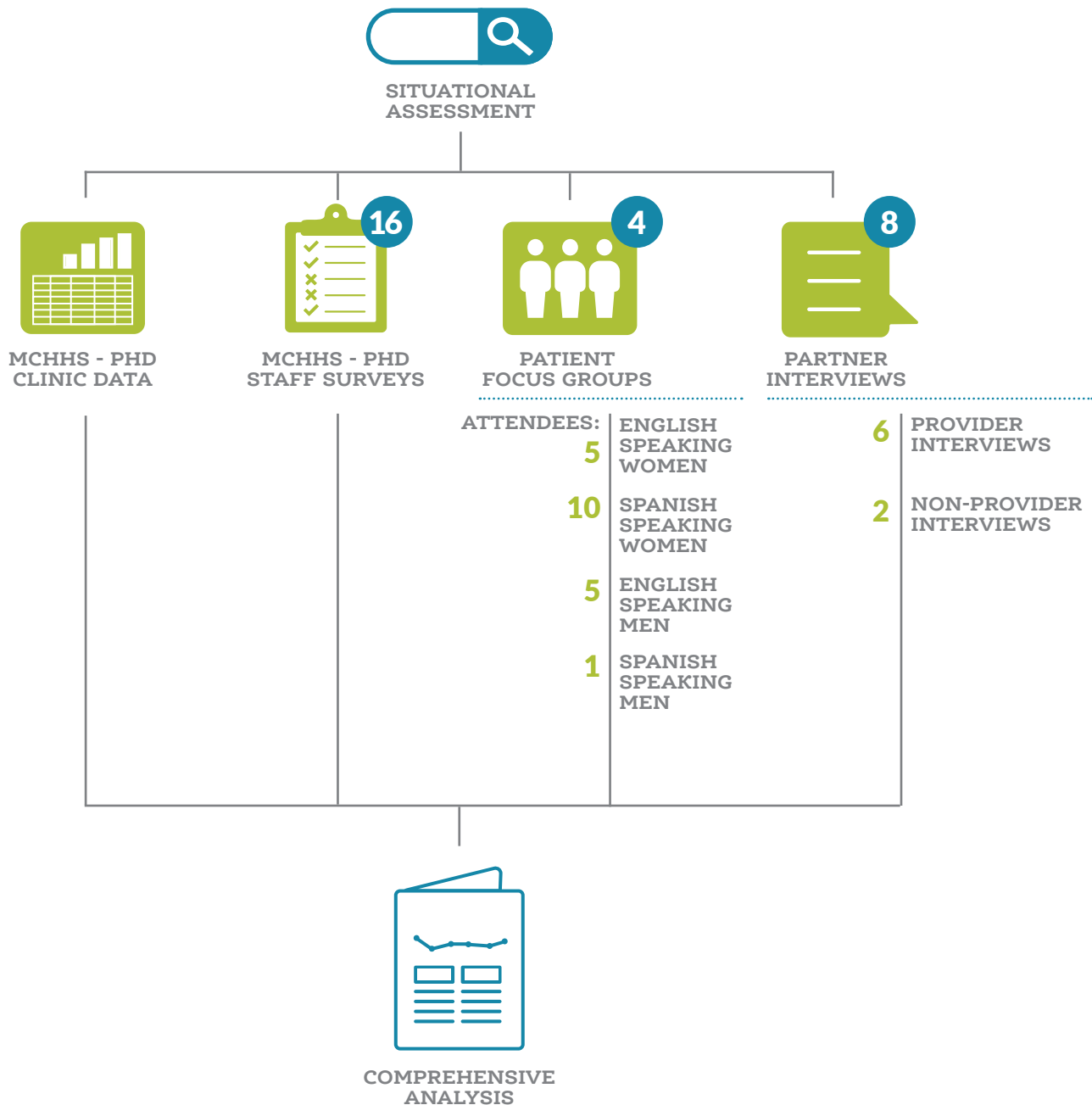
1. Aurora Family Health and Maternity Care Services
2. Woodburn Internal Medicine
3. Woodburn Family Medicine
4. Salud Medical Center
5. Pacific Pediatrics
6. Mount Angel Family Medicine
7. Chemawa Indian Health Center
8. West Salem Medical Clinic
9. Salem Free Clinic
10. Planned Parenthood
11. Lancaster Family Health Center
12. Host Youth and Family Program
13. Homeless Outreach & Advocacy Project
14. Salem Clinic - Primary Health Care Clinic
15. Willamette Family
16. Physicians Building Group
17. WVP Boulder Creek Clinic
18. The Doctors' Clinic, LLP



METHODS & ANALYSIS

METHODS & ANALYSIS

Figure 2: Components of the assessment



METHODS & ANALYSIS

This assessment included a combination of qualitative and quantitative data collection methods to gather information from three distinct stakeholder groups:

1. Community members who receive clinical preventive services from MCHHS - PHD;
2. MCHHS - PHD community partners including health care providers; and
3. MCHHS - PHD staff who are currently engaged in clinical preventive service programs.

Key assessment activities were comprised of structured interviews with MCHHS - PHD partners, both providers and non-providers, in-person focus groups with patients, and an online survey of MCHHS - PHD staff. In addition to the primary data sources, clinical preventive services data shared by MCHHS - PHD were analyzed in this study.

MCHHS - PHD CLINIC DATA

MCHHS - PHD provided Rede Group an Excel spreadsheet with de-identified clinic data to describe the count of unique “service tickets” (generated every time someone receives services) and the count of unique patients for four services areas: immunizations, family planning, sexually transmitted infections, and tuberculosis (See Appendix A). The sexually transmitted infections (STI) service area focuses on reportable STIs: HIV, Chlamydia, Gonorrhea and Syphilis. These data are from January 4, 2010, through December 31, 2019, and are used to show trends in utilization of the public health clinical services provided by MCHHS - PHD. The data were analyzed via pivot tables and charts in Excel.

PARTNER INTERVIEWS

SAMPLE AND DATA COLLECTION

Rede Group conducted eight key informant interviews with MCHHS - PHD partners (health care providers and non-providers). A list of 21 community partners was provided to the Rede Group by the MCHHS - PHD Director. Community partners were specified to partners serving non-dominant culture groups. An initial email was sent by the MCHHS - PHD Public Health Director to the 21 partners requesting participation in the interview for this study. Of the list of partners, 11 agreed to participate, one declined to participate, and 10 were unresponsive to the initial request. A follow-up email/phone call was conducted to non-responders by the Division Director. Rede Group distributed an interview scheduling email to the 11 partners who agreed to participate. Eight partners responded to the scheduling email and took part in an interview. Rede sent a follow-up email to non-responsive partners and the MCHHS - PHD Public Health Director was notified and conducted final outreach to non-responsive partners.

Two interview guides were developed; one for providers and one for non-providers (See Appendices B-C). Providers were asked about services they offer for immunizations, family planning, sexually transmitted infections, and tuberculosis. Non-provider partners were asked about where the population they serve/represent seek care for the four services areas. Both provider and non-provider interviews included questions about barriers to accessing these services for the populations they serve and

METHODS & ANALYSIS

expectations from MCHHS - PHD in managing changes in clinical preventive services currently provided. Both interview guides were reviewed and approved by the MCHHS - PHD project team. Rede Group conducted six interviews with health care providers representing four organizations and two interviews with non-provider partners in the community. An interviewer and a notetaker participated in each interview. Interviews were recorded and transcribed to aid in the accuracy of reporting.

ANALYSIS

Transcripts were analyzed using Dedoose⁵ qualitative analysis software, and quantitative data were analyzed in Excel tables. Data were analyzed to identify important themes and key narratives.

PATIENT FOCUS GROUPS & KEY INFORMANT INTERVIEW SAMPLE AND DATA COLLECTION

Rede Group conducted three in-person focus groups and one key informant interview with individuals who had received immunizations, family planning, sexually transmitted infections, and/or tuberculosis services at MCHHS - PHD in the past two years. Participants were recruited through the MCHHS - PHD clinic in person and by phone and email using patient contact lists. All interview participants were screened to ensure that themselves or their children had received clinical preventive services from MCHHS - PHD in the past two years and did not work for MCHHS - PHD. The screener also included a few demographic questions. Recruitment and focus group screening materials were distributed in English and Spanish and participants were offered a stipend of \$75.00. Rede group divided focus groups by gender (Women/Men) and language preference (English/Spanish). Interview questions were developed with input from the MCHHS - PHD project team (See Appendix D). They were designed to gather descriptive accounts of experiences, accessibility, and barriers to receiving immunizations, family planning, sexually transmitted infections, and tuberculosis services at Marion County Public Health Clinics and other providers in the area.

