

Health Reform and Local Health Departments: Opportunities for the Centers for Disease Control and Prevention

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I. Executive Summary

This is an unprecedented time for the American public health system at the federal, state, and local levels. It is the worst of times, with the recession decimating state and local public health infrastructure and services. But it is also a time of hope and promise created by the passage of the federal Patient Protection and Affordable Care Act (PPACA). This national health reform legislation expands access to public and private insurance and access to medical care along with many related provisions that will impact governmental public health and community health.¹

“We can’t say we have passed health reform, now it’s over and done; that would be a terrible mistake.”

The Centers for Disease Control and Prevention (CDC) commissioned this report to learn more about local health departments (LHDs), including the forces shaping their services and roles, their strategies for the future (including promising innovations), their perspectives on the role of public health in a reforming health care system and finally how CDC can best support LHDs in the future. In order to provide this information, we interviewed over 40 visionary public health leaders in 13 states, including urban and rural directors, several state health directors, directors of state public health laboratories, health plan executives and leaders of national public health organizations. We also drew on published materials regarding health reform, public health systems and efforts to integrate and coordinate public health and medical care delivery.

Generally, our informants are pleased with CDC’s support of LHDs in the form of resources, programs and tools. Recent efforts to set public health priorities and to communicate more directly with LHDs have been well received. The creation of the Office for State, Tribal, Local and Territorial Support (OSTLTS) within CDC, and even the commissioning of this report, are seen as indications that CDC leadership is interested in LHDs.

Local leaders hope that this is only the beginning. “We can’t say we have passed health reform, now it’s over and done; that would be a terrible mistake.” Now is the time for intense and focused leadership from CDC and other federal health agencies. Our informants want CDC to make progress in three key areas:

1 The Trust for American’s Health provides a summary of PPACA prevention and public health provisions at http://healthyamericans.org/assets/files/TFAH_Timeline_March2010.pdf.

Develop and Promote a Compelling Case for Public Health’s Crucial Role in the Nation’s Health

CDC should become an engaged and visible advocate for recognizing public health and population health as cornerstones of health reform. The CDC Director should be an active participant in the National Health Council and CDC leaders and staff should contribute to formulating the National Prevention and Health Promotion Strategy called for in PPACA. This process presents an opportunity to educate policy makers and thought leaders about a genuine health agenda, rather than just a narrow medical care agenda. National, state and local policies to support and preserve health are needed; public health agencies, including CDC, should play a key role in supporting and mobilizing for “health in all policies.” Ideally, the Council will affirm the importance of traditional public health services and also will support the role of public health in creating partnerships that unite families, health providers, schools, non-profits, and others “to create the underlying conditions in which people can be healthy.”

Focus and Align Research, Practice and Priorities

Public health leaders appreciate CDC’s role in developing and protecting the scientific basis of public health. CDC should expand and continue this work by developing a research agenda focused on the most important challenges in the field; local public health leaders would like to have input into that agenda. Research should be fueled by, and feed back into, LHD strategies and programs. CDC needs to compress the lengthy time frame for transforming research into practice. CDC should develop a process for identifying and evaluating effective practice models and processes for sharing them with public health practitioners through training and educational services. The identification and development of more public health tools and standardized approaches, along with education and support in their use, would also be welcome.

Strengthen the Foundation of the Public Health System

Effective public health programs require a sound foundation — a system that contributes to, bolsters and tracks their effectiveness. Informed governance, capable leadership and reliable funding are necessary to support a public health system that has the capacity to hire, develop and retain qualified staff; use technology and data effectively; and build working relationships with a wide range of partners, to name a few of the basic capacities that cut across and support effective public health programs and services. LHD leaders encourage CDC to prioritize the importance of building “public health as a system.” Specific infrastructure issues need to be addressed. Federal, state and local governments should establish shared expectations about the responsibilities of different levels of government to fund public health. The country

needs to plan for an adequate public health work force and create opportunities for development and education of public health professionals at all levels. Governmental public health must increase its capacity to use health information and data systems and be sure that this rapidly evolving field addresses the needs of the public health system. As CDC implements PPACA by distributing new funding, coordinating with other federal agencies and developing plans and projects, it would be helpful to ask, “Does this approach have implications for weakening or strengthening a system of public health?”

Section II of this report introduces the study context and provides more information on the methodology. Section III describes the challenges shaping local health departments and Section IV presents information on various LHD initiatives. The potential impacts of health reform on the delivery of public health services and on the delivery of LHD medical care services are addressed in Section V. The report concludes with “Recommendations from the Field for CDC” (Section VI) presenting specific suggestions from the public health leaders who contributed to this report. Attachments to the report (assembled in a separate volume) include selected prevention and public health provisions of the PPACA, a listing of the public health leaders we talked with for the report and a summary of relevant literature on public health. A statistical profile of LHDs (including financing, governance and programs) completes the Attachments.

LHD leaders are delighted that federal health reform will reduce the number of uninsured and expand access to medical care and preventive services. But of equal or greater importance is the formation of a National Health Council that will develop a strategy to improve the nation’s health. Public health leaders hope that CDC will promote and support the contributions that population-based services and “health in all policies” can make to “creating health.” Local public health leaders believe that the promises of health reform cannot be realized without a strong public health system. There are many challenges the public health system must meet before it can optimally contribute to the nation’s health; many of these are described in this report. CDC need not address these issues alone; LHDs are anxious to work in partnership with federal and state government and they bring many strengths and achievements to the table. Even as the recession constricts LHD operations today, public health leaders believe CDC is uniquely poised to help create a bright future for public health in the era of health reform.

II. Introduction, Background and Context

An Historic Moment

The spring of 2010 brings the confluence of two important events for the American public health system: the passage of the Patient Protection and Affordable Care Act (PPACA, or health reform) and the soon-to-be released Healthy People 2020, a set of “science-based, 10-year national objectives for promoting health and preventing disease.”² Federal health reform addresses health insurance coverage and access to medical care. At a policy level, the formation of a Prevention Council and development of a National Prevention Strategy are important both for the creation of a coherent national public health and health care strategy and for the explicit recognition of the importance of prevention in the context of health reform. Other provisions that will affect the public health system include:

- Expansion of Medicaid eligibility to cover adults with incomes to 133% of poverty.
- Mandates for coverage of preventive clinical services in private and public plans, and a public outreach campaign to increase use of these benefits.
- Significant new funding for community prevention programs, community clinics, public health laboratory-epidemiology programs and a public health workforce loan repayment program.
- Over 40 categorical programs in research, chronic disease prevention, aging, school health, maternal and child health, wellness and workforce development in health care and public health professions.

Achieving PPACA’s goals will require the resources and collaboration of state, federal and local government entities, community organizations of all kinds, health plans, insurers and medical care providers. Organizing the implementation of these provisions would be a challenging task under any circumstances; at the federal, state, and local levels, our fragmented public health systems have long been disconnected from equally fragmented medical care delivery systems.

Federal health reform opportunities come at a time of great economic pressure on state and local public health departments. In many states, the economic crisis has underscored the need to re-think public health processes and programs; “business as usual” is not sustainable. Last year’s H1N1 epidemic further strained local public health capacity even as it had the positive effect of highlighting the essential role of public health for policy makers, residents and medical care providers.

The Centers for Disease Control and Prevention (CDC) commissioned this report in order to better understand the types of support and initiatives that would be most useful to local health departments

(LHDs),³ given the challenges and opportunities of the time. We interviewed 40 public health leaders from a variety of settings, including large urban departments, small rural public health units, state health departments (SHDs) and national non-profits associated with public health. The informants are not a cross-section of public health officials; they are a special group selected for their vision and commitment to a vigorous public health system engaged in helping the nation achieve its goals. While many of our informants were from California, we also talked with leaders in Illinois, Indiana, Louisiana, Massachusetts, New Jersey, New York, North Carolina, Ohio, Oregon, Texas, Virginia, and Washington. Leaders of national organizations provided further perspective.

In structured telephone conversations, the leaders were asked about the most important forces influencing their organizations, recent changes to their departments and programs and the innovations they have developed that allow public health to be more effective. Finally, they were asked about the kinds of support and resources that CDC (and potentially other components of the federal government) could provide to address the challenges and opportunity of a reforming health system. Most of our conversations with local leaders were conducted at a time when no one knew whether federal health reform legislation would pass, much less its specific provisions. Thus, we could not discuss PPACA and its impact on LHDs. Instead, we discussed the challenges and opportunities contained in a reforming health care system that would expand coverage and rationalize expenditures. With PPACA's passage, LHDs and national public health organizations are pivoting toward the specific provisions and gearing up to participate in planning and implementation.

In addition to talking with contemporary leaders, we also performed a literature review, contained in Attachment C, identifying published articles from the past 20 years on public health system issues including roles, organization, financing and relationships. The size, scope and complexity of the nation's public health system can be daunting; much of the systems literature has emphasized the lack of consistent support for public health, the decentralized and diversified nature of local governmental entities and the challenge of how to best relate to medical care delivery.

3 Local health departments are defined by the National Association of County and City Health Officials as "an administrative or service unit of local or state government, concerned with health, and carrying some responsibility for the health of a jurisdiction smaller than the state."

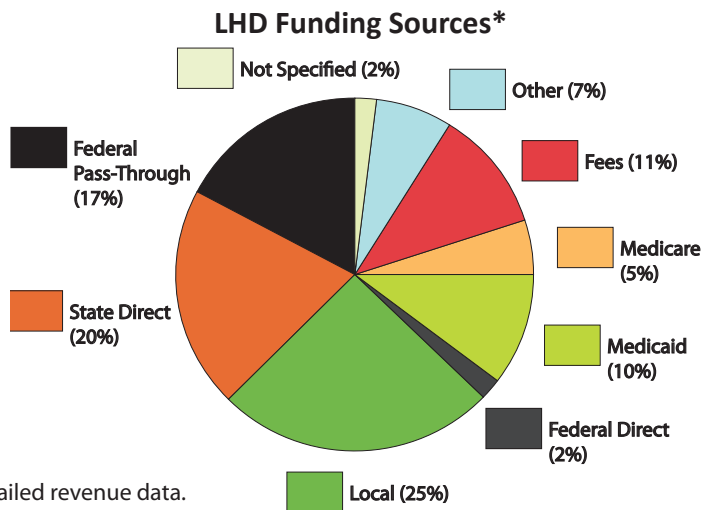
III. The LHD Perspective: Challenges and Opportunities

The Challenge of the Economy

LHD directors were unanimous in declaring the economic recession to be the single biggest factor shaping their departments. LHDs are seeing waves of reductions in state and local funding: county general funds, sales tax, property taxes, permit fees and medical care revenues have all declined. Several directors expressed appreciation for continued federal support for public health: “Without the CDC and other federal funding, our State Department of Public Health would be in even worse shape than it is now,” and, “I don’t know what we would have done without continued federal funding.”

