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

Section VII — Attachments

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Note

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

Attachments

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Attachment A. H.R. 3590: The Patient Protection and Affordable Care Act (PPACA) Prevention and Public Health Implementation Timeline

2010

National Prevention, Health Promotion and Public Health Council. PPACA establishes the National Prevention, Health Promotion and Public Health Council (National Prevention Council) within the Department of Health and Human Services (HHS), composed of department secretaries from across the government and chaired by the Surgeon General. The National Prevention Council is charged with developing the National Prevention Strategy, coordinating among federal agencies and making recommendations to the President on federal policy changes needed to achieve national wellness, health promotion and public health goals. (Sec. 4001)

Prevention and Public Health Advisory Group. PPACA creates the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health within HHS. Comprised of 25 stakeholders, the Advisory Group will advise the National Prevention Council on the development of policy and program recommendations. (Sec. 4001)

Prevention and Public Health Fund. In fiscal year 2010, first year funding ($500 million) is appropriated to the Prevention and Public Health Fund to expand and sustain a national investment in prevention and public health programs. The Fund will support programs authorized by the Public Health Service Act for prevention, wellness and public health activities such as the community transformation grant program, the education and outreach campaign for preventive benefits and immunization programs. (Sec. 4002)

Health plan coverage of preventive health services. For plan years beginning on or after September 23, 2010, all new group or individual health insurance coverage must cover and not impose any cost sharing for preventive services graded 'A' or 'B' by the U.S. Preventive Services Task Force; immunizations recommended by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices; preventive care and screenings for infants, children and adolescents included in guidelines from the Health Resources and Services Administration (HRSA); and, additional preventive care and screenings for women not described by the U.S. Preventive Services Task Force but included in HRSA guidelines. (Sec. 1001)

Medicaid coverage of tobacco cessation services for pregnant women. Effective October 2010, states will be required to provide Medicaid coverage for tobacco cessation counseling and drug therapy for pregnant women without cost-sharing. (Sec. 4107)

Childhood obesity demonstration project funding. PPACA appropriates $25 million for the period of fiscal years 2010 through 2014 for the child obesity demonstration project authorized in the Children's Health Insurance Program Reauthorization Act of 2009 (P.L.111-3). (Sec. 4306)

Community transformation grants. The Secretary of Health and Human Services (Secretary), through the CDC director, will award competitive grants to state and local government agencies and community-based organizations to implement, evaluate and disseminate evidence-based community preventive health activities designed to reduce chronic disease, prevent the development of secondary conditions, address health disparities and develop a stronger evidence base of effective prevention programming. At least 20 percent of the grants will be awarded to rural and frontier areas. Grantees are required to develop detailed plans addressing the policy, environmental, programmatic and infrastructure changes needed to promote healthy living and reduce disparities, and to implement programs and policies to promote healthier lifestyles. Such sums as may be necessary are authorized for these activities for each of fiscal years 2010 through 2014. (Sec. 4201)

Preventive Services Task Force. An independent Preventive Services Task Force will be convened by the director of the Agency for Healthcare Research and Quality to develop and update clinical preventive recommendations and to publish the Guide to Clinical Preventive Services. The Task Force will review scientific evidence regarding effectiveness, appropriateness and cost-effectiveness of clinical preventive services. At least once during every five year period, the independent Preventive Services Task Force will update the recommendations. The Task Force will make yearly reports to Congress identifying gaps in research and recommending research areas. There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.(Sec. 4003)

Community Preventive Services Task Force. The CDC director will convene an independent Community Preventive Services Task Force to review the scientific evidence related to the effectiveness, appropriateness and cost-effectiveness of community preventive interventions and make recommendations. The Task Force will publish the Guide to Community Preventive Services. At least once during every five year period, the Community Preventive Services Task Force will review and update recommendations. The Task Force will make yearly reports to Congress identifying gaps in research and recommending research areas. There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force. (Sec. 4003)