A total of 21 patients participated in a focus group/key informant interview. The number of participants in each focus group/key informant interview is shown in Table 1 on the following page. The men's Spanish group did not have enough attendees to conduct a formal focus group and, therefore, was structured as a key informant interview. Focus group guides were translated from English to Spanish and Spanish speaking groups were led by a Spanish speaking MCHHS - PHD staff member. Rede Group met with the Spanish speaking facilitators prior to performing the focus groups to review facilitation guidelines and ensure the translated interview guide was accurate. Rede Group staff led the focus groups in English and had a staff member in attendance at each of the focus groups to record and manage the group.

notes:

5. Dedoose Version 8.0.35, web application for managing, analyzing, and presenting qualitative and mixed method research data (2018). Los Angeles, CA: SocioCultural Research Consultants, LLC www.dedoose.com.

METHODS & ANALYSIS

Each focus group recording was transcribed; Spanish speaking focus groups were translated and transcribed. All transcripts were reviewed for accuracy before uploading to Dedoose for analysis.

Table 1: Focus group participants

Focus group	Number of participants
English speaking women	5
Spanish speaking women	10
English speaking men	5
Spanish speaking men (key informant interview)	1

ANALYSIS

Rede Group developed a coding tree based on predetermined and emerging codes. Transcripts were systematically excerpted by focus group attendee, and a theme analysis was applied. A code table was generated to examine the frequency of codes overall and by interviewee to inform the results in this report.

STAFF SURVEY

SAMPLE AND DATA COLLECTION

Rede Group conducted an electronic survey of MCHHS - PHD staff regarding the delivery of clinical preventive services at MCHHS - PHD, the impact of changes to services, and those most burdened by changes to services currently provided. The survey instrument included 14 open-ended questions and was reviewed and approved by the MCHHS - PHD project team (See Appendix E). Rede Group administered the survey to a list of MCHHS - PHD staff involved in providing and managing the provision of immunization, family planning, sexually transmitted infections, and tuberculosis services. The list of staff was given to the Rede Group by the MCHHS - PHD Director. The survey was distributed to 19 staff members through SurveyMonkey.⁶ The survey remained open for three weeks and three email reminders to complete the survey were sent. Staff were allowed to skip questions related to a particular service (immunizations, family planning, sexual transmitted infections, tuberculosis) if they were not familiar with those services provided at MCHHS - PHD. Rede Group received 16 survey responses from MCHHS - PHD staff (84% response rate).

ANALYSIS

Rede Group extracted the surveys from SurveyMonkey and uploaded individual responses into Dedoose for qualitative analysis. Survey responses were coded by service and analyzed for themes.

notes:

6. Survey Monkey, online survey development software. SurveyMonkey Inc. San Mateo, California, USA. www.surveymonkey.com



RESULTS

RESULTS: CLINIC DATA

MCHHS - PHD CLINIC DATA

MCHHS - PHD provided Rede Group with 2010-2019 clinic data to examine trends over time (years). In 2019, approximately 2500 unique patients received clinical public health services at MCHHS - PHD.⁷ This represents less than 1% of the approximately 346,868 Marion County residents (2018 US Census).

The clinic data can be examined in two ways: the count of service tickets which represents a service provided (e.g., a vaccination, an HIV test, etc.); or the count of unique patients who received services at MCHHS - PHD each year. Importantly, the same patient may have received multiple services in the same year, which is why there is a higher number of service tickets compared to patients. For example, there were approximately 2000 service tickets submitted in 2019 for tuberculosis, but approximately 100 patients received those services in the same year (See Appendix A for exact numbers). This is because each tuberculosis case will generate numerous service tickets due to the intensity of services required for appropriate intervention and care.

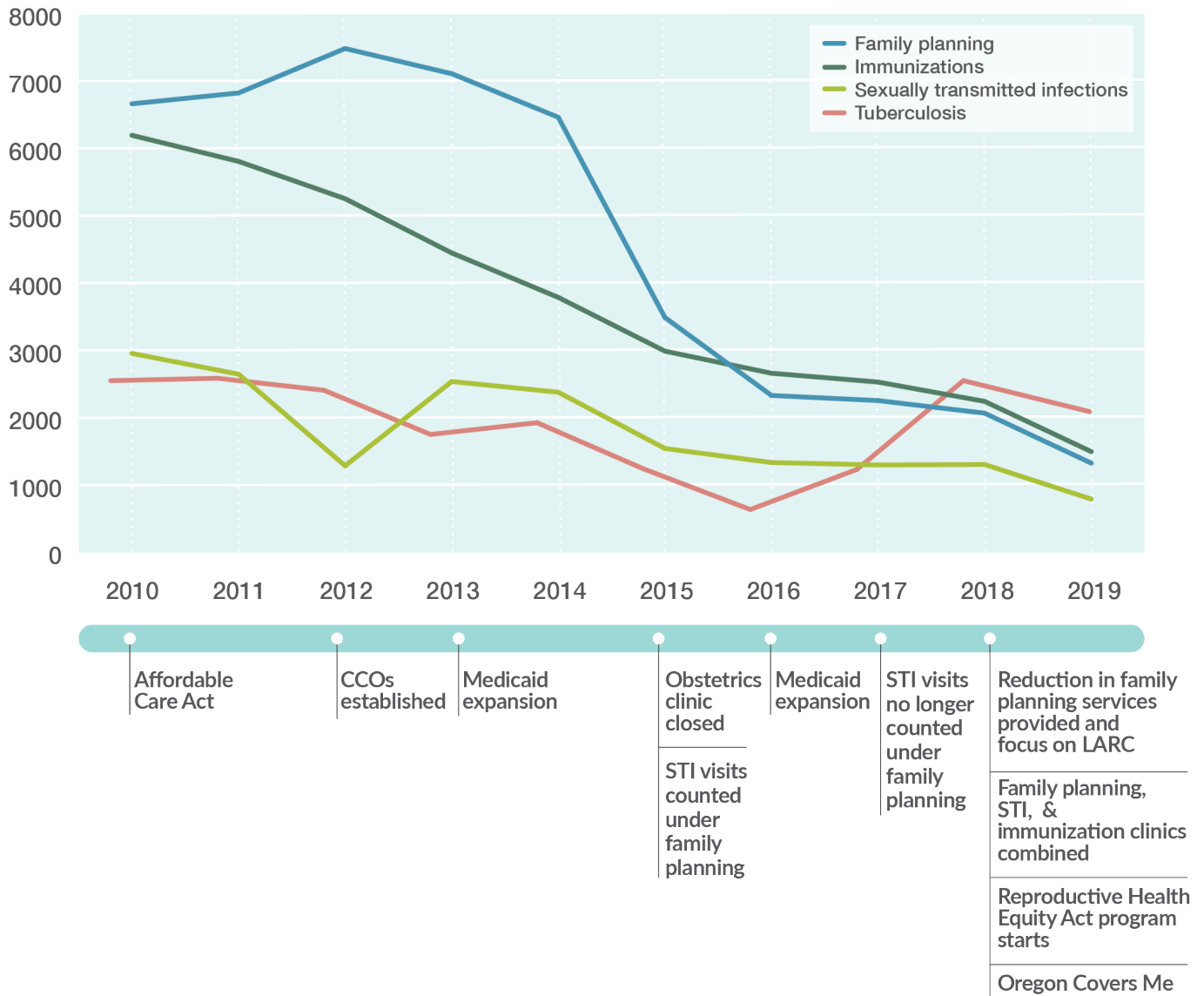
Figure 3 on the following page displays the count of unique service tickets; all services provided have declined, especially since 2014. Between 2010 and 2019, family planning service tickets declined by 80%, immunizations by 75%, sexually transmitted infections by 73%, and tuberculosis by 15%. (Note: the data on unique patients receiving tuberculosis services does not show an increase between 2016-2018, see Figure 12). Additional internal and external factors that may have impacted services are displayed in the timeline below the graph.

notes:

7. Because some patients may receive services in multiple service areas, there is not an exact total for unique patients seen by MCHHS - PHD in a year

RESULTS: CLINIC DATA

Figure 3: Count of unique service tickets by public health service area, 2010-2019



RESULTS: CLINIC DATA

Figure 4: Count of family planning service tickets per quarter, 2010-2019 with trendline