“Without the CDC and other federal funding, our State Department of Public Health would be in even worse shape than it is now.”

On average, LHDs receive 25% of their funding from local sources and 20% from the state, although there is much variation in this. The federal government provides the largest share of LHD funding, which comes from a variety of sources: CDC, the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMSHA), the Department of Housing and Urban Development (HUD), the U.S. Department of Agriculture (USDA), and the U.S. Department of Homeland Security (DHS) provide funds to the states, which are passed through to LHDs. Two percent of these funds are provided directly from federal agencies to LHDs and additional funds are received by some departments that bill Medicare and Medicaid for medical services.



* Among LHDs reporting detailed revenue data.

Many LHD directors described the recession as a “1-2 punch,” with a reduction in funding accompanied by an increase in demand. As a result, LHDs are rethinking their priorities and programs — and, in some cases, developing new partnerships to offset reductions.

- **Program and staff reductions:** According to a National Association of County and City Health Officials (NACCHO) survey, LHDs have on average lost 15% of their workforce over the past 2 years and an additional 10-15% of public health employees are working reduced hours.⁴ In some states, the reductions have been much greater; other states have had less reduction in funding and capacity. LHD directors were distressed that there was no source of stable funding for some core public health functions such as disease control and public health nursing. One large California county (with a population of over 1 million) has been forced to eliminate programs in environmental health (small water systems/housing), the food stamp outreach and nutrition network, dental services, and refugee services. They also have reduced service levels in all programs (including tuberculosis, HIV, Maternal and Child Health, family planning, and field nursing). A medium-sized LHD closed its STD, family planning and HIV clinics (outsourcing them to Community Health Centers). Others mentioned cutting injury control, chronic disease, tobacco control and services for children and pregnant teens.

Most health directors are weary of continual budget reductions and the complexities of trying to reorganize programs and reduce staff in public organizations: “We’ve been at this for 2 years with no end in sight. There is no clear target. We just get the local budget balanced and the state sends down more cuts and our revenues come in lower than planned.”

- **Public health laboratories under pressure:** State public health laboratories are an essential part of the LHD system. Most small and medium-sized LHDs rely on the state-operated public health laboratories to provide tests and services for them. Some large LHDs operate their own public health laboratories but still look to the state for “super-specialized” and confirmatory testing, as a source of reagents and probes, as the hub for data collection and analysis and as a source of training and leadership. State laboratories have a close and important relationship with CDC and value the financial and technical support they receive. But long-term financial constraints for public health laboratories are a problem. “The reality is that our budget is about the same as it was in 1992 (actual dollars, not adjusted). We rely much more on grant funding now and we wonder how much worse the situation will be in several years. I’m not a fan of the Block Grant program, where the laboratory might or might not be included. Laboratory services need to be specifically mentioned in the allocations or the lab gets shortchanged.”

4 Local Department Job Losses and Program Cuts: Overview of Survey Findings from January/February 2010 Survey (March 2010; NACCHO). www.naccho.org/advocacy/upload/JobLossSurvey_Overview-3-10.pdf.

Another state public health laboratory director cautioned that while laboratories desperately need additional funding and resources, the state often provides fewer funds when CDC provides more, and recommended that the funding structure for public health laboratories should be changed to reflect their growing needs. "CDC provides categorical funding, which is in essence organizing my lab and determining what we do. But CDC's categorical funding has allowed the state general funds to be reduced." Federal disaster preparedness funds allowed states to add and equip new laboratory space but some states can't hire or retain the staff needed to make those resources useful.

- **Increased demand for medical care and preventive services:** Many private providers and clinics are referring newly uninsured patients to public health programs, including immunization clinics, cancer screening programs and child health programs. And many of the newly uninsured are enrolling in Medicaid,⁵ a program that often relies on public clinics and hospitals to provide access to beneficiaries. In California, where 1 in 8 Americans lives, 19 publicly-operated hospitals provide 70% of their inpatient days to Medicaid or uninsured patients and provide 30% of all Medi-Cal outpatient visits.⁶ Contra Costa County, in the San Francisco Bay Area, provided 640,000 outpatient visits last year to Medi-Cal and low-income patients. While federal American Recovery and Reinvestment Act (ARRA) requirements prevent states from reducing Medicaid eligibility criteria, 34 states (and Washington, DC) have reduced provider payments in response to their budget crises. Lower reimbursement further stresses public hospitals and other safety net providers that count on Medicaid as their key revenue source.
- **Deteriorating health status:** Higher rates of unemployment and un-insurance may contribute to more uncontrolled chronic disease and mental distress.⁷ The faltering economy is making people sicker, which translates into greater demand on the medical care system and an increase in health disparities.
- **Rethinking priorities:** While some informants expressed concern about hastily and reactively "slashing the budget," others felt the financial crisis had been a type of "creative destruction" that led to a re-evaluation of public health priorities and activities and forced increased clarity and accountability. "This process is making it easier to change what we do and to evolve our relationships to others in the community. There isn't so much resistance from long-established

5 According to the Kaiser Commission on Medicaid and the Uninsured, Medicaid enrollment "grew by an average of 5.4 percent in state fiscal 2009, the highest rate in six years, surpassing the projected 3.6 percent increase at the start of the year. Similarly, total Medicaid spending growth averaged 7.9 percent in FY 2009, the highest rate in five years... For FY 2010, states estimate Medicaid enrollment will grow by 6.6 percent over FY 2009 levels." Kaiser Family Foundation, "The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession" www.kff.org/medicaid/7985.cfm.

6 www.caph.org/fastfacts.htm

7 Catalano R. (2009) Health, Medical Care, and Economic Crisis. *NEJM* 360(8):749-51).

programs when everything seems to be changing.” In order to survive, programs not only have to demonstrate positive outcomes, but contribute to public health’s highest priorities. Sometimes this prioritization and evaluation process included a community dialogue or strategic planning process. As a result of having to reduce expenditures and services, some LHDs are seeking out new community partners and developing innovative ways to meet community needs. (See Section IV, Community Empowerment and Engagement Initiatives.)

“At the end of the day, we were the only ones who could really get the shots into people’s arms. Being invited to the White House in recognition of our role was a proud moment.”

The Challenge of Emergency Preparedness and Pandemic Influenza

Local public health departments are also being shaped by the need to respond to “all hazards,” including bioterrorism, natural disasters and epidemics. While emergency preparedness has been a long-time traditional public health responsibility, the “9/11 experience” elevated and transformed it. Fueled by federal funds and new mandates, LHDs suddenly had the resources and the authority to undertake serious preparedness work. The outbreak of H1N1 influenza in 2009 was also an important event that shaped LHDs and brought many of them into close contact with the CDC for the first time.

Local leaders spoke of their recent experiences with federal programs for preparedness and influenza with mixed feelings. On one hand, these initiatives had positive impacts: they provided new resources that supported building partnerships with the medical care sector, the public safety arena and the community and clarified the central role of LHDs in emergency preparedness and response. On the other hand, the crisis atmosphere that accompanied these programs resulted in a loss of attention to ongoing public health needs.

Comments on the federal-local relationships during the H1N1 response were generally very positive. While the earlier preparedness planning had been about hypothetical threats, the H1N1 experience tested the ability of governmental public health to respond to a real and immediate one. The influenza pandemic highlighted the importance of an effective communication protocol. Initially, this was problematic. Having the CDC relay messages through the SHDs took too long and led to “mixed messages.” More direct communication between the CDC and the LHDs, with the SHDs involved, seemed to work better. On the whole, local leaders felt that the H1N1 response demonstrated the resilience, capacity and strong relationships of the public health system and that LHDs were recognized as valued partners. “At the end of the day, we were the only ones who could really get the shots into people’s arms. Being invited to the White House in recognition of our role was a proud moment.”

While these activities were continuing, however, some agencies had to put their infrastructure initiatives on hold — that is, ongoing participation in accreditation or regionalization plans and programs. Finally, agencies are now concerned that the declining revenue from preparedness and influenza grants, combined with the loss of local revenues, will have a very serious impact on capacities of the local public health system over the next 2 to 3 years, including the ability of LHDs to provide important services such as disease control, primary and secondary prevention, and, in some cases, medical care.

The Opportunity of Health Reform

LHD leaders have given different levels of attention to the national health reform process. Many of the smaller departments and local health units adopted a “wait-and-see” attitude. While they understood the importance of expanding health coverage, they felt they could not affect the process or outcome and they “had enough to worry about already.” The larger health departments, most of which provide medical care, paid close attention to the federal debate and in some cases were involved in it, going to Washington and meeting with their representatives, working through their national organizations and mobilizing local community involvement. One LHD sponsored over a dozen community meetings on health reform so that residents could provide input to the President. With support from the LHD, the Board of Supervisors in this county held public hearings and adopted a set of governing principles for health reform that were widely distributed and discussed.

LHDs and public health organizations are excited about the bill’s provisions that will affect the roles and resources for public health. Federal health reform is one of the most important public health developments in this century. From the creation of a National Prevention Plan to the Community Transformation grants, from the expansion of Medicaid to the requirement that commercial insurance cover preventive services with no share of cost, PPACA is a “game changer” for public health. Many are hopeful that public health will finally get the opportunity to “work hand-in-glove” with medical care and will be recognized as an essential activity. Others warn that the new legislation could further submerge population-based public health in the “tyranny of medical care.” Some leaders hope that insurance reform will lead to public health reform and that there will be more national debate and legislation regarding public health. Others are just hoping that the existing bill’s provisions will be implemented with “transparency and integrity.” CDC can play a role in this by advocating for a relatively open planning process and by supporting implementation decisions grounded in science and public health principles.

From the creation of a National Prevention Plan to the Community Transformation grants, from the expansion of Medicaid to the requirement that commercial insurance cover preventive services with no co-pays, PPACA is a “game changer” for public health.

Today's recession is very real and present for LHD leaders; while they hope for new funding and opportunities, they first have to survive the next 3 to 4 years. They are worried that there "may not be much left" by 2014. One LHD leader saw incongruity in the goals and potential of the new law and current local conditions: "I have spent the last 5 years educating my community about population health and forming community initiatives to support healthy lifestyles and address the determinants of health. Our new partnerships and programs were gathering momentum. Then state and local funding cuts forced us to eliminate all discretionary funding. We've had to reduce support for basic programs as well as local health planning efforts and community mobilization. We're slipping backward at key time in the process."

"I have spent the last 5 years educating my community about population health and forming community initiatives to support healthy lifestyles and address the determinants of health. Our new partnerships and programs were gathering momentum when budget cuts eliminated our discretionary funding."

IV. Local Health Department Initiatives

LHDs are currently engaged in a wide variety of innovative efforts. Understanding the nature and scope of these initiatives could help federal public health agencies assess where the leaders in the field are going and the kinds of support they need and would welcome. Some initiatives are aimed at strengthening the public health system and services through quality improvement (including accreditation and regionalization). Other initiatives are focused on engaging and empowering communities to achieve population-based health goals. Still others relate to medical care and promote improvements in access to coverage, access to care and improved quality of care. Information technology is the infrastructure that increasingly allows for broad-based data exchange and analysis. Many of these local initiatives were started with federal, private foundation and even local grant funds. Examples of innovative initiatives are presented below:

Quality Improvement Initiatives

Local leaders are aware of the national conversation about the need to improve the infrastructure of the public health system and are experiencing the pressures for efficiency and effectiveness firsthand as they allocate scarce resources and defend their budgets to local elected officials and constituents. Thus, many of the informants in this study were involved in one or more national infrastructure initiatives, including accreditation, reorganization and regionalization.

- **Accreditation:** According to the 2008 NACCHO survey, 77% of LHDs were familiar with voluntary national accreditation programs. About half expressed interest in seeking voluntary national accreditation, with 38% planning to seek accreditation within the first two years of the program (estimated for launch in 2011–2012). There was no consensus on accreditation. Some of the more enthusiastic promoters of accreditation are in mid-sized health departments that have a Board of Health. They see accreditation as a way of consolidating and improving credibility and authority in their own communities — not only for their organization, but for its governing body and for the community at large. Despite limited local resources, they are committed to the accreditation process and are closely following national work on this issue.⁸ A director of a large urban department said, “This is long overdue; public health cannot compete without being able to standardize and measure quality. The medical care system has been doing this for decades; we need to get started.”

“We see accreditation as our North Star. We will move toward it and it will help to guide our quality improvement work but we may never apply to be formally accredited.”

Another larger urban department director also had a positive but slightly different approach: “We see accreditation as our North Star. We will move toward it and it will help to guide our quality improvement work but we may never apply to be formally accredited. Some of the criteria aren’t all that relevant to us.” Noted in particular were the requirements pertaining to governance that were relevant to local Boards of Health, but not as useful for departments governed by county or city elected officials.

When queried about the relationship between accreditation and future funding, a number of leaders echoed these sentiments: “Accreditation is supposed to be a voluntary process unrelated to funding, but that won’t last. Of course it will eventually become a condition of receiving resources.” Not everyone was comfortable with a new “voluntary mandate.” “Calling this accreditation makes it sound like what JCAHO [the Joint Commission on the Accreditation of Health Care Organizations] does for hospitals. It is quite different. The expectations for LHD accreditation are inappropriate. We need to reconsider how this should be used.” Another national leader also expressed caution: “We just hope the condition isn’t imposed prematurely. We must be sure that complying with accreditation standards improves the practice of public health and ultimately the outcomes of the department. We believe in effectiveness-based medical care and should expect no less for public health.”

8 Exploring Accreditation Steering Committee (2007). *Exploring Accreditation: Final Recommendations for a Voluntary National Accreditation Program for State & Local Health Departments (Full Report)*.

Though House provisions for Health Department Accreditation Grants were not funded in the final version of PPACA, efforts to promote accreditation (from a funding and/or legislative standpoint) are likely to continue.

- **Regionalization:** Finding the right scale for providing public health services and addressing community health issues is not a simple matter. Thirty-eight percent of LHDs employ fewer than 10 full-time equivalent employees (FTEs) and some states have hundreds of very small counties or boroughs, each of which has its own small local health unit, consisting of perhaps a part-time sanitarian and a Registered Nurse serving a small town or suburban area. Trying to build the capacity of each and every health unit to provide the full array of modern public health services would be expensive and not very effective. Functionally, rural health units serving vast areas with a small population share some of the same problems as these small units.

While regionalization and consolidation of health departments may sound like the answer from the national perspective, the local realities are more complicated.⁹ The legal framework of public health involves delegation of a police power from states to local political entities accountable to elected officials; the reasonable wish to create local departments of an efficient size runs afoul of the many political, cultural, historical and legal ramifications of consolidation. LHDs have found that regionalization often depends on local political processes that are difficult to influence; the director of one suburban county's LHD said, "My staff does not want to join our neighboring counties because there is a concern that these larger counties will not prioritize our needs." Currently there is not an effective advocacy process for the creation of consolidated departments; perhaps CDC could work with the appropriate states to support local planning for change.

The work on consolidation that is being undertaken by the Robert Wood Johnson Foundation has broadened the definition of regionalization to include a wide range of structures, from service sharing arrangements to memoranda of understanding and joint powers authorities for specific components of local public health services.

Many of these regional arrangements have been created over the past 5 years by different health departments. They include an epidemiologist shared by two rural counties, a public health laboratory shared by four LHDs, multi-county chronic disease prevention initiatives, multi-county Medicaid managed care plans, regional emergency medical service agencies, and many others. For example, Fresno County and three neighboring California counties are creating a Medi-Cal managed care plan that will be operated by HealthNet under contract with the counties. Fresno is also part of a four-county regional emergency medical services (EMS) system that has

9 California Health Policy Forum (2007). *Regionalization in Local Public Health Systems*.

significantly improved pre-hospital care and brought paramedic services to previously underserved communities.

Most of the public health leaders in this study seemed convinced that the movement towards regional shared activities was well underway and will continue with or without pressure from the national level. Interestingly, large urban/suburban health departments seemed the least involved in 'shared services.' They tend to have extensive internal resources and strong local elected officials wary of sharing power and responsibility with other entities. Nonetheless, these leaders were involved in a wide range of regional planning and coordination efforts, particularly around chronic disease or environmental protection initiatives. As one urban director pointed out, "Many determinants of health are under regional control already; the transportation system is not controlled by the County, nor is air quality. LHDs should work regionally on issues that cross their borders."

"Many determinants of health are under regional control already; the transportation system is not controlled by the County, nor is air quality. LHDs should work regionally on issues that cross their borders."

- **Performance improvement:** Formal, systematic efforts to improve performance were undertaken by just over half of the LHDs in 2008. Among LHDs with performance improvement activities, 76% included a focus on customer service and satisfaction; 50% reported "related activities in management practices, public health capacity, data and information systems, health status, and human resource development." Fifty-nine percent of those engaging in performance improvement indicated that no specific framework or approach had been used. Among specific approaches, the Total Quality Management (TQM) strategy was most often mentioned.¹⁰

Several health department leaders we spoke with indicated that they have invested in quality improvement and/or process improvement systems that include not only public health, but also the department's hospitals, mental health services, drug and alcohol programs, and others. The Indiana SHD developed a technical assistance resource for hospitals to help them use the Lean management processes.¹¹ This was later expanded to selected LHDs that became eligible to receive state funding for quality improvement projects. Contra Costa County in California is one of many health entities working with the Institute for Healthcare Improvement (IHI)¹² using the Triple Aim approach to quality improvement. The goal is to simultaneously accomplish three critical objectives: improve the health of the population; enhance the patient experience of care

10 NACCHO 2008 Profile, Attachment D.

11 Lean management principles have been used effectively in manufacturing companies for decades, particularly in Japan, in driving out waste so that all work adds value and serves the customer's needs. www.ihl.org/results/whitepaper/goingleaninhealthcare.htm

12 The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization helping to lead the improvement of health care throughout the world. www.ihl.org.

(including quality, access and reliability); and reduce, or at least control, the *per capita* cost of care. The Triple Aim project is conducted in partnership with other hospitals in the United States and Europe; the group meets monthly by conference call and is, in effect, a “learning community” (which has been one of the most exciting and rewarding aspects of the work).

Public health laboratories have been helped greatly by CDC support for bench training of staff. Not only do the laboratories need travel money for the employee being trained, but they also need to fill behind them during their absences. More CDC support in this area would be welcome.

Community Engagement and Empowerment Initiatives

Many of the LHDs we talked with are working with community coalitions to address broad population health goals, especially changing the lifestyle drivers of chronic disease. As one local director explained, “We know that medical care is not the answer; changing the built environment, changing diet and culture is not something we can do by ourselves.” Using the innate capacity of governmental public health, LHDs are convening community leaders and serving as honest brokers of information, data and expertise to help guide the development of policy and programs that promote prevention and healthy behavior and support community change. Community coalitions are addressing the rising burden of chronic disease, the need to reduce health disparities across income and ethnic groups, the challenges of health care access and even the underlying social determinants of health.

“We know that medical care is not the answer; changing the built environment, changing diet and culture is not something we can do by ourselves.”

A number of models exist for organizing coalitions, but considerable research is still needed to define the best models for specific circumstances and to identify the success factors for different approaches. The Minnesota Department of Health has found that engaging community members in problem-solving is an effective approach to achieving public health goals. The Department has established a community engagement Web site that provides models and resources on the subject.¹³

LHDs particularly want help from CDC and other federal health partners with these types of community-based, healthy lifestyles initiatives. Which models work? They want to “stand something up and get going” without spending months or even years wrestling with a structure for the partnership. They also want to be able to provide evidence-based guidance to the coalitions they are supporting. Only one respondent mentioned CDC’s “Community Guide to Preventive Services”¹⁴ as a resource for selecting appropriate population interventions. This is a free, online CDC tool that provides information about

13 Minnesota Department of Health. Community Engagement Web Page. Available at <http://www.health.state.mn.us/communityeng/>, Accessed April 23, 2010.

14 <http://www.thecommunityguide.org/index.html>.

“program and policy interventions that have been proven effective.” Over 200 interventions have been reviewed and rated by the Task Force on Community Preventive Services. PPACA supports CDC’s continued work on the Guide; ideally, this will include promotion and education on how to use the tool and increased involvement of LHDs in identifying interventions and data for evaluation.

A few representative community health engagement initiatives are described below:

- **Chronic disease initiatives:** The challenge of chronic disease is perceived as one of the most important issues facing public health: “When you compare where we are investing public health resources with the causes of morbidity and mortality, the biggest mismatch is in chronic disease.” And, “Our biggest challenge is dealing with the pandemic of chronic disease and the challenges of creating a robust enough public health primary prevention system to head off problems. We also must provide secondary prevention for the patients we have in our systems. We must look at ways to minimize harm and redirect the community and individual patients on a path of health.”

“When you compare where we are investing public health resources with the causes of morbidity and mortality, the biggest mismatch is in chronic disease.”

San Diego County is working on a “3 for 50” initiative, based on the fact that 3 lifestyles (smoking, lack of exercise and poor diet) cause 4 diseases (cardiovascular disease, cancer, diabetes and respiratory diseases), which in turn lead to over 50% of fatalities worldwide. The County is working to coordinate existing programs and funding streams to promote healthy lifestyles; they also are trying to transform care delivery to focus on these problems and developing partners among other community organizations.