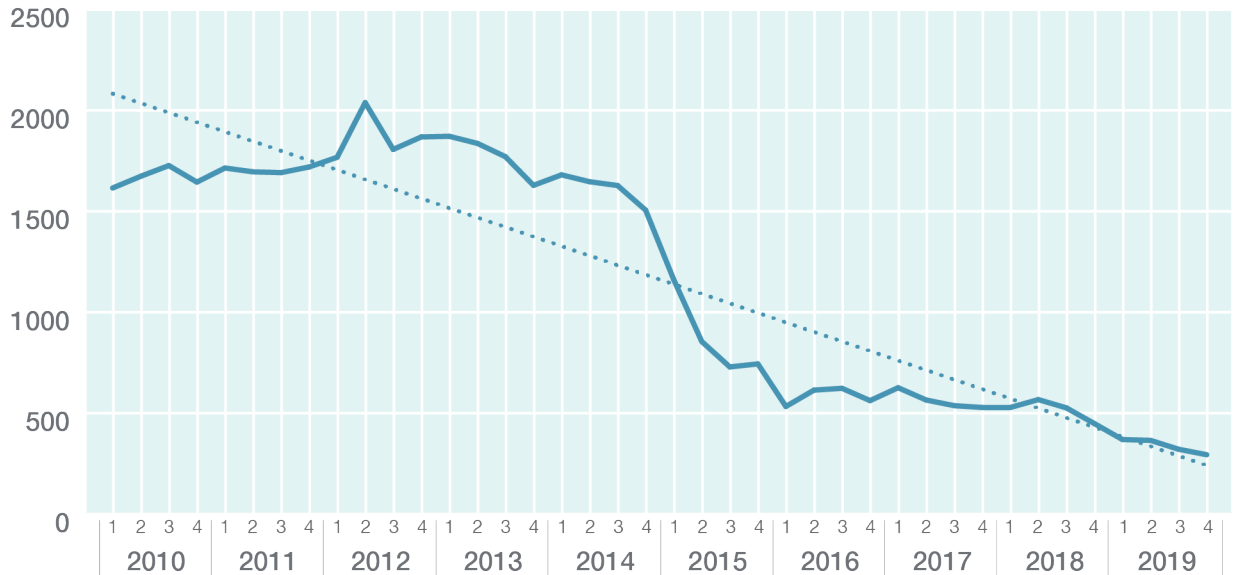
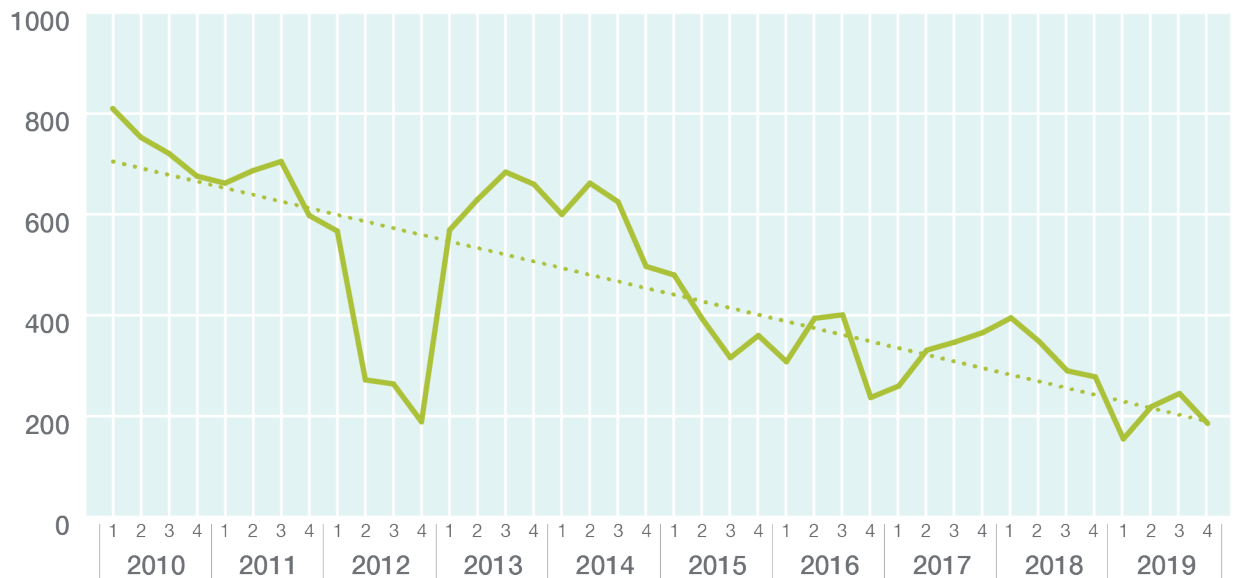


Figure 5: Count of sexually transmitted infection service tickets per quarter, 2010-2019 with trendline



RESULTS: CLINIC DATA

Annual variability seen in immunization services provided each year (Figure 6) are most likely related to school exclusion days when students are required to get vaccinations or they can no longer attend classes. The same variability is not seen in the data for unique patients receiving immunization services (see Figure 11).

Figure 6: Count of immunization service tickets per quarter, 2010-2019 with trendline

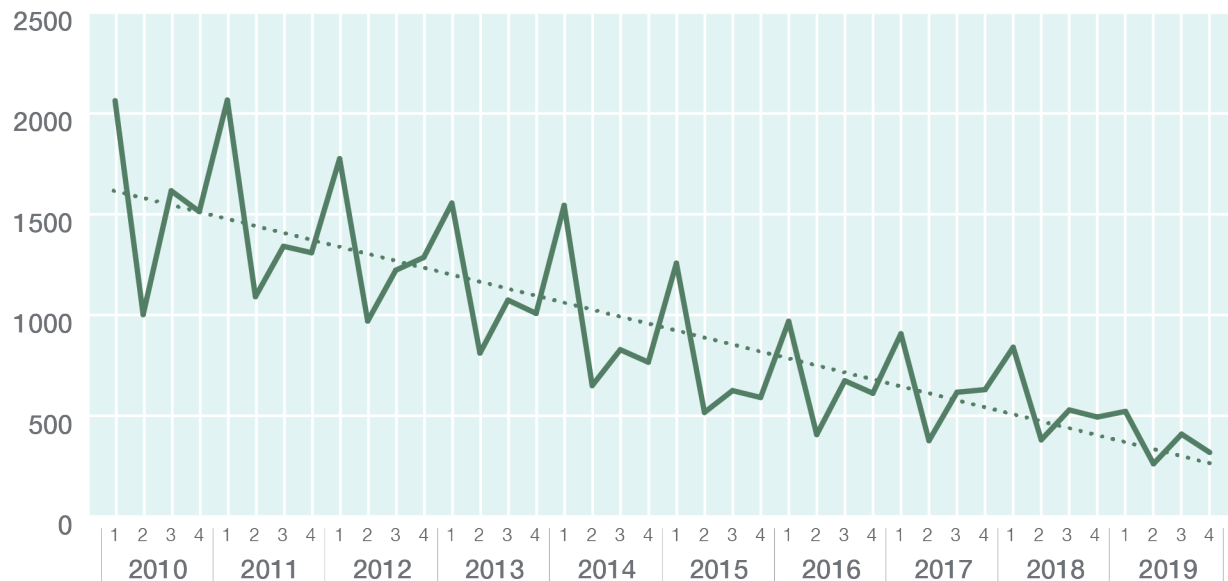
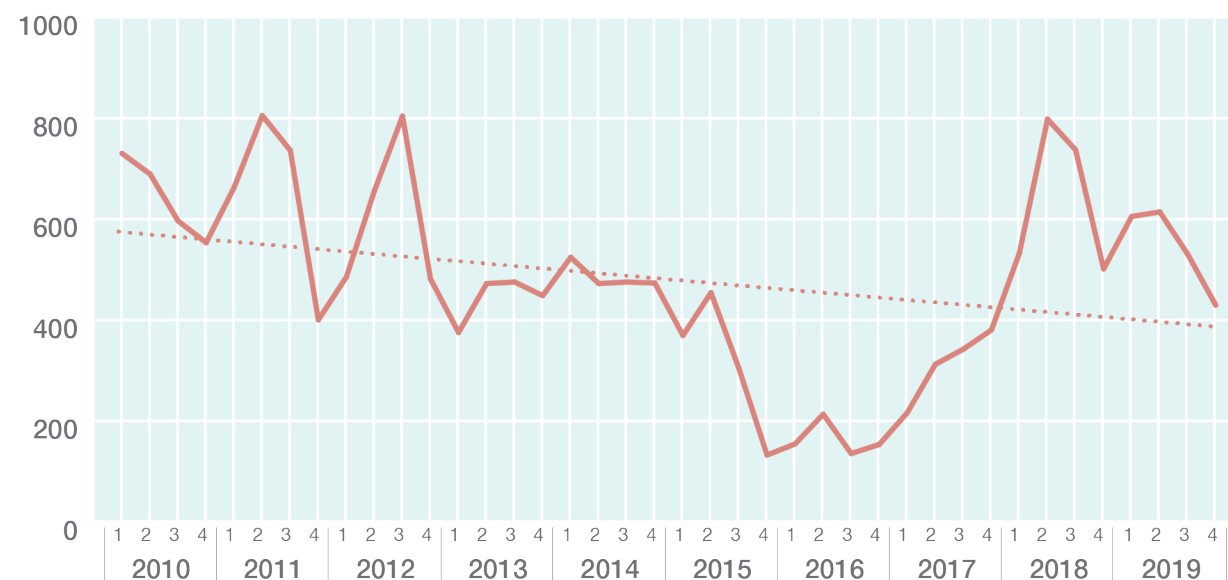


Figure 7: Count of tuberculosis service tickets per quarter, 2010-2019 with trendline



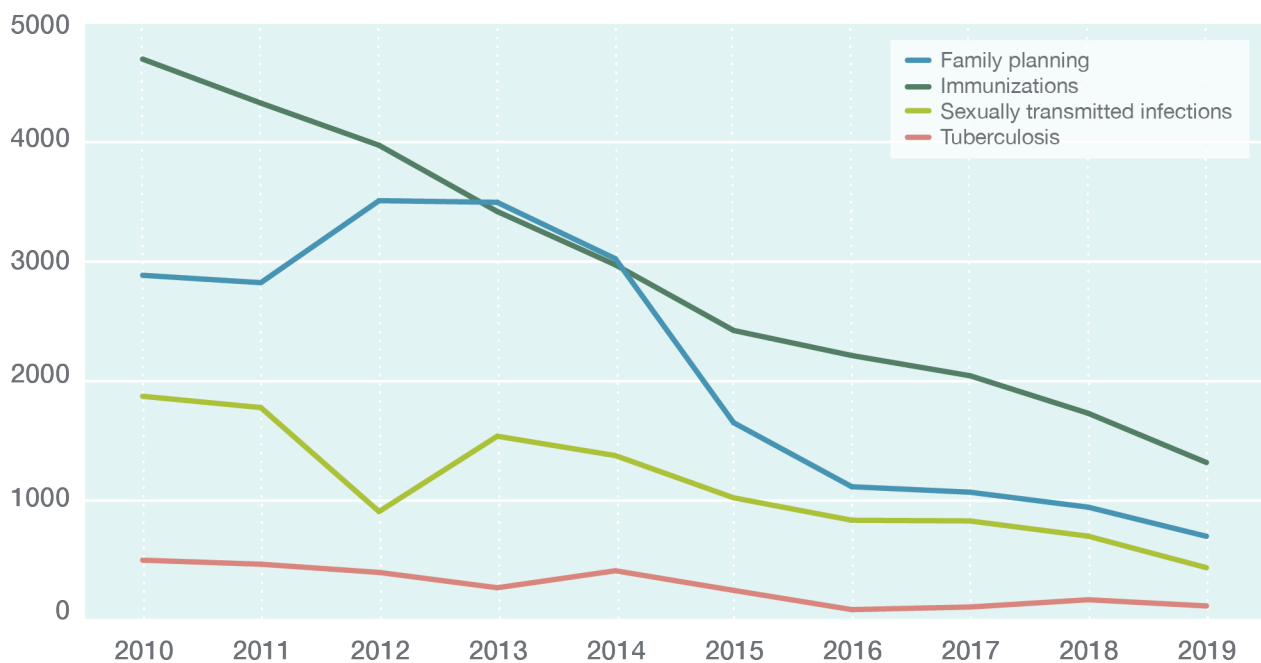
RESULTS: CLINIC DATA

Another way to look at clinic data is by the count of unique patients. These data show similar reductions as seen in the declining number of service tickets in Figure 3. Between 2010 and 2019, family planning patients declined by 76%, immunization patients by 72%, sexually transmitted infection patients by 77%, and tuberculosis patients by 76%. The 15% reduction in tuberculosis tickets compared to the 76% reduction in the number of patients receiving tuberculosis services may be explained by the intensity of services required for appropriate intervention and care for each patient.

Table 2: Percent decrease in public health services, 2010-2019

Public health service area	Service tickets	Unique patients
Family planning	80%	76%
Sexually transmitted infection	75%	72%
Immunization	73%	77%
Tuberculosis	15%	76%

Figure 8: Count of unique patients by public health service area, 2010-2019



RESULTS: CLINIC DATA

Figure 9: Count of unique patients receiving family planning services, 2010-2019 with trendline

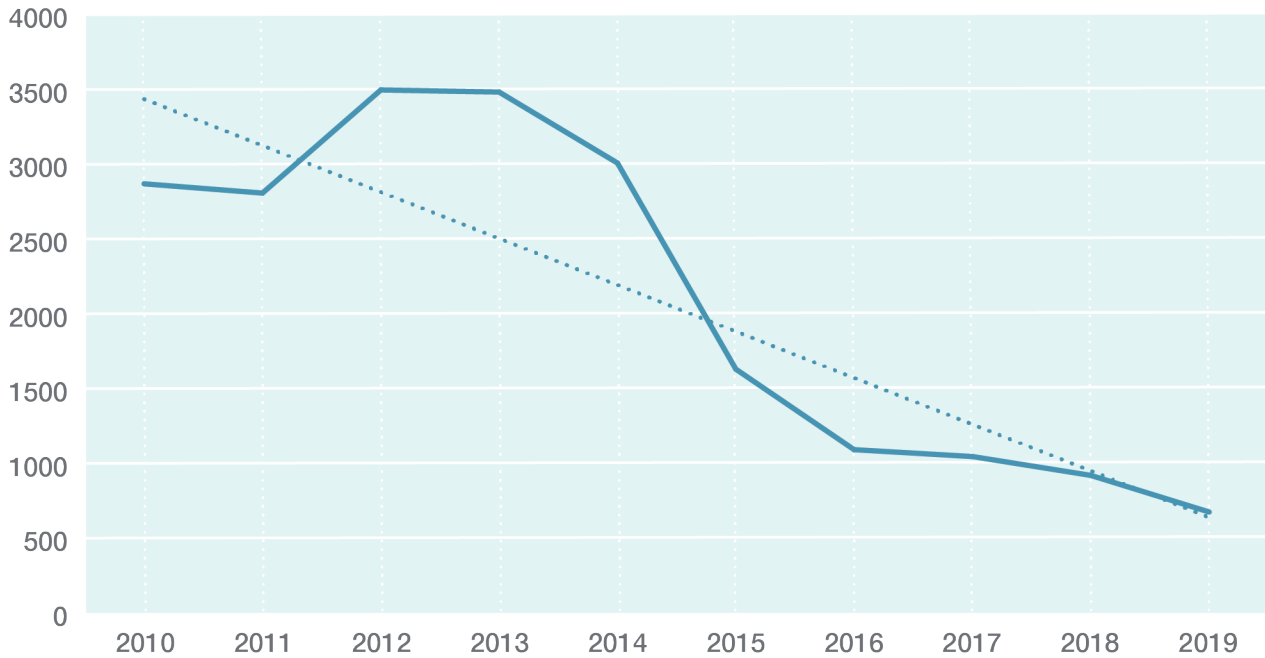
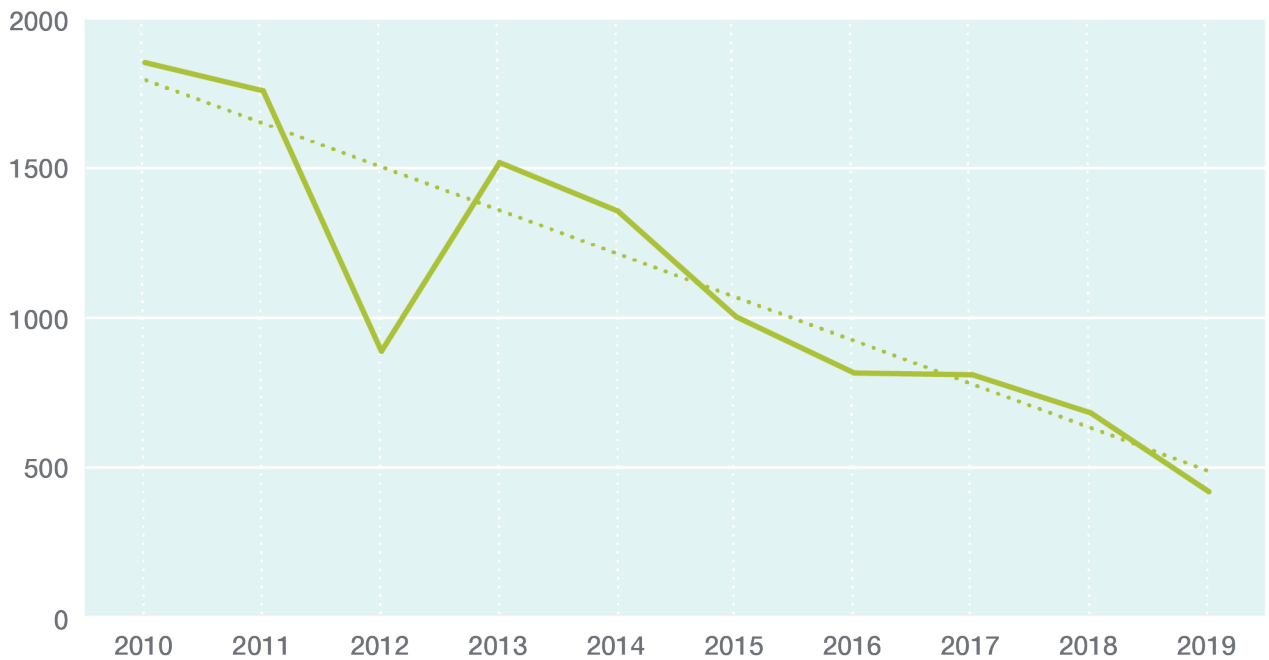