New York City was mentioned as a leader in reshaping public health by approaching chronic disease prevention through a policy approach rather than a service delivery approach.

Sonoma County’s Health Action Coalition (including medical providers, elected officials and business leaders) has developed a strategic plan for a healthier community. The work of this group has helped schools to address health issues and has led local governments to preserve parks programs that contributed to health but might otherwise have been cut as frills. The City of Santa Rosa has added a health component to its General Plan and a number of employers have developed exemplary worksite wellness programs serving high-risk groups.

Medical Care Initiatives

Each LHD leader with whom we talked was involved in a unique relationship with the medical care delivery system in his or her jurisdiction. Some departments — particularly those in large, urban areas — operate an extensive system of hospitals and clinics, providing a continuum of medical care

services from primary care to tertiary care (including burn units and Neonatal Intensive Care Units). Sometimes, these services are well-integrated with private sector hospitals and providers; other times, they are isolated or competitive. Understandably, the departments that provide medical care services have programs and goals regarding outreach and enrollment, access to care, utilization and sharing of electronic medical information and improving the quality and safety of care in their facilities and in the larger medical care delivery system. These departments expect to be greatly affected by PPACA's expansion of health coverage and access provisions.

Other departments provide limited public health clinics (immunizations, STD, and TB) and have no responsibility for medical care access. Many of these departments are not connected to the private medical care system, even if they work closely with various safety net service providers. In between these extremes are a myriad of approaches. Several LHDs whose leaders we interviewed deliver primary care services (often as Federally Qualified Health Centers) and purchase specialty and hospital care in the private sector. Others do not deliver even primary care, but are involved in supporting and shaping a substantial community safety net system. In Indiana, public health departments and Community Health Centers have found that co-locating in the same building is convenient for patients and staff and leads to good partnerships.

Many LHDs have developed innovative programs to improve access to medical care, contain costs and improve quality. In some cases, these focus on the department's own services; in other cases, they are broad-based collaborative efforts that include dozens of entities and affect the medical care in the region more systemically. They demonstrate the ability of LHDs (often working with policy and financial support from states) to improve medical care delivery in a way that supports public health goals and outcomes. Section V examines more fully how health reform may impact LHDs in regard to the provision of medical care services. Below are a few examples of systemic approaches related to medical care:

- **Outreach and enrollment:** Many LHDs are working to increase enrollment in health insurance coverage by convening or participating in community outreach coalitions, funding outreach workers (either their own employees or through community non-profits), partnering with schools to reach families receiving free and reduced lunches, and contracting with benefits specialists who document disability and help patients qualify for Supplemental Security Income (SSI)/Social Security Disability (SSD) Medicaid. California's Medi-Cal program¹⁵ contains an option for LHDs and their sub-contractors to claim federal matching funds for public expenditures on

15 Similar claiming programs exist in Washington, Oregon, Michigan and Texas and undoubtedly in other states, but certainly not in every state.

Medicaid Administrative Activities (MAA) and targeted case management services (TCM).¹⁶ While participating in MAA entails high administrative costs, the availability of 50% federal matching funds has legitimized and financially supported outreach, enrollment and case management activities by public health departments and their CBO partners.

For example, rural Humboldt County Health Department in remote northern California has created a Community Health Alliance to work on increasing enrollment in public insurance programs, access to medical care services and linkages to programs such the Supplemental Nutrition Assistance Program and school lunches.

- **Expanding insurance:** Local Children’s Health Initiatives (CHIs) have been leading the way in California on health coverage expansion for children. Following a model developed in Santa Clara County, 29 of California’s 58 counties have organized insurance/coverage programs, (frequently known as “Healthy Kids” programs) to cover all low-income children. These efforts are accompanied by local collaborative outreach and enrollment initiatives. As of December 2009, 71,000 children were enrolled in Healthy Kids programs and many times that number had been enrolled in Medi-Cal and the State Children’s Health Insurance Program (SCHIP) as a result of local outreach efforts. Nearly all of these programs involve LHDs that appreciate evaluation results showing an increased use of primary care, a decrease in ED visits, higher immunization rates and better oral health as compared to similar uninsured low-income children.¹⁷
- **Case management:** Project Connect is a Santa Cruz County health department initiative that works with local hospitals to identify and better serve “frequent users” of acute services. Project Connect provides intensive, multi-disciplinary case management that connects patients with primary care (either through a county or community clinic), supported housing, mental health services, benefits advocacy and other health and social services. Program participants have dramatically reduced ED visits, inpatient hospitalizations, ambulance runs and jail bookings, which in turn have led to dramatic net savings.¹⁸ Seattle-King County Health Department provided support to another “frequent user” program focused on chronically homeless alcoholics who utilized the County hospital and criminal justice system extensively. The program evaluation, published in the Journal of the American Medical Association, found that “after one year in the

16 www.dhcs.ca.gov/provgovpart/Pages/localgovernment.aspx.

Claimable MAA activities include outreach and enrollment assistance for health insurance, outreach for the provision of Medi-Cal covered services, program planning and policy development. TCM services, which must be provided to a Medi-Cal beneficiary include assessment and care planning, information and referral to a wide range of health and social services, arranging and providing transportation, arranging and providing interpretation, crisis planning, etc. Schools as well as other local government units can claim.

17 www.cchi4kids.org.

18 Lewin Consulting’s evaluation and description of Project Connect and five other locally operated frequent user programs can be found at www.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=4224&parentID=3803.

program, the 95 participants had reduced total costs relating to their care by more than \$4 million compared to the year before.”¹⁹ Information about other successful programs to serve multi-need, high-utilizing clients is available from the Corporation for Supportive Housing (a national advocacy and technical assistance non-profit).²⁰

- **Delivery system initiatives:** San Mateo County has been working with the state on a long-term care initiative that would reduce the use of skilled nursing facilities through the provision of community-based services and support. (This County has one of the highest proportions of elderly residents in California). It has been difficult to work out the financing (in part because of the role of Medicare), but the “silver tsunami” of aging baby boomers will only add urgency to the goal of redesigning long-term care.

Yolo County (California) is leading a healthcare access/coordinating group made up of federally qualified health centers, hospitals and others, who work to improve referrals of indigent patients to specialty and subspecialty care and to create less expensive options for tertiary care. Several LHDs have discussed initiatives around emergency medical services and decreasing emergency department utilization.

Information Technology Infrastructure Development

Information and communication technology is an increasingly important component of the public health infrastructure at the national, state and LHD levels. Information technology facilitates essential public health functions, including communicable disease reporting, health data collection, management and analysis, information sharing between health sectors and outreach through various health promotion, prevention and intervention services. Information technology, including global information system (GIS) mapping, provides data necessary to support the development of policies that address local and national health problems and priorities. It also supports standardized public health practices using evidence-based initiatives and performance improvement management techniques.

Our conversations revealed that many technology initiatives for LHDs are still in the early stages. Public demand, increased availability of funding for technology and evidence demonstrating efficacy and cost-effectiveness will drive future growth in technology use by LHDs.

- **Disease surveillance and reporting:** Advanced electronic systems that track, evaluate and report disease and chronic conditions (including data from public health laboratory results) are increasingly seen as a key element of a broader strategy for strengthening states’ health

19 <http://jama.ama-assn.org/cgi/content/abstract/301/13/1349>.

20 www.csh.org/index.cfm?fuseaction=page.viewPage&pageID=4501&nodeID=81.

information technology (HIT)/health information exchange (HIE) infrastructures. Strengthening these systems is critical to the integration of the public health and medical care delivery sectors.

- **HIEs and medical records:** According to one LHD director, HIEs will become essential to linking public health with the medical healthcare sector. The state of Indiana and San Diego County both stated that they actively use a strong HIE system.

LHDs also are working on electronic medical record (EMR)-related initiatives to share data among individuals, medical institutions and public health. For example, San Mateo County is working to integrate health data from different departments in their county (including long-term care, mental health and criminal justice), while Spokane County in Washington is working with 35 hospitals to integrate their EMR systems.

- **Data mash-up:** Data from these and other electronic public health systems and registries will increasingly be merged with complementary, non-public health data sets. There are a number of data sets — from State of the USA and MATCH to Healthy People 2020, as well as emerging data platforms — that impact LHDs, policy stakeholders and community advocates.²¹ Interactive GIS mapping capabilities will strengthen the decision support and planning processes of LHDs by providing them with the ability to rapidly identify and address health problems and priorities within communities and among populations at risk.

CDC is helping to create a Community Health Data Initiative²² that will “establish a network of suppliers and demanders of community health data, indicators, and interventions. Its purpose is to help Americans understand health and health care system performance in their communities, thereby sparking and facilitating action to improve performance and value.” The U.S. Department of Health and Human Services (HHS) Health Indicators Warehouse that is currently under development will serve as the data hub for the initiative. This project responds to numerous LHDs’ requests for better access to data from a variety of sources that can help with community health initiatives. Although LHDs were very aware of the County Health Ranking project, this impressive effort to organize an accessible data warehouse was not well-known.

Another example of a central process for organizing and sharing public health data is the work of the Healthy Communities Institute (HCI). Five LHDs and the state of Hawaii are using HCI’s Web-based tool to seek, track and trend data and best practices.²³ The system seeks to help LHDs, hospitals, and community coalitions to measure community health, share best practices and collaborate on community health initiatives.

21 Examples of data platforms include Community Issues Management, Health City California, Health Equity Atlas and Healthy Kids GIS.

22 http://www.cdc.gov/nchs/data_access/chdi.htm.

23 www.healthycommunitiesinstitute.com.

- **Health equity:** Information technology also complements public health efforts to reduce disparities by increasing access to health and social services for populations in need. Examples of technologies in this category include online benefit enrollment programs. As an active participant in a Community Health Alliance that has worked for some years on Medi-Cal enrollment, Humboldt County is developing linkages to other services (such as food stamps) through One-E-App and is now hoping to link with the school lunch program. The ability to expand linkages to a broader set of needed services (integrated around online benefits enrollment programs) provides significant public health benefits through addressing a broader set of social determinants of health.
- **Support for workforce efficiency and service quality:** San Diego County re-engineered its remote nurse workforce by equipping public health nurses with electronic tablets to facilitate workflow and streamline processes. Productivity increased by 27% as a result. The County has received recognition for this initiative and the use of electronic tablets has since been transferred to other programs as well.
- **E-government services:** Electronic, Web-based applications that leverage consumer technologies — such as the Web, mobile, and social media technologies — have the potential to dramatically transform relations with the public and other stakeholders in community health through better delivery of government services and improved public health outreach efforts in health promotion, prevention and treatment. In particular, consumer technologies offer a wide variety of tools with significant potential for collaboration and broad-based participation in data sourcing, knowledge building, social networking and advocacy, and grassroots organization around public health and community health issues.