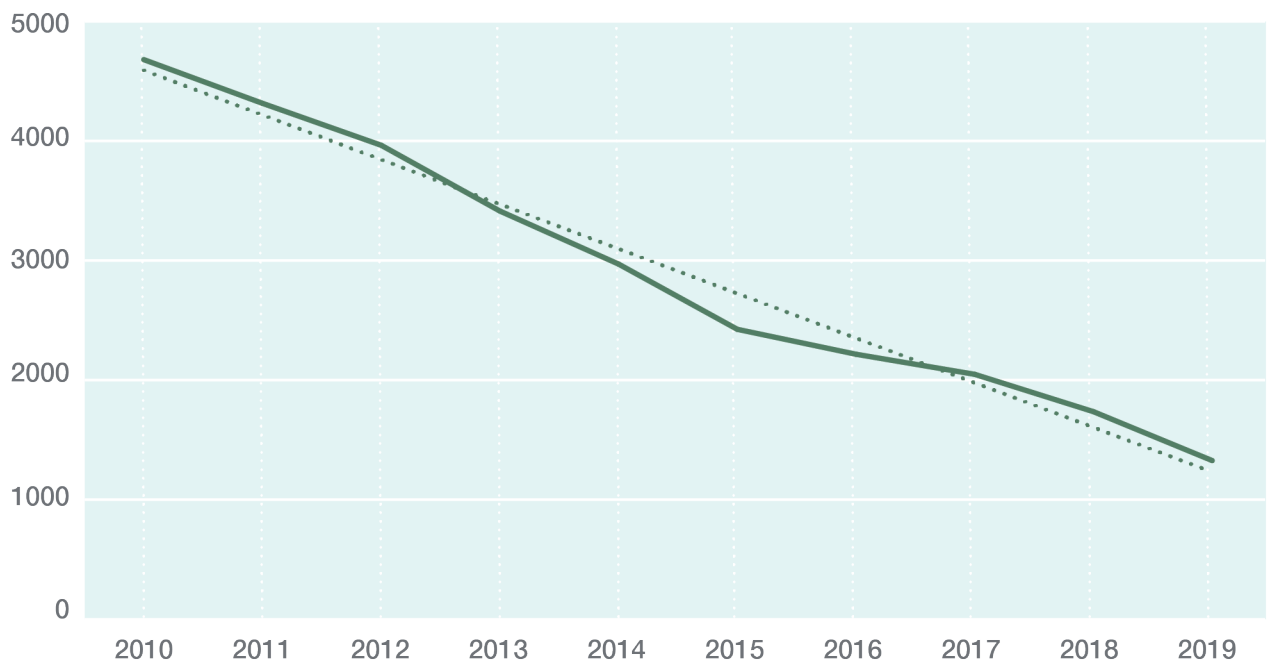
Figure 10: Count of unique patients receiving sexually transmitted infection services, 2010-2019 with trendline



RESULTS: CLINIC DATA

The annual variability seen in immunization service tickets (Figure 6) are not reflected in the number of patients receiving immunization services (Figure 11). This is most likely due to each patient receiving multiple vaccinations at one time.

Figure 11: Count of unique patients receiving immunization services, 2010-2019 with trendline

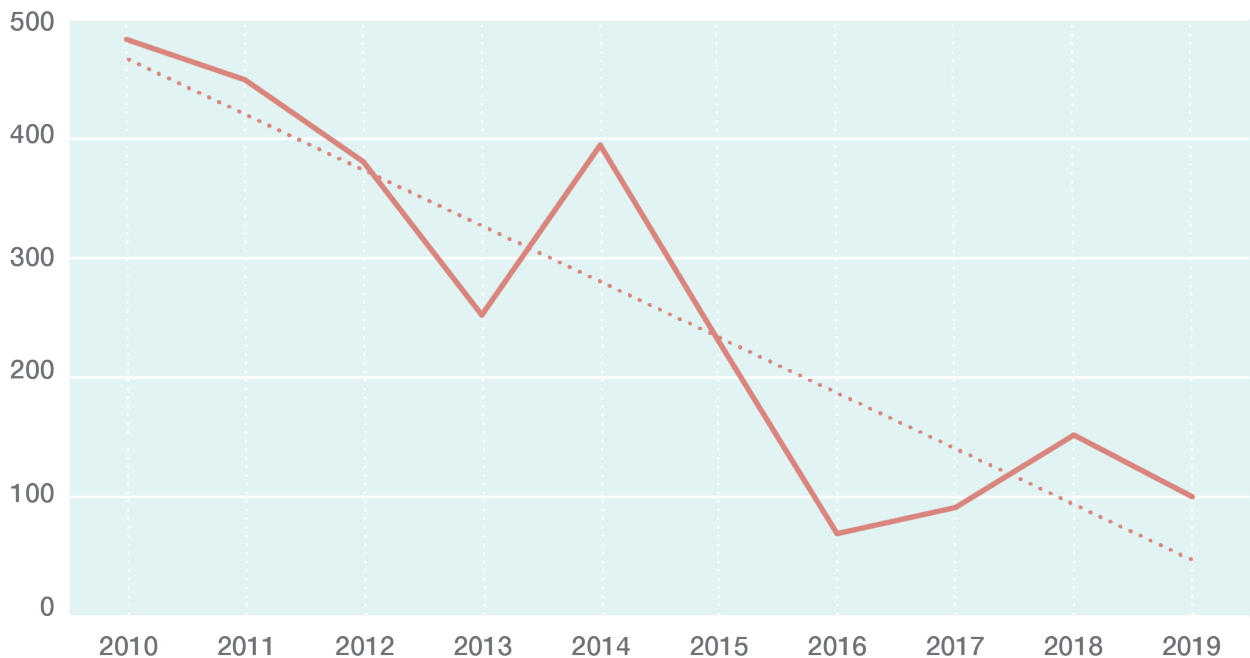


RESULTS: CLINIC DATA

In 2013 there was a potential tuberculosis cluster in Marion County which caused a spike in the tuberculosis incidence rate.⁸ This may be reflected in the 2013 increase in patients receiving tuberculosis services at MCHHS - PHD, see Figure 12.

People exposed to known TB patients, in a variety of settings, are at risk of contracting LTBI and active TB, especially within the first year of exposure. Contact investigations are a key public health practice to prevent the spread of disease, and involve identifying and evaluating anyone who may have been in contact with someone who has TB to identify potential new cases of TB. Although contact investigations are critical to reducing TB in Marion County, they are resource intensive and are not necessarily reflected in the number of unique patients receiving TB services at MCHHS - PHD. For example, in 2018, over 569 contacts were identified and 527 were evaluated for TB and LTBI.

Figure 12: Count of unique patients receiving tuberculosis services, 2010-2019 with trendline



notes:

8. Marion County Health Department. (2017). Community Health Assessment. Retrieved from: <https://www.co.marion.or.us/HLT/communityassessments/Documents/2017CHAUpdate.pdf>

RESULTS: INTERVIEWS & SURVEY

PARTNER INTERVIEWS, PATIENT FOCUS GROUPS & KEY INFORMANT INTERVIEWS, AND STAFF SURVEY

This assessment included three primary data sources: interviews with MCHHS - PHD partners, focus groups/key informant interview with patients, and a survey of MCHHS - PHD staff. This section of the report includes the results of primary data collection efforts. Interviews and surveys included a series of open and closed-ended questions.

REASONS FOR RECEIVING SERVICES AT MARION COUNTY PUBLIC HEALTH CLINIC

In this study, community partners interviewed, focus group participants, and MCHHS - PHD staff surveyed described reasons community members utilize immunization, family planning, sexually transmitted infections, and/or tuberculosis services at the Marion County Public Health Clinics. Table 3 summarizes themes identified within and across data collection groups (partner interviews, focus groups, staff surveys). In some cases, those informing the study identified reasons that applied to specific services. In other cases, statements were more generalized across all clinical preventive services provided by MCHHS - PHD. Although 16 staff surveys were submitted, only 14 included responses to questions analyzed and presented in Table 3 and 4.

Table 3: Reasons for receiving services at Marion County Public Health Clinic

Reasons for receiving services	Percent of community partners interviewed (n=8)	Percent of patient interview groups (n=4)	Percent of staff surveyed (n=14)
Respectful providers and staff	0%	100%	14%
Sexually transmitted infection and reproductive health services provided with anonymity	63%	25%	21%
Between providers, no established primary care provider, or only see a health care provider when sick	0%	50%	43%
Difficulty navigating the healthcare system including accessing services through their insurance and lack of awareness of services provided through their primary care provider	13%	50%	21%
Low cost or no cost of services (uninsured)	0%	50% (unable to identify insurance status)	79%
Low cost or no cost of services (insured)	0%		36%
Ability to be seen quickly for an appointment	13%	50%	14%

RESULTS: INTERVIEWS & SURVEY

Reasons for receiving services	Percent of community partners interviewed (n=8)	Percent of patient interview groups (n=4)	Percent of staff surveyed (n=14)
Partners or family members receive services at MCHHS - PHD	13%	50%	0%
Primary care provider does not provide immunizations	25%	0%	36%
Other providers do not provide all sexually transmitted infection treatment and birth control services needed	0%	25%	29%
Availability to communicate and provide paperwork in Spanish	0%	50%	0%
Primary care providers, community clinics, or emergency departments send patients to Marion County Public Health Clinic	13%	25%	14%

Focus group participants in this study did not describe the absence of immunization services offered by their primary care provider as a reason for receiving services at the Marion County Public Health Clinic. However, the results of a survey of patients receiving immunization services conducted in winter 2019 by MCHHS - PHD immunization providers, showed some patients on OHP reported going to the Public Health Clinic to receive immunization services for this reason.

RESULTS: INTERVIEWS & SURVEY

BARRIERS TO ACCESSING SERVICES

Partner and patient interviewees described several barriers to accessing immunizations, family planning, sexually transmitted infections, and tuberculosis services in their community. Table 4 lists the barriers identified as thematic within and across data collection groups. Two providers interviewed described there to be no barriers regarding access to services in the community.

Table 4: Barriers to accessing services at Marion County Public Health Clinic

Barriers to accessing services	Percent of community partners interviewed (n=8)	Percent of patient interview groups (n=4)
The knowledge that services are available and where they are provided	25%	100%
Cost or fear of cost of services	38%	75%
Stigma	38%	25%
Lack of providers	0%	75%
Unable to receive treatment needed	0%	50%
Availability of appointments during times individuals are not working	13%	25%

Note: MCHHS - PHD staff were not asked specific questions about barriers to accessing services

When focus group participants were asked to describe what would make it easier to access immunization, family planning, sexually transmitted infections, and/or tuberculosis services, the most common answer was education about where to access existing services (at the Public Health Clinic and other community providers) and the importance of seeking services. Other factors that would increase access included bilingual clinic staff and forms provided in Spanish, lower cost of services, and transportation to clinics.

RESULTS: INTERVIEWS & SURVEY

PERCEPTIONS ABOUT CLINICAL SERVICES AND COMMUNITY NEED

Partners interviewed and MCHHS - PHD staff surveyed identified populations that would be most burdened by changes to clinical preventive services provided at MCHHS - PHD clinic. If changes are implemented, the change team should take special consideration to ensure access to clinical preventive services for the following groups: adolescents/teens; African American; Compact of Free Association Migrants (COFA Communities); County prisoners; exchange students; Hispanic; homeless; immigrants; LGBTQ+; low-income; non-English speakers; Pacific Islander; refugees; uninsured; women.

A majority of MCHHS - PHD staff surveyed felt that clinical preventive services provided by the County fill an important need in the community.

Percent of staff surveyed highlighting a need in the community for clinical preventive services provided by the Public Health clinic:

- + Immunizations – 86% of staff surveyed
- + Sexually transmitted infections – 79% of staff surveyed
- + Family planning – 69% of staff surveyed
- + Tuberculosis – 78% of staff surveyed

The change process should include the intentional involvement of MCHHS - PHD staff, taking into consideration their experiences. It will be essential to share with staff the intended outcomes of the change and steps the change team will take to ensure populations currently served by the Marion County Public Health Clinic continue to receive the care they need.

Although many staff expressed concern about changes in clinical preventive services provided by MCHHS - PHD, a few staff shared the sentiment that the provision of services outside of the primary care provider contributes to sporadic and fragmented care.

EXPECTATIONS ABOUT CHANGE

MCHHS - PHD staff described the following expectations from the MCHHS - PHD change management team:

- + Extensive communication to the community and providers about the changes, the reason for the change, services that remain at MCHHS - PHD and who can access them, and where services can be accessed that were previously provided by the Marion County Public Health Clinic
- + Include staff in the decision-making process

MCHHS - PHD partners described the following expectations from the MCHHS - PHD change management team:

- + Extensive communication to the community and providers about the changes, the

RESULTS: INTERVIEWS & SURVEY

reason for the change, services that remain at MCHHS - PHD and who can access them, and where services can be accessed that were previously provided by the Marion County Public Health Clinic

- + Communications distributed through a variety of methods including social media, print, radio, YouTube, Closed Circuit Television.
- + Communications provided in multiple languages
- + Engagement with PacificSource CCO to disseminate information about the change
- + Ensure patients referred to a primary care clinic understand and agree to establish a primary care home for services

Providers interviewed in this study were not concerned about adding new clients who currently receive services through the Marion County Public Health Clinic. One provider was already in the process of increasing capacity to shrink wait times and increase the number of patients seen through their clinic.

POPULATION-BASED HEALTH INTERVENTIONS

MCHHS - PHD staff identified opportunities for population-based health interventions within the foundational public health program if additional funding became available. A high level of consistency existed among survey respondents identifying the following possibilities:

- + Increase MCHHS - PHD staff to provide the services offered adequately
- + Community education regarding the services offered at MCHHS - PHD clinic and the importance of seeking services. Provide sexually transmitted infection and reproductive health education
- + Community partner engagement and education
 - Provide data to community partners that will help to address barriers to receiving services for the populations they serve
 - Work with community partners to address the social determinants of health
- + Focus on issues not typically addressed before such as pollution and antibiotic resistance



DISCUSSION

DISCUSSION

SUMMARY

- + Since 2010, MCHHS - PHD has experienced a significant decline in the demand for clinical preventive services in: immunization, family planning, and sexually transmitted infection programs. This finding is expected in a post Affordable Care Act and Medicaid Expansion environment
- + When considering changes, community health care providers, community partners, and MCHHS - PHD staff express concerns, citing a fear that uninsured/underinsured individuals will not receive care elsewhere because no other provider in the county will be able or willing to provide these services
- + Current MCHHS - PHD patients describe ease of effort, short wait times for scheduling appointments, respectful clinicians/staff at MCHHS - PHD, and materials available in alternate languages as main reasons for seeking services at MCHHS - PHD

PROGRAM SPECIFIC CONSIDERATIONS: IMMUNIZATIONS

Statewide, some Coordinated Care Organizations are assigning OHP-covered children to providers who do not offer immunizations or do not offer immunizations to children on OHP. This appears to have been the case in Marion County under the former Coordinated Care Organization, Willamette Valley Community Health. Thus, primary care providers are referring patients to MCHHS - PHD for immunizations. Given the strong evidence that all clinical preventive service metrics are improved when provided by primary care providers (indeed, this is the very point of a primary care provider), and the likelihood of attrition between referral by a primary care provider to MCHHS - PHD, this circumstance is being addressed by MCHHS - PHD.

Due to reductions in demand for services, Local Public Health Authorities in Multnomah, Washington, and Clackamas County have discontinued, contracted out, or dramatically reduced immunization services.

“It is important to ensure community health providers are able to provide the same services as the Public Health Clinic.”

—MCHHS - PHD STAFF

“Immunizations are a direct service that MCHHS - PHD does well. Providing immunizations meets a need that may not be able to be addressed by local providers. We have clients who come to us for immunizations because they are new to the area and have no provider and no insurance, but need to get immunizations before they can begin school.”

—MCHHS - PHD STAFF

DISCUSSION

SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections (HIV, chlamydia, gonorrhea, and syphilis) are a significant public health problem in Marion County. According to the CDC, rates of combined cases of gonorrhea, chlamydia, and syphilis continue to rise.⁹ Left untreated, STIs can cause reproductive health complications including infertility, increased risk of HIV (non-HIV infections), and long term abdominal/pelvis pain.

Some respondents to community partner interviews and staff surveys opined that some individuals do not want to visit their primary care provider to receive testing for STI's due to fear of being judged or having their disease status revealed to others.

TUBERCULOSIS

Tuberculosis is an airborne infection, requiring public health and legal interventions. According to OAR 333-018-00(00),(05),(10),(15), health care providers are required to report tuberculosis cases or suspected cases to the Local Public Health Authority within one day of detection.

In order to protect public health, active cases of tuberculosis require intensive follow-up by public health departments in the form of Directly Observed Therapy.

The Oregon Health Authority provides limited financial support to Local Public Health Authorities for Tuberculosis programs; evidence suggests the MCHHS - PHD tuberculosis program is understaffed with the current workload.

“You don’t feel like your name’s being broadcast [at the Public Health Clinic]. It feels like if I go to my regular PCP, everyone knows me.”

—FOCUS GROUP PARTICIPANT

“Since we don’t test for every STI (like herpes or genital warts), we often end up referring people to other community clinics, which represents a further burden on the client.”

—MCHHS - PHD STAFF

“It’s quick and easy [at the Public Health Clinic]. There’s very little wait time. It’s not, ‘take this card and sit in a waiting room,’ it’s a very personable feel. They don’t ask any questions. You don’t need to be referred or anything like that. You don’t have to call and make an appointment. You can literally just come in and take care of your needs.”