LHDs expressed different levels of awareness and interest in the use of mobile and social media technologies, but many fully understood their considerable potential, particularly in pushing out timely, relevant information to the public during emergency situations. A combination of funding limitations, traditional thinking and a lack of qualified staff have limited their broad adoption and widespread use in public health thus far. For example, one interview mentioned that access to popular Web sites such as Facebook and Twitter are currently blocked at some LHDs. However, despite these challenges, the use of consumer technology in public health should increase due to the high penetration of mobile and Internet technology, the development of engaging public health applications and the success that existing initiatives to reframe thinking around technology have had in public health. In addition, LHDs unanimously agreed that the CDC's online information resources, such as Diseases A-Z, were of great value for informational

and outreach purposes. LHDs would like to continue to have access to more of these and other similar resources.

V. Potential Impacts of Health Reform on LHDs

For the most part, LHD leaders are very hopeful about the impact of the recently enacted PPACA legislation. Whether or not an LHD provides medical care directly, LHD leaders feel the negative impact of un-insurance on their clients and communities. Currently, the mandate to fund Medicaid, combined with a mobilized constituency for health access and broader benefits, has left population health programs scrambling to retain their relatively small amounts of state and local funding. If health reform covers more of the uninsured, moderates the cost of medical care through effectiveness research and national policies and identifies appropriate roles for prevention, it will help to achieve public health goals and will support governmental public health.

Some leaders expressed the hope that national health reform will be joined by national *public* health reform that will set forth a new vision, strategies and funding for public health at all levels. The current approach to the provision of local public health can best be described as a “patchwork” of funding, programs and capacities. Driven by federal and state categorical funding, alcohol and drug prevention is separate from other public health prevention and education efforts. Maternal and child health is separate from communicable disease control, while HIV has its own network of CBOs (many of which are now losing federal funding and turning to local governments for support). Community Health Centers are funded independently from LHD clinics, which have difficulty securing federal grants or participating in the associations of Community Health Centers. A number of our informants expressed the hope that national health reform would finally render this fragmented system obsolete and that federal, state and local stakeholders would develop a better, more focused and integrated approach.

Potential Positive Impacts

LHD leaders anticipate a number of positive impacts from health reform:

- **Increased recognition of the importance of public health:** Numerous provisions in the bill point to an increased role for CDC and public health in general. But beyond specific requirements, health reform already has made more explicit and visible the ways medical care is financed, thus creating pressure to improve outcomes and contain costs. In effect, this raises the question of “what we as a society can do collectively to assure the conditions in which people can be healthy.” This, of course, is the Institute of Medicine’s definition of public health from its 1988 report, *The Future of Public Health*. In short, public health leaders hope that over time, health

insurance and medical care reform will lead to the discovery and pursuit of public health solutions, as opposed to simply paying for and measuring the receipt of medical care services. This is particularly important given the increasing chronic disease burden and the growing emphasis on social determinants of health — both problems that can be effectively tackled through public health approaches. “Medical care and public health must be equally strong components of our system and they must operate hand-in-glove. Health reform could help that come about.”

“Medical care and public health must be equally strong components of our system and they must operate hand-in-glove. Health reform could help that come about.”

- **Formation of a National Prevention, Health Promotion and Public Health Council:** Health reform establishes the “National Prevention Council” within HHS. Chaired by the Surgeon General, the Council will bring together department secretaries from across the government. The Council will create a National Prevention Strategy; coordinate among federal agencies and make recommendations to the President on federal policy changes needed to achieve national wellness, health promotion and public health. The process of bringing together all federal health agencies to formulate a coherent and coordinated strategy for prevention, health promotion and wellness represents an opportunity to build a more robust and effective public health system for the nation. It also helps advance the importance of integrating public health and medical care resources in the service of the Healthy People 2020 goals. Finally, it provides an opportunity to more closely align the work of federal, state and local public health agencies.
- **Medicaid expansion:** By 2014, Medicaid programs across the country are required to provide eligibility to cover people with incomes up to 133% of poverty, including adults without dependent children (who have previously been excluded from Medicaid). This will fill a large hole in the safety net, offering the promise of improved access to care for the nation’s most vulnerable while simultaneously providing LHDs and other Medicaid service providers more resources to serve this population.
- **Mandates for prevention services:** PPACA mandates coverage of proven clinical preventive services for patients covered by private insurance and Medicare and encourages and rewards coverage of these services by Medicaid programs. These preventive benefits are to be provided without cost-sharing in order to eliminate any financial barrier to utilization. Medicare also will cover an annual wellness visit and personalized risk assessment and prevention plan. Medicaid programs must offer tobacco cessation benefits for pregnant women and must also design a public awareness campaign to educate Medicaid enrollees regarding coverage and availability of preventive and obesity-related services.

- Education and outreach campaign on preventive benefits:** The bill directs the HHS Secretary to provide for a national public-private partnership for a prevention and health promotion campaign to raise public awareness of health improvement across the lifespan. It requires the CDC Director to establish and implement a national science-based media campaign on health promotion and disease prevention.
- Funds for Community Transformation Grants:** The Fund represents the largest new investment in prevention in the nation's history; CDC is authorized to "award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation and dissemination of evidence-based community preventive health activities." LHD leaders hope these funds will be focused on achieving a limited number of key Healthy People 2020 goals and will build upon the models of community-based public health that they have been engaged with for the past decade or more. LHDs did not want to see these funds spread thinly across the country such that no real impact was possible, nor did they want to have CDC conduct a wide-open competitive grant program. A number of informants hoped CDC would use states as the primary grantees but require them to submit plans and proposals developed with the input of LHDs. Ideally, the community transformation funds will create long-term systems change and leverage other funds. "Don't just pay for one playground; create coalitions that support healthy lifestyles and change the built environment for everyone."
- Funds for community clinic expansion, public health laboratory-epidemiology support, and public health workforce recruitment and retention:** These provisions in health reform represent substantial new revenues to expand community clinic capacity, improve public health laboratory and epidemiological services and provide support for public health workforce education and training. Loan forgiveness provisions encourage health professionals to work in community clinics and health scarcity areas.
- Special program grants:** Many sections of the bill establish programs in the following general areas: chronic disease prevention, aging, maternal and child health, breast feeding, school-based health services, oral health, wellness, nutrition, health disparities, public health workforce and research and demonstration programs and pilot projects. Many of these programs will be of support and significance for LHDs and population health.

"Don't just pay for one playground; create coalitions that support healthy lifestyles and change the built environment for everyone."

Causes for Concern

Some of our informants also expressed concerns about the potential for negative impacts from health reform on public health.

Many felt that the federal legislation did not go far enough in reforming the way we pay for and organize medical care. Without a shared understanding on delivery system reform and acceptable ways to contain costs, implementation of health reform will “consume all the bandwidth and all the funds for health at the state and national levels.” We have seen this concern play out already: Medicaid, SCHIP and community clinics are visible, easily understood programs with vocal advocates who have access to the courts and the press. Some public health programs may be mandated, but the level of service is not. These programs may start out with a special grant or dedicated funding, but that is vulnerable to being whittled away over time. Funds are redirected and staff, services, clients and communities cut back until the program exists in name but can’t do much. An oft-cited statistic tells the story. Approximately 95% of the trillion dollars spent nationally on health supports direct medical care services; only 5% is allocated to population-wide approaches to health improvement — despite the fact that nearly 40% of deaths can be traced to modifiable behavior patterns.²⁴ Given this glaring mismatch between preventable causes of death and actual funding allocations, one could, as public health’s proponents have done for decades, “question a funding scheme that places so much emphasis on medical care and not on prevention.”²⁵

In a worst-case scenario for public health, national health reform could result in public health resources of all types being redirected into supporting the medical care system and the provision of individual clinical services. States and the federal government will need more funds to support expanded Medicaid eligibility as well as increased enrollment in traditional Medicaid eligibility categories.²⁶ Expanded insurance coverage will increase the already strong demand for safety net and other medical services; it will be tempting for local governments to assign their public health nurses to work in the primary care clinics. However, dismantling the public health system in order to support medical care would be the ultimate counterproductive response. Our society can’t reduce the impact of smoking purely through individual cessation “treatment.” Nor can we focus only on the medical treatment of chronic diseases and abandon the promotion of healthy lifestyles. CDC and the public health system as a whole should be

24 Centers for Medicare and Medicaid Services, Office of the Actuary, “National Health Expenditures, by Source of Funds and Type of Expenditure: Calendar Years 1994–1998,” (5 December 2000); and R. Brown et al., “Effectiveness in Disease and Injury Prevention: Estimated National Spending on Prevention—United States, 1988,” *Morbidity and Mortality Weekly Report* (24 July 1992): 529–53.

25 McGinnis JM, Williams-Russo P, Knickman JR. (2002). The case for more active policy attention to health promotion. *Health Affairs*;21(2):78-93.

26 When SCHIP was implemented, states saw an increase in Medicaid enrollment as families who were attracted to apply for SCHIP were determined to have one or more members who qualified for Medicaid.

prepared to counter plans to redirect public health funding and resources into the provision of medical care.

Local leaders also were concerned about the possible HIT changes that will be implemented with the support of massive amounts of federal funding. These developing systems largely have been focused on hospitals and medical providers. The increasing automation of medical records and the use of HIEs, while necessary and worthwhile, have the potential to undermine current public health data collection processes: “Currently, we go down to our local hospital and copy certain paper records to get information and we receive carbon copies of hospital and commercial laboratory results. What will happen when this is all automated?” HIT also has the potential to create a wonderful new system, in which public health has an increased ability to assess and assure the health of the public. In order to realize this potential, CDC (and SHDs) need to become more involved in defining “meaningful use” of HIT and assuring that the new systems communicate with and meet governmental public health needs, in addition to the needs of the medical and payment/insurance sectors.

Challenges for Health Reform

Exactly how the potential positive effects of health reform will play out is a subject of debate and speculation. State coverage expansions in Oregon, Massachusetts and California, as well as our experience with existing coverage programs, suggest that the following challenges will still exist after health reform is implemented. LHDs are involved in many of these areas now and may be called upon to expand their work.

- **Eligibility doesn’t equal enrollment:** Health reform will require state Medicaid programs to expand eligibility to cover childless adults up to 133% of poverty, increasing the number of Medicaid eligibles by 30% and 15 million people.²⁷ However, being theoretically eligible for coverage does not mean people actually get enrolled and stay enrolled. A recent national survey found that over 12 million people (one-fourth of the uninsured) were already eligible for Medicaid or SCHIP but were not enrolled.²⁸ Reasons for non-enrollment included lack of awareness that the program existed, not knowing how to enroll, fear of being linked with welfare and difficulty staying enrolled. A major outreach and enrollment effort is needed to realize the potential of health coverage expansion. Ideally outreach efforts would support all coverage options. Outreach efforts for SCHIP (when they finally occurred) also increased Medicaid (the

27 Medicaid is the single largest source of public hospital and community clinic revenue, accounting for 40% of all safety net revenues. States may begin expanding Medicaid eligibility immediately to 133% of poverty. By 2014, all state programs must meet this requirement. Rosenbaum S, Shin P, Darnell J. “Economic Stress and the Safety Net: A Health Center Update,” and *Issue Paper* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2004).