—FOCUS GROUP PARTICIPANT

notes:

9. *Sexually Transmitted Diseases – Reported Cases and Rates of Reported Cases*, United States, 1941-2018*
<https://www.cdc.gov/std/stats18/tables/1.htm>

DISCUSSION

FAMILY PLANNING

Children and family health is significantly improved when women have access to evidence-based family-planning services. In addition, “prominent racial/ethnic and socioeconomic disparities in rates of unintended pregnancy, abortion, and unintended births exist in the United States. These disparities can contribute to the cycle of disadvantage experienced by specific demographic groups when women are unable to control their fertility as desired”.¹⁰

In 2017, the Oregon Reproductive Health Equity Act was passed to increase access to quality programs. This law provides for expanded coverage for some Oregonians to access free reproductive health services, as well as protections for the continuation of reproductive health services with no cost sharing, and prohibits discrimination in the provision of reproductive health services (Reproductive Health Equity Act, HB 339, 2017).

In addition, community-based family planning-programs that bring family planning information and methods to women and men, as well as adolescents, in the communities where they live and work, rather than requiring visits to health facilities show promise in improving outcomes and reducing disparities.¹¹

“If services end here, I do not see anyone in the community willing to care for our clients. We support a lot of the community clinics with LARCs. Clients can get in quickly for a LARC here and that is very important to preventing unplanned pregnancies.”

—MCHHS - PHD STAFF

“We would want to accept new patients, but we want them to be agreeable to being our patients. We wouldn’t be someone that would be there for a one-time immunization. We would like to be primary care.”

—PARTNER INTERVIEW

notes:

10. Dehlendorf, C., Bryant, A. S., Huddleston, H. G., Jacoby, V. L., & Fujimoto, V. Y. (2010). Health disparities: definitions and measurements. *American journal of obstetrics and gynecology*, 202(3), 212–213. doi:10.1016/j.ajog.2009.12.003. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835625/>
11. Measure Evaluation. *Family Planning and Reproductive Health Indicators Database. Community-Based Family Planning Services*. Retrieved from: https://www.measureevaluation.org/prh/rh_indicators/family-planning/cbfp



RECOMMENDATIONS

RECOMMENDATIONS

The following pages contain recommendations based on the results of this assessment.

In short, we suggest that MCHHS - PHD consider transitioning the provision of select clinical preventive services in the program areas of Family Planning, STI Screening, Testing, and Treatment, and Immunizations to community providers.

Taken individually, each of these changes will require significant effort for staff at MCHHS - PHD. Taken as a whole, this set of recommendations represents a body of work that must be undertaken incrementally.

We suggest MCHHS - PHD implement changes by program area, starting with either Family Planning or Immunizations. Unless significant resources are directed at restructuring and community education, we recommend undertaking one change process at a time with no less than one year to enact a full process. This aggressive timeline allows for establishing change plans, engaging community providers, negotiating timing with community providers, providing technical assistance, working to transition (and possibly retrain) affected staff and critically educate the community about pending change and evaluate community impact. To support evaluation, we recommend to actions: During the transition phase, build a simple database with contact information for current MCHHS - PHD patients; and During the Monitor/Quality Improvement phase, conduct brief telephone surveys to assess patient experiences with community providers.

This sequenced approach allows for learning and quality improvement in change initiation and management that can be applied to subsequent change processes. Timelines for enacting a change process can be reduced to approximately six to seven months with additional resources including (minimally):

- + Allocation of FTE at no less than .5 for planning, provider outreach, and technical assistance, active client referral management ; and
- + Funds for community education/notification to conduct telephonic and direct mail campaigns

Initiating and managing structural change requires significant intellectual and emotional resources across the entire organization. Designing a new structure with community partners while managing the current structure can lead to fatigue and stress. Change architects must manage the healthy tension that accompanies any change while monitoring employee morale. As changes progress, change teams must be encouraged to innovate and experiment retaining approaches that work and discarding those that do not.

FAMILY PLANNING

RECOMMENDATIONS:

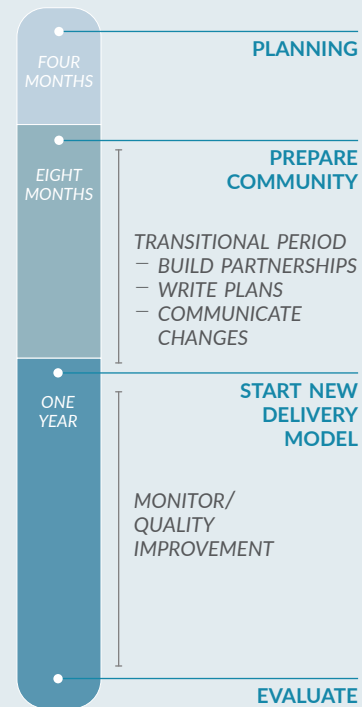
Modify current approach to:

1. Develop strategic partnerships with shared accountability to support public health goals related to reproductive health
2. Identify provider(s) within the county willing to provide family planning services through Reproductive Health Provider application and certification process with OR RH Program which includes all RH funding sources. If applicable, (i.e., previously provided reproductive health clinical services) develop and execute a transition plan, to ensure that current clients are aware of options for continued care
3. Consider strategic partnerships with the Coordinated Care Organization and community providers to increase utilization of evidence based family planning methods
4. Given the reduction in demand for services at the Woodburn Clinic, consider closing this clinic first

EVALUATION METRICS:

- Build a current MCHHS - PHD patient list to conduct a telephone survey one year post transition
- Assess/increase number of community providers who are certified under the Oregon Reproductive Health Program
- Assess/increase the number of community providers providing evidence based family planning methods

TIMING:



RATIONALE:

Like all clinical preventive services, family planning is best when provided by a primary care provider. Moreover, Oregon's Reproductive Health Equity Act expands availability of reproductive health (i.e., family planning) services to individuals who previously did not qualify due to immigration status and barrier to access, such as cost-sharing for low-income individuals, have been eliminated. Ensuring that community providers are providing women with appropriate family planning services will stabilize reproductive health services throughout the community.

IMMUNIZATIONS

RECOMMENDATIONS:

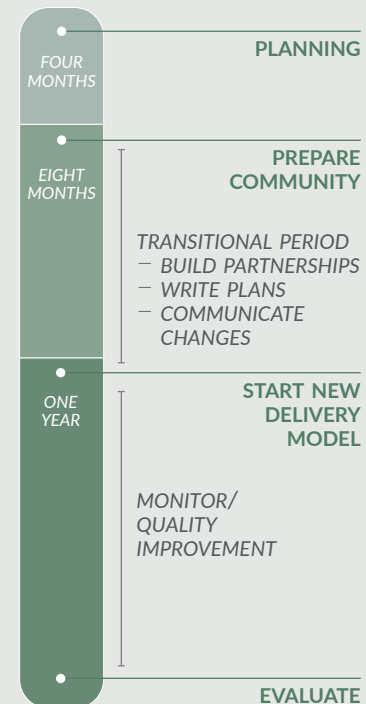
Re-envision immunization programs to focus on:

1. Ensuring access to all immunization-related services necessary to protect the public and prevent the spread of vaccine-preventable disease through providing guidance and best practices for the provision of clinical preventive services to local organizations, including those that serve community members with lower access to care.¹² Maintain capacity to respond to emergent vaccination needs
2. Acting as a convener and health strategist, MCHHS - PHD should work with local providers to improve cultural responsiveness related to immunization across Marion County's health care system to ensure vaccines are provided at convenient times and locations, and that no one is denied immunizations due to inability to pay
3. Provide a list of contact information of clinics offering immunizations
4. Addressing vaccine hesitancy especially in vulnerable populations who have been targeted by misinformation campaigns. Provide interventions with communities that are disproportionately non-immunized
5. Ensuring that Medicaid providers provide vaccinations for their patient populations
6. Providing limited (e.g., twice yearly) vaccine clinics for underserved/vulnerable populations
7. During transition, support community providers to ensure access to necessary immunizations. (See Appendix F for an example from Spokane Health District)

EVALUATION METRICS:

- Build a current MCHHS - PHD patient list to conduct a telephone survey one year post transition
- Conduct a clinical system gaps analysis
- Assess number of community providers participating in the Vaccines for Children program
- Conduct telephone surveys of how many people are receiving vaccines ensuring culturally responsive approaches

TIMING:



RATIONALE:

The healthcare provider network in Marion County is adequate to support immunizations. Currently, an overreliance on governmental public health for immunization services leads to fragmented care for vulnerable populations.

notes:

12. Oregon Health Authority. (2017). *Public Health Modernization Manual*. Retrieved from: https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf

STI SCREENING, TESTING, & TREATMENT

RECOMMENDATIONS:

Focus screening and treatment programs on:

1. Disease surveillance, investigation, and partner notification services
2. Working with providers to establish a community-wide standard of care for screening and treatment of STI's and a referral network of providers that offer STI screening and treatment
 - a. Offer trainings to providers
3. Evidence-based sexually transmitted disease prevention education and messaging including community education to destigmatize STIs
4. Maintain limited, targeted mobile services to provide screening services to vulnerable communities
5. During transition: providing technical assistance to providers about screening and treatment of STI's, including consultation on complex cases ensuring patient confidentiality

EVALUATION METRICS:

- Build a current MCHHS - PHD patient list to conduct a telephone survey one year post transition
- Conduct a clinical system gaps analysis
- Assess/increase knowledge of community providers on screening/treatment of STIs
- Monitor referrals and provide cases management (when necessary) during first six months post implementation

TIMING:



RATIONALE:

Increases in sexually transmitted infections in Oregon and significant health disparities indicate a need for the Local Health Authority to focus on prevention. Stakeholders raise important concerns about testing hesitancy related to patient fears around stigma and confidentiality; governmental public health's role should be centered around designing systems to ensure that individuals are confident they can receive the care they need and deserve from community providers.

TUBERCULOSIS

RECOMMENDATIONS:

Continue services to:

1. Ensure TB cases are diagnosed and treated using Directly Observed Therapy

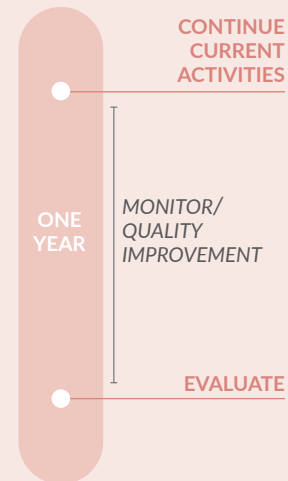
Maintain capacity to respond to TB outbreaks/spikes:

2. Ensure appropriate diagnosis and treatment of those with latent TB infection (including contacts of people with TB, new immigrants, other high-risk populations)
3. Conduct contact investigations for identifying and treating new TB infections
4. Implement a culturally responsive system to support primary care providers in screening and testing for TB and LTBI, especially providers serving new immigrants and other high-risk populations

EVALUATION METRICS:

- Assess/increase knowledge of community providers on screening/treatment of TB
- Track latent TB separately from active TB cases
- Assess MCHHS - PHD capacity and gaps related to providing TB services; identify additional funding

TIMING:



RATIONALE:

Due to the nature of tuberculosis, the burden of treatment is best met by the Local Public Health Authority. Community providers can decrease the overall burden of tuberculosis in Marion County through vigilant LTBI screening of at risk members of their patient populations.



CHANGE MANAGEMENT PLAN

CHANGE MANAGEMENT

In this report, Rede has recommended significant changes to the business model, operations, and organizational identity of MCHHS - PHD. If these changes are executed, appropriate strategic change management will be crucial to success.

HIGH LEVEL OVERVIEW PRINCIPLES AND THEORY

FOUR FRAMES

Every organization operates in a context that includes four basic frames:¹³ structural; human-centered; political; and symbolic. Informed change management takes into account each of these frames for all key stakeholder groups.

Table 5: Organization frames and change management

Frame	What it is	What it means for staff	What it means for community providers	What it means for community partners	What it means for community members
Structural	The organization must be restructured to accommodate change. Restructuring requires rigorous effort.	Some work units will be changed significantly	Some providers may need to offer more or different services	Community partners try to understand changes in structure so they can help community members navigate	Clients need to navigate in a new structure
Human-Centered	The relationship between the organization and the people	As people's work changes they need to find meaning and reward in new roles. Staff's concerns about client care inform their ability to adjust.	Community providers must navigate change and mitigate anxiety	Community providers must navigate change and try to mitigate anxiety among community members	Clients need to find trusted providers outside MCHHS - PHD
Political	Interpersonal or interorganizational power dynamics	As changes unfurl, people jockey for power	As changes unfurl, organizations jockey for power	Shifts in systems create unease for partners	Clients advocate for themselves to increase their power
Symbolic	Meaning, purpose, and identity (often expressed in organizational systems culture)	Connection to meaning, purpose, and identity	Creating new meaning	Shifts from traditional views of public health to new views	Historical patterns and paradigms

notes:

13. Bolman, L. G., & Deal, T. E. (2008). *Reframing organizations: artistry, choice, and leadership*. 4th ed. San Francisco: Jossey-Bass.

CHANGE MANAGEMENT

Table 6: Leadership strategies

Frame	Barriers to change	Essential strategies
Structural	Loss of direction, clarity, confusion	Communicating, realigning and renegotiating formal patterns and agreements
Human-Centered	Anxiety, uncertainty, emotional loss, feelings of incompetence	Training to develop new skills, participation and involvement, psychological support
Political	Disempowerment; conflict between “winners and losers”	Developing arenas where issues can be negotiated and new coalitions can be formed
Symbolic	Loss of meaning and purpose; clinging to the past	Creating transition rituals; mourning the past and celebrating the future

CHANGE MANAGEMENT

CHANGE MANAGEMENT PROCESS

The timing of changes to specific services is outlined in each recommendation.

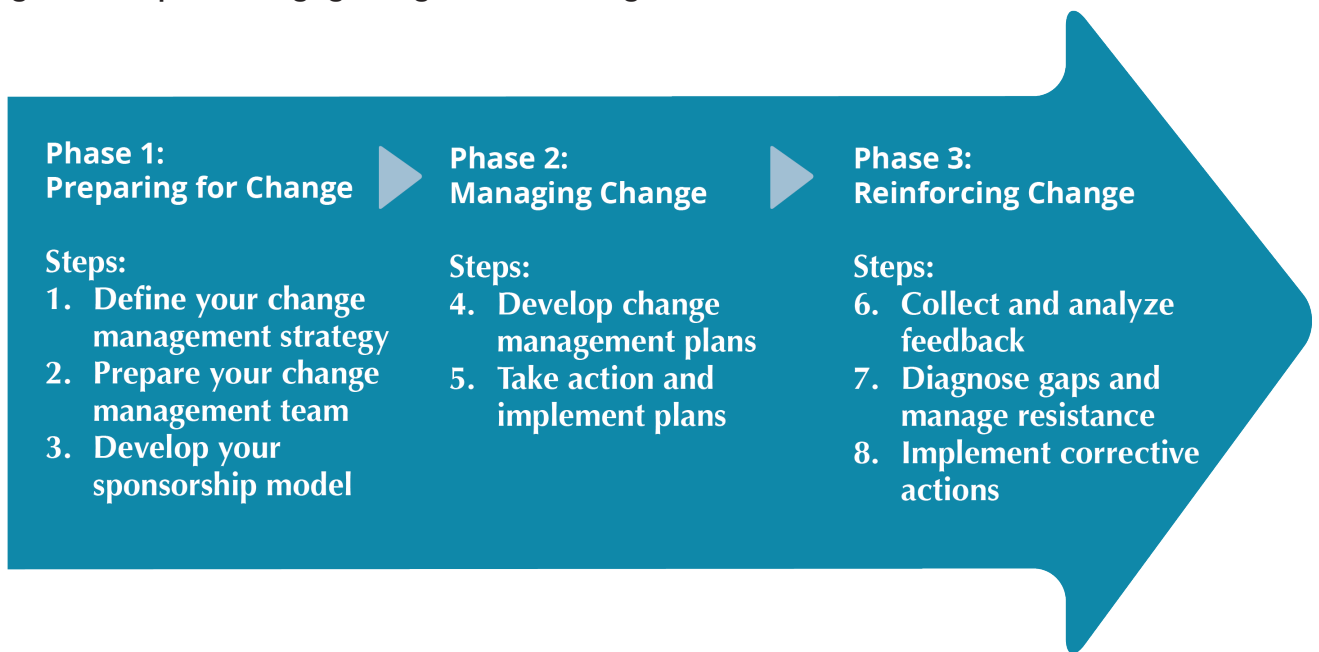
We recommend:

1. Identifying resources for structuring and managing change. The timing of changes to programs should be based on available resources for conducting change processes. We do not recommend initiating co-occurring change processes
2. Organizing specific change teams to implement each step of the change management process described below
3. Designating a change manager for each team
4. Supporting change management with mapping, process flow, outreach, and communication templates
5. Identifying strategies and champions for each stakeholder group

See Appendix G for a Sample Change Management Outline for transitioning Family Planning clinical preventive services to community providers.

See Appendices H-M for additional change management tools and resources.

Figure 13: Steps to managing an organizational change¹⁴



notes:

14. CLHO Public Health Modernization Roadmap. (2017). Change Management in Public Health Modernization. Retrieved from: https://orphroadmap.org/docs/modernization/Change_Management_Process_Tool.pdf



APPENDIX

APPENDIX

- A. MCHHS - PHD Clinic Data
- B. Partner Interview Guide – Provider
- C. Partner Interview Guide – Non-provider
- D. Patient Focus Groups Interview Guide & Key Informant Interview Guide
- E. Staff Survey Tool
- F. Supporting community providers to provide vaccines: example from Spokane Regional Health District
- G. Sample Change Management Plan Outline
- H. Change Management Process Tool
- I. Checklist Engaging Staff and Managing Change MCHHS - PHD Clinic Data
- J. Checklist – Communication Planning
- K. Communication Planning Template
- L. Value Proposition Canvas
- M. ADKAR Tool