28 National Institute for Health Care Management Foundation, “Understanding the Uninsured: Tailoring Policy Solutions for Different Subpopulations.” NIHCM Foundation Issue Brief, April 2008. www.nihcm.org/pdf/NIHCM-Uninsured-Final.pdf.

so-called “wood work effect”). California counties that started Healthy Kids coverage programs found they enrolled two children in Medicaid or SCHIP for every child they enrolled in Healthy Kids. Outreach is most effective when it is an organized coordinated process; states can do this work directly, or involve LHDs in organizing and overseeing coalitions of organizations involved in outreach and enrollment. Ideally, these community based efforts also link low-income residents with a source of care, educate them on using the health system and provide referrals to other public health programs such as Head Start, nutrition education, and WIC.

Eligibility Does Not Equal Enrollment

Enrollment Does Not Equal Access

Access Does Not Equal Optimal Services

Optimal Services Do Not Equal Optimal Outcomes

- **Enrollment doesn’t equal access:** Currently, many people with Medicaid and even Medicare coverage have difficulty getting a doctor to accept them for care. There is a serious shortage of primary care providers in the United States that is projected to worsen even without the increased demand that health reform will generate. Many Medicaid patients get services in Community Health Centers, but these non-profit agencies are operating at capacity. Expanded hours or even new buildings are helpful, but clinics are struggling to recruit providers and nurses to serve more patients.
- **Access doesn’t equal optimal services:** Even though new enrollees may select a primary care provider or have a usual source of care, they will not necessarily receive beneficial prevention and screening services. Even when financial barriers to receipt of preventive services are removed (which health reform will be helping to do), more widespread use of EHRs will better enable primary care practitioners to recommend, remind and track the receipt of preventive services. Community education and awareness campaigns, along with intensive outreach to special populations, will still be needed even when more people have coverage.
- **Optimal services don’t equal optimal outcomes:** Even when people are consistently enrolled in health insurance and have access to optimal medical care, they won’t necessarily be healthy. Addressing the broad range of needs outside of medical care is also important. Unhealthy environments and lifestyles accompanied by poorly managed chronic conditions will undermine the real goal of health reform: healthy people.

The Impact of Health Reform on Clinical Public Health Services

Many LHDs now operate and fund specialized screening and treatment services for diseases and conditions of public health significance, such as STDs, immunizations, TB, and HIV testing. Will these services still be needed if there is universal access to health insurance or will LHDs be able to turn these

responsibilities over to primary care providers in the community? Our LHD informants believe they will continue to directly provide clinical public health services for the foreseeable future. Not only will there continue to be a substantial number of people who lack health insurance and who must rely on public services, but there will be others who choose to use these services. In addition to low financial barriers, public health clinics have other positive attributes as well. Well-run LHD specialty clinics can function as a “focused factory.”²⁹ For example, public system patients may want the anonymity of STD and HIV clinics; the convenience of immunization clinics; the expertise of TB clinics and the educational approach of family planning clinics. Moreover, some public health clinics will be geographically more accessible and culturally more welcoming to new Medicaid enrollees than the official “medical home” to which they are assigned.

Fifteen years ago, the state of Oregon expanded Medicaid and implemented various health insurance reforms. The results of that process for LHDs were mixed. In the rural county of Hood River, all the primary practitioners decided to stop giving childhood immunizations and refer their patients to the LHD immunization clinics. They thought this approach was more efficient and effective for the health care system as a whole. Ordering, storing and accounting for biologicals, participating in the federal Vaccines for Children program and maintaining expertise on the ever-evolving immunization schedule all take time and money. Having one entity responsible for these tasks for the entire population seemed more efficient. Moreover, having one central provider meant the County could keep consolidated immunization records that did not rely on patient–provider continuity. Coordination with the schools and communication with the families were simplified. It is true that PCPs “missed opportunities to immunize” and some argued that this approach fragmented care, yet for this community, the trade-offs were worthwhile.

One of our informants expressed the opposite perspective. Budgetary pressures are already forcing them to delegate clinic operations to other safety net providers. That LHD will instead focus on assessment, policy support and assurance regarding the provision of clinical preventive services.

Another possible impact of health reform on LHDs is financial. Legislative bodies, looking for funding for health insurance, may decide to defund those “redundant” public health clinics. When it expanded Medicaid coverage to serve childless adults, Oregon redirected state general funds away from LHD clinics into the state’s Medicaid match. The Legislature reasoned that fewer patients would be using public health clinics after coverage expansion and health departments would be able to bill for the services they provided to the newly insured. While some Medicaid patients left the public health specialty clinics for their new managed care homes, other uninsured patients stepped into the clinics’

29 “Focused factories” is a manufacturing concept applied to focused specialty hospitals that provide one specific type of service (e.g., hernia operations) at a lower cost with higher quality.

vacant slots. Public health clinics had difficulty billing Medicaid³⁰ and had fundamental differences with the fee-for-service delivery model.³¹ Several years later, it was determined that the public health clinics had not recouped lost state funds through billing Medicaid and they seemed to have as many clinic patients as ever.

Health Reform and LHD Medical Care Services

LHDs anticipate that national health reform will increase the demand for medical services, especially outpatient services, and will be accompanied by a welcome shift in payer mix. Many patients who were previously cared for as county indigents, general assistance, charity care and sliding-scale patients will be eligible for Medicaid or subsidized coverage through the health insurance exchanges. Having more insured patients will be very positive, but as one LHD director said, "It's hard to celebrate when there is a minefield between you and the goal post." The intervening dangers include the continuing state and local budget meltdown and the continued high rate of unemployment. People are now losing COBRA coverage and their unemployment insurance is running out, increasing the number of uninsured people who need care.

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The biggest impact on LHDs' delivery of care will come from changes to the Medicaid program — the engine that fuels the safety net.³² Effective April 10, 2010, States may expand Medicaid coverage to the "newly eligible" (primarily childless adults with annual incomes up to 133% of the Federal Poverty Level, or \$14,404 for one person). States *must* cover this population by 2014 and will receive 100% federal funding for the new eligibles through 2016, slowly declining to 90% federal support in 2020. The Congressional Budget Office estimates that Medicaid rolls would grow 30% (or 15 million people) over 10 years. According to the Kaiser Family Foundation, Medicaid expansion will "reduce long-standing disparities across the states in the reach of public coverage, build Medicaid's role as a cost-effective source of health coverage for those with low incomes who cannot afford or obtain private coverage, and facilitate access to preventive and coordinated care for millions of uninsured Americans."³³

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- 30 They lacked administrative billing services which cost money to create. Moreover, managed care plans did not easily add them as providers and resisted pre-authorizing services at the clinics (in spite of State regulations requiring Health Plans to contract with Public Health departments).
- 31 State Medicaid programs do not generally pay providers (including public health clinics) for services that are provided to the public at no charge. This requires clinics to establish fee schedules and show they are billing all types of insurance. Clinics can offer a sliding fee scale to avoid charging low-income uninsured patients but this requires collecting income information and making a decision on who qualifies for what fee. This adds to the cost and complications of billing and runs the risk of creating financial barriers where none should exist.
- 32 Regenstein M, Nolan L, Wilson W, Mead H, Siegel B. *Walking A Tightrope: The State of the Safety Net in Ten U.S. Communities* (Washington, DC: George Washington University Medical Center, May 2004).
- 33 Kaiser Family Foundation. "Expanding Medicaid: Coverage for Low-Income Adults Under Health Reform." February 2010. www.kff.org/healthreform/8052.cfm.

Low-income adults comprise 37% of the uninsured, with the majority having incomes below 50% of the federal poverty level. These 17.1 million uninsured adults have problems accessing routine health services and about one-third have been diagnosed with a chronic condition.³⁴ LHDs that operate safety net clinics and hospitals expect to continue providing care even after coverage is expanded. Oregon's State Office of Health Policy Research published a paper examining the role of the safety net in health reform and concluded it was still an essential component for delivering care.³⁵

"It is sometimes assumed that if universal coverage is available the safety net will not be needed. Mainstream providers will pick up the slack because reimbursement will be improved and will be available for the uninsured. While this perspective is understandable and has some truth to it, it is based on several assumptions that Oregon history and experience indicates are not entirely accurate:

- It assumes that the availability of reimbursement and its amount will be sufficient to convince providers to see newly covered individuals.
- It assumes that there are enough providers located in the right places who can competently serve individuals with special needs.
- It assumes that all providers will render the range of enabling services that are needed and will be able to provide them from the beginning of universal coverage.
- It assumes that coverage equals access."

Having Medicaid coverage will make it possible for LHDs to incorporate these patients into "systems of care," including Medicaid managed care plans and medical homes. Having insurance coverage will improve access to comprehensive services including diagnostic testing, medications, specialty referrals and scheduled hospitalizations that are now difficult to arrange for the uninsured.

One PPACA provision that could increase private sector access for Medicaid patients is the requirement for Medicaid plans to increase Medicaid payment rates to primary care doctors to match Medicare payment rates in 2013 and 2014. Although many primary care providers are concerned about low Medicare rates, in 2008 Medicaid programs paid only 66% of what Medicare paid for primary care services.³⁶

34 Expanding Medicaid: Coverage for Low Income Adults Under Health Reform; The Kaiser Family Foundation, www.kff.org/healthreform/8052.cfm.

35 The Safety Net within Broad Health Reform – SB 329 and the Oregon Health Fund Board (page 21). http://www.oregon.gov/OHPPR/SNAC/docs/SNACreport_FINAL.pdf.

36 Kaiser Family Foundation, StateHealthFacts.Org , Medicaid-to-Medicare Fee Index, 2008. www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4.

LHDs also expect to see new Medicaid and private coverage enrollees who were not previously known to them. After the state of Oregon extended insurance coverage to all low-income children under 19, Multnomah County Health Department primary care clinics (in Portland) saw almost 1,500 newly insured children. A quarter of these had clinic records indicating they had received some care at the clinic in the past, but 75% of the patients were entirely new to the County.

The Massachusetts experience with universal healthcare coverage (which has been referenced as a model for the nation's health reform bill) resulted in a significant decrease in the rate of uninsured as well as an increase in demand for medical services. A 2009 report found that Community Health Centers and safety net hospitals continue to be a very important care component for the newly insured, with the total number of patients served by Community Health Centers increasing by 50,000 from 2005 and 2007.³⁷ In addition, a 2008 study found that health reform has not affected emergency room utilization rates (for either emergency or non-emergency care), which have remained higher than the national average.³⁸

The executive director of the Boston Health Commission spoke about other roles for public health during this time of transition: "Times have changed and we want to make sure we have a high quality set of primary care services. We are really focused on health equity, which has involved retooling our training, skill sets and thinking around the issue of health. We're continuing to focus on the delivery of services, but there is also a much stronger focus in empowering residents, being active in the policy agenda, working with community coalitions and other organizations and making a difference in outcomes." And, "Health outcomes aren't necessarily better if more money isn't spent on prevention." With the goal of improving health outcomes in addition to coverage, the city of Boston currently is undertaking initiatives around preventing avoidable hospitalizations, improving the built environment and linking preventive and clinical services.

Public health laboratory directors also expressed a concern regarding their workforces that could be intensified by health reform. "We do not have the budget and salary structure to retain qualified people; no sooner do we get someone trained than they leave for a higher-paying position in a private hospital or commercial laboratory." Health reform, by increasing the demand for medical care services, may increase the "brain drain" of skilled laboratory technicians and other health professionals out of the public system into the private sector.

Medicaid expansion is being accompanied by reductions (but not elimination) of federal Medicaid Disproportionate Share Hospital (DSH) funds that now help to pay for Medicaid and uninsured patient

37 Ku, L. et al. (2009). *How is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform*. Kaiser Commission on Medicaid and the Uninsured. Kaiser Family Foundation.

38 Long, S. (2008). On The Road To Universal Coverage: Impacts Of Reform In Massachusetts At One Year. *Health Affairs* 27(4): w270-w284.

care.³⁹ In many areas, a substantial number of uninsured patients will continue to look to the LHD hospitals and clinics for access. The reduction in DSH (which is only available for inpatient expenditures) and the increase in Medicaid and other insurance revenues could free hospitals to provide more cost-effective outpatient services, but the total funding amounts received by specific institutions may not balance. Many LHDs fear they will lose funding in the trade-off.

State governments also may seek to reclaim and redirect funding that was provided to LHDs to support care of the indigent.

ARRA and PPACA provide major allocations of federal funds to expand Community Health Center locations and capacity. This will provide a much-needed expansion of primary care capacity for underserved communities. Unfortunately, clinics operated by LHDs have difficulty qualifying for federal Community Health Center status because their boards of directors are local elected officials and do not meet the requirement of having 51% consumer membership. Without overturning the consumer requirement, HRSA could make it easier for LHDs to qualify for these funds. This could provide important support for expanding outpatient capacity through LHDs.

VI. Recommendations from the Field for CDC

Most informants were delighted that CDC was interested in getting their input. They were heartened that CDC wanted to hear about their challenges, their innovations and their vision; they had many ideas to share about the ways in which CDC could best support LHD efforts and public health's "ideal future."

Virtually all of the public health leaders with whom we talked are engaged in the practice of a collaborative and community-based model of public health — one that could be termed "21st century public health" or, as others have called it, "Public Health Version 3.0." Most are working in a variety of collaborations and partnerships with non-profit community organizations, businesses, schools, cities and other governmental entities. In addition, they are also extending their partnerships into the domain of medical care delivery, working with hospitals, private physicians and health plans on a range of goals from reducing tobacco use and pediatric obesity to reducing hospital readmissions. This group of leaders is moving in the direction of greatest opportunity for the future of public health practice — and demonstrating the capacity of LHDs to be leaders and full partners in the transformation of health care

³⁹ The House reduced the Senate's proposed cuts to DHS on the grounds that there will still be uninsured people living in the United States/ Medicaid DSH, would be cut an estimated \$14 billion over 10 years; for Medicare DSH, the cut would be 22.1 billion. Those Medicare and Medicaid DSH reductions would begin in FY 2014, rather than FY 2015 as proposed by the Senate.

and public health. As these leaders demonstrate what public health can do, they may be able to help other organizations around the country build their own roles and capacities, too.

The task of providing the kinds of support outlined below to the diverse universe of LHDs across the entire country is substantial; it is unlikely that CDC could accomplish all or even part of this by itself. A number of leaders in national associations and organizations recommend the use of partnerships or third-party administrators to help CDC best support LHDs. (Several are mentioned below.)

Develop and Promote a Compelling Case for Public Health's Crucial Role in the Nation's Health

Our informants believe CDC has a unique opportunity to engage in a national conversation on the role and capacity of public health to support the goals of national health reform. LHDs would like CDC to be eloquent and persuasive about the importance of primary prevention in a community context and to support the involvement of LHDs in "health in all policies." They hope that CDC will promote the concepts of social determinants of health and community-based primary prevention and will continue to show commitment to addressing issues of health equity and health disparities. They believe that CDC should keep these concepts before the public through its communication strategies and continually reinforce these priorities among the HHS partners in the federal government, through the National Health Council and other means. The planned expansion of Medicaid by the Centers for Medicaid and Medicare Services (CMS) and community clinic capacity by HRSA should be carried out in coordination with public health priorities and organizations at the national, state and local levels, particularly LHDs that provide a significant portion of the safety net services. CDC should support the integration of prevention activities at the local level, thus helping to keep the focus on 'health,' and not simply more medical care services delivery.

- "When I stand up in front of my elected officials and tell them I want to work on changing planning requirements so that people can walk in their communities, I could use some support from CDC. I want to be able to tell them (and my community partners), 'CDC says this is important. It's my job to work with you on this.' It's hard to do this by ourselves and there is no local constituency for this yet."
- An effective public health system will require a great deal more coordination among federal agencies, including HRSA, SAMHSA, CMS, HUD, DHS, and others. "CDC needs to strengthen its presence in Washington, DC, participating actively in cross-agency work groups. High-ranking CDC officials need to meet regularly with the heads of the other health agencies to talk about how they can support each other and align their programs."

- CDC and HRSA should explore the implications of health reform for medical care delivered by LHDs, which are an essential component of the nation’s safety net system. Providing LHDs with access to federal resources that support primary care could benefit the entire system.
- “I wish CDC could play a role in setting national health goals, helping other agencies identify effective strategies to achieve those goals and supporting the alignment of goals, strategies and funding across agencies.”
- “Can CDC support the role of local public health with other federal agencies? The private practitioners in my community don’t want to hear from the Department of Homeland Security about medical matters related to emergency preparedness. They trust the CDC and the State and County Health Departments. We know there are turf issues, but can we figure out a way to deliver messages from the trusted communicator using existing channels?”

CDC could play a role in setting national health goals, helping other agencies identify effective strategies to achieve those goals and supporting the alignment of goals, strategies and funding across agencies.

Focus and Align Research, Practice and Priorities

Numerous informants would welcome ‘more leadership and guidance’ from CDC in regard to articulating public health priorities, identifying effective strategies for addressing those priorities and then directing funding accordingly. In this time of tight public resources, they see the need to both focus program activities, and to better integrate research and evaluation efforts with those activities. They hope that CDC can take the lead in identifying best practices, disseminating information on them and integrating them into workforce education and training systems. They are especially interested in models of community collaborative health improvement that link local public health and primary care, particularly in the public sector. They see CDC’s role as organizing, implementing and continually improving the research agenda for public health practice. The research agenda must continue to include performance measurement and accountability measures, to support the evidence base for public health. They expressed these ideas in a number of ways:

- “It’s great to have Healthy People 2020, but there are so many goals, it doesn’t help us focus on the most important priorities.” And, more succinctly: “Chase too many rabbits, catch none.”
- “We should all be required to address the top priorities and then have an option to add on some local priorities.”

“It’s great to have Healthy People 2020, but there are so many goals, it doesn’t help us focus on the most important priorities . . . Chase too many rabbits, catch none.”

- “The new funding devoted to community transformation is great and it sounds like a lot of money! But it isn’t enough to do everything; it’s not the answer to all our needs. The CDC needs to have a clear focus for what these funds will accomplish; we need specific deliverables so that we can show Congress and the country that public health can perform.”

“We need help from CDC on identifying and disseminating best practices for changing the determinants of health.”

When we asked leaders about specific CDC priorities, they were less interested in the group of clinical priorities (Aspirin for cardiovascular disease, Blood pressure control, Cholesterol control and helping people quit smoking). They felt these priorities, while very worthwhile and important for the medical care system, were too limiting as goals for the entire public health system. Blood pressure and cholesterol can be improved through diet and exercise, which is an area that resonates with a community-based “healthy lifestyles” focus. LHD leaders were much more positive about CDC’s promotion of population-oriented goals, described as “Key Winnable Battles,” including tobacco, nutrition, physical activity and obesity, injury prevention and the prevention of unintended pregnancy (especially in teens). The selection of goals for improving the nation’s health is an important step that could be central to the work of the National Health Council as well as to CDC. LHDs hope CDC (and/or the Council) will have a good process for selecting the most important goals and, through that process, will get “buy-in” from other federal partners.

- “Allowing expenditure of the federal prevention Block Grant funding on any of the hundreds of Healthy People goals is too broad; everyone is doing something different and there are no tangible outcomes. It weakens support for the funds.”
- “We need help from CDC on identifying and disseminating best practices for changing the determinants of health. What types of interventions are effective and what partnerships will support these interventions? Everyone is re-inventing the wheel and we’re wasting effort by not having better roadmaps. Tobacco control has become more standardized (thanks to CDC). Now, how about pediatric obesity and unintentional injury prevention?”
- “Our work to create healthy communities should be informed by the strategies employed successfully in developing countries: link public health and primary care (co-locate and more), use community health workers, support economic development and community empowerment and operate targeted campaigns within this environment.”
- CDC should have a research agenda for public health. This should include study and analysis of both the determinants of health and disease and on the most effective approaches to improving population health, including the roles of policies, engaged communities, technology, etc.

- CDC could provide more guidance about where the newborn screening program should be going. This is a major public health program whose future is now being driven by private companies seeking business opportunities, rather than by public health analysis regarding the new tests that would be the most beneficial.

Strengthen the Foundation of the Public Health System

LHD leaders support CDC working to create infrastructure and capacity at the local level as a foundation or platform for supporting the many programs that will be directed towards achieving the nation's health goals. They understand that improved public health infrastructure requires better integration of systems and strategies between different levels of government, such as that shown to be necessary in recent planning efforts around emergency preparedness. Further, they believe that integration will require addressing more than programs and plans, but also the improvement of financial and administrative mechanisms so that they support program effectiveness, rather than hinder it.

- “I no longer see my work as being all about programs; I am trying to build systems and relationships. I am trying to educate everyone (my bosses, colleagues, employees, CBOs etc.) about health and to build our capacity to work with communities. We must be able to address issues at both the policy and neighborhood levels. It will be a different issue tomorrow but if the capacity is there, we are ready.”
- CDC has an excellent program to build governmental health capacity internationally; it could apply some of those same skills and approaches to building public health capacity in this country.

LHD leaders support CDC working to create infrastructure and capacity at the local level by prioritizing activities and programs that build a more consistent, capable public health system across the country. Just as the vertical relationships between the national, state and local public health agencies need attention, so do the horizontal relationships at the local level — that is, the relationships of LHDs with medical care, education, business, other local governments and community sectors. While many LHDs have pioneered models of community-based prevention, there is a need to better evaluate and disseminate the best practices in this area. The leaders we spoke to emphasize the need to develop better accountability measures, expanded workforce training and support and to greatly improve data systems that support effective programs and evaluations.

Roles and Responsibilities

Past federal actions (and inactions), across a range of agencies and administrations have helped to create “fragmented, siloed and disconnected” public health activities at the local level. Public health leaders are not asking CDC to “neaten things up by issuing mandatory organization charts.” Our

informants understand that “one size doesn’t fit all.” In some of the smaller states, the provision of direct services by the SHD is an efficient model. And in some states, the larger counties with their integrated Health Services Agencies and even Health and Human Services Agencies are demonstrating how to align diverse programs. Local leaders want CDC to affirm the importance of building effective, capable public health entities that provide local services with some type of governmental accountability.

“Public health will lose policy maker support if it doesn’t modernize and become more accountable.”

- “CDC should continue to work primarily through the SHDs. That is the only way to get state and federal priorities in alignment and to create some consistency of approach across a state.”
- “CDC should require SHDs to involve the locals in developing the plans and proposals they submit to CDC, especially when the locals will be carrying them out! The H1N1 concurrence model gave us a seat at the table (and let’s have a requirement that 70% or more of federal public health funds be spent at the local level).”
- “The MCH Title V Block Grant planning process is a good model. The feds set the high-level priorities, the experts at the SHD have a major role in defining the plan and how monies will be spent in their states, but they have to consult with the locals. We are all accountable for performance and achieving the goals.”
- “CDC should work directly with more of the larger health departments, not just New York, Los Angeles and Chicago, but other big sophisticated departments. These departments are ‘orphaned.’ They don’t get help and attention from their SHDs (who must focus on helping the small and medium-sized departments) and they aren’t allowed to work directly with CDC.”
- “CDC should resist political pressure to directly fund CBOs, unless the LHD is involved. LHDs should be supported in adopting newer models and practices. Don’t undermine their standing and forego the benefits of having public health programs be part of locally accountable governments just because of their own history of scarce funding and staffing.”
- “LHDs aren’t the right entity to lead every initiative in every jurisdiction. The role of LHDs is to contribute ‘the public health voice’ to joint goals that lead to health.”
- CDC could offer LHDs the “right of first refusal” and/or require LHDs to sign off on another entity’s application for CDC funding.

Quality Improvement Processes

Many LHDs are participating in the movement towards credentialing LHDs and affirm the importance of accountability and the need to find better ways of evaluating performance and measuring outcomes. Ideally, CDC will develop a research agenda that brings academic researchers and practitioners together to answer questions about effective practices and next steps in prevention.

- “Public health will lose policy maker support if it doesn’t modernize and become more accountable.”
- “We must develop more effective performance measures. Much of what we do is outcome measures that are far downstream from our interventions and are impacted by many variables. In addition, we should move upstream and measure things that our interventions are likely to impact directly, that we know are associated with better outcomes.”

“Contact with public health leaders in other communities had the most influence on me. Reading about all the wonderful things other LHDs were doing didn’t necessarily make me feel like I could and should do the same. But talking to people — hearing the problems, not just the sanitized versions of success — made a huge difference.”

Training and Education

LHDs were very interested in having CDC assure the availability of training and education resources for the local workforce. These efforts could build common values and language among the many professions that contribute to public health. Ideally, public health could develop a “National Learning Network” that would share best practices in a range of areas from hiring community health “promotoras” to working effectively with schools.

- “Compared to other fields of government and compared to the private health care sector, we are under-investing in the development and professional growth of public health leaders and managers. Many local (and state) governments restrict membership in professional groups and restrict out-of-state (or even out-of-county) travel!”
- “Public health has to build the capacity and confidence to interact with local hospitals and private physicians. The community work has to get connected to the medical home. CDC can help LHDs with this.”

Ideally, state laboratories would like to be able to offer more training to technicians and professionals working in hospital or commercial laboratories. A large percentage of Clinical Laboratory Improvement Amendments (CLIA) licensing funds stays at the federal level to administer the program, while the

urgent priority of training and education to improve the quality of medical care services in laboratories receives limited public attention.

CDC does not need to undertake all of this with its own staff and resources. NACCHO has a program to identify models and best practices and would like to expand it; the Public Health Foundation has wonderful “tool kits” with templates and other models that could be more widely disseminated; public health institutes and others have been conducting applied research and providing training and consultation to LHDs. CDC has developed important tools for distance learning, which are an efficient way of reaching large audiences. In addition, several LHD leaders suggested that face-to-face training builds a deeper understanding of issues, creates relationships and has the potential to form learning communities that will continue their work beyond the classroom experience.

- “Contact with public health leaders in other communities had the most influence on me. Reading about all the wonderful things other LHDs were doing didn’t necessarily make me feel like I could and should do the same. But talking to people — hearing the problems, not just the sanitized versions of success — made a huge difference.”

Data and Information Systems

LHD leaders mentioned several key needs in relation to data and information systems, including the provision of high-quality local data to help develop and assess health priorities; increased funding to support information system initiatives and new social media approaches; public health data systems standardization (including establishing basic data sets that will be collected across grant programs); inclusion of public health in establishing HIEs, particularly the definitions of “meaningful use;” support for public health laboratory reporting and platform integration; and guidance from the CDC on communications strategies in an age of instant information (e.g., sharing information about H1N1). Local leaders said the following about technology and data:

- “Data and information systems are fragmented and siloed. This is a state and local problem, but CDC contributes to it by creating new data sets and reporting requirements for each grant. Effective streamlining is needed.”
- “Data goes in but nothing comes out. The feds and the states need to invest money in giving us our data in a timely manner. For example, H1N1 vaccination data for private providers were submitted, but I can’t find out which high-risk groups were adequately vaccinated and which ones need more outreach. I have the County clinic data, but that is only part of the picture. ”

- “CDC and public health must get involved in defining the meaningful use of HIT. The data set public health needs to do its work, especially its new and evolving work on chronic disease and assessing medical care services, must come out of those new systems that are being built with federal funds.”
- “States and localities are buying and building new IT systems for public health reporting. Could CDC identify effective systems and encourage us to use them? We don’t want to waste time and money by having each jurisdiction sift through all the possibilities.”
- “We need local/regional data to evaluate the impact of local efforts to create healthy lifestyles. Short of doing mini-NHANES studies, how can we tell if our efforts are working? Perhaps CDC can identify intermediate measures that are related to final outcome goals? Or perhaps there are other substitute data points that we can access and extrapolate from.”
- “We would like to be able to utilize other federal data sets. For example, USDA’s WIC data could be matched with Medicaid or vital statistics data to find low-income, at-risk newborns who haven’t been enrolled in WIC.”
- There is an opportunity now for CDC to support use of a standardized data system for states and large local public health laboratories. It would create a stronger information flow between states and to CDC and lead to economies in training, system customizations, etc.
- “During the H1N1 crisis, it would have been nice to have guidance on how to communicate in an age of instant information, particularly using new media. Our Department tried to communicate something almost every day, even if it was to say we were waiting for additional information. Crisis and emergency communications is something we want to learn more about.”

Bridging the Federal and Local Gap

Local leaders did not express a lot of conflict with CDC, but many of them said they did not have much of a relationship with CDC. LHD leaders noted the importance of enhanced communication between all levels of government during this phase of transition into the reformed health system. Several commented very favorably on the fact that they already had met the new CDC Director, and hope that executive leadership at CDC will follow this practice of seeking information from them as CDC leaders travel and attend meetings around the country. As a federal agency, CDC will always have an organizational culture that is different from that of a local public agency, but it is helpful to increase understanding of each others’ cultures and values.

LHDs appreciate direct communication from CDC; it helps them stay abreast of federal and public health developments and anticipate changes in programs, funding and technology. Having an opportunity for local participation in CDC planning processes, work groups, surveys, grant reviews and similar efforts would be welcomed by many LHD leaders.

Most of our informants were very interested in the idea of having CDC provide federal FTEs to work in their departments and also would like to give local professionals the opportunity to work at CDC or in other federal agencies. However, they cautioned that roles and responsibilities will need to be clarified ahead of time, in order to avoid confusion and provide maximum benefit.

- “Our local government has all kinds of problems hiring the expertise we need: hiring freezes, uncompetitive salaries, lack of specialized job descriptions, no talent pool from which to recruit. Assignment of CDC staff could leapfrog over these problems. We can provide a great experience for epidemiologists, health educators, media specialists, statisticians, etc. And, in turn, they can develop a firsthand view of how local public health gets done, what we need and how we think. CDC would benefit from having these people return back to Atlanta and bring those perspectives to their colleagues.”
- “It needs to be clear what the role of out-stationed staff will be. Who will they actually work for?”

Financing and Funding Issues

The question of how CDC should distribute public health funding was of great interest to LHDs and their national organizations, but there was less agreement in this area. The divergent comments below illustrate the cross-cutting values involved and suggest that there is more than one right answer to how financing can be used to create a better system and good outcomes.

- “Can CDC help the country sort out which levels of government are responsible for funding what public health services? When everyone is responsible, no one is responsible. The state hopes the feds will fund local public health. The feds defer to the foundations. The locals are left trying to patch something together.”
- “We know that distant funders (in Congress, for instance) will put more strings on the money; so federal money for basic capacity is not the best plan. We should all work to develop state and local responsibility for funding basic public health capacity and infrastructure.”
- “Categorical, competitive grants take a lot of administrative work and reward LHDs with the capacity to write them, not necessarily those who have the greatest need. Competitive funding is not equity.”

- “Categorical grants perpetuate silos. We shouldn’t be approaching every disease state and every population with a separate grant and funding stream.” **Health reform without a public health system is a hollow and ultimately unaffordable promise.**
- “CDC and the states may take a year or more to issue an RFP, but LHDs are expected to respond in a matter of months. Our partnerships and approval process can be complex, too. Can we average out the total time available between the levels of government?”

In summary, building national support for an empowered, capable public health system and developing the programs and infrastructure that will make this vision a reality in communities across the country will not be a simple task. But health reform without a public health system is a hollow and ultimately unaffordable promise. If we truly want to see healthy people in healthy communities, we must do the hard and exciting work of supporting the revitalization of local public health.



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