National Prevention Council progress updates. By July 1, 2010 and in each subsequent year through 2015, the National Prevention Council will submit to the President and the relevant congressional committees a report describing the Council's activities, progress on meeting the national goals to be developed by the Council, a list of national priorities on health promotion and disease prevention, and plans for initiatives (including coordinating and consolidating federal programs) to target health behaviors. (Sec. 4001)

Demonstration program to improve immunization coverage. The Secretary, acting through the CDC director, will establish a demonstration program to award grants to states to improve immunizations for children, adolescents and adults. Grants will be used to implement interventions recommended by the Task Force on Community Preventive

Services and other evidence-based interventions. Four years after the date of enactment, the Secretary will report to Congress on the effectiveness of the program and make recommendations about whether to continue and expand the program. Such sums as may be necessary are authorized for these activities for each of fiscal years 2010 through 2014. (Sec. 4204)

Healthy Aging, Living Well pilot programs. The Secretary, acting through the CDC director, will award grants to state or local health departments to conduct five-year pilot programs to provide community interventions, screenings and clinical referrals for individuals between the ages 55 and 64. Community interventions may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance use, improve mental health and promote healthy lifestyles. Screening activities may include mental health, behavioral health, physical activity, smoking and nutrition screening. Individuals between 55 and 64 years of age who are found to have chronic disease risk factors through these screening activities will receive referral for clinical follow-up. The program evaluation will consider changes in the prevalence of uncontrolled risk factors among new Medicare enrollees. Such sums as may be necessary are authorized for these activities for each of fiscal years 2010 through 2014. (Sec. 4202)

National diabetes prevention program. The Secretary, acting through the CDC director, will establish a national diabetes prevention program targeting adults at high risk for diabetes. Eligible grantees include state and local health departments, tribal organizations, national networks of community-based non-profits focused on health, academic institutions or other entities determined by the Secretary. Such sums as may be necessary are authorized for each of fiscal years 2010 through 2014 for these activities. (Sec. 10501)

Public health workforce loan repayment program. The Secretary will establish a Public Health Workforce Loan Repayment Program for public health or health professionals who work for at least three years in a federal, state, local or tribal public health agency or fellowship. Annual loan repayment is capped at the lesser of $35,000 per individual or one third of total debt. The program is authorized at $195 million in fiscal year 2010 and such sums as may be necessary are authorized for each of fiscal years 2011 through 2015. (Sec. 5204)

Public health training for mid-career professionals. The Secretary is authorized to make awards to educational entities for scholarships to support the training of mid-career professionals in public health and allied health. In fiscal year 2010, $60 million is authorized. Such sums as may be necessary are authorized for each of fiscal years 2011 through 2015. Fifty percent of appropriated funds will be allotted to public health mid-career professionals and 50 percent to allied health. (Sec. 5206)

Epidemiology-laboratory capacity grants. The Secretary, acting through the CDC director, will establish an Epidemiology and Laboratory Capacity Grant Program to award grants to state and local health departments and, at the director's discretion, to academic centers, to assist public health agencies in improving surveillance and response to infectious diseases. PPACA authorizes $190 million for each of fiscal years 2010 to 2013 for these grants, of which at least $95 million per year would be for epidemiology, $60 million per year for information management and $32 million per year for laboratory capacity. (Sec. 4304)

Training in cultural competency, prevention, public health and working with individuals with disabilities. The Secretary will support the development and evaluation of research, demonstrations and model curricula for use in health professions schools to provide training in cultural competency, prevention, public health proficiency, reducing health disparities and working with individuals with disabilities. Such sums as may be necessary are authorized for each of fiscal years 2010 through 2015 for these activities. (Sec. 5307)

Lifting the cap on the Commissioned Corps. PPACA removes the cap (set at 2,800) on the number of commissioned officers in the U.S. Public Health Service Regular Corps. (Sec. 5209)

Establishing a Ready Reserve Corps. PPACA establishes the Ready Reserve Corps within the Commissioned Corps to address the need for additional commissioned personnel to assist in emergency response and other public health situations, including backfilling critical positions left vacant during deployment of active duty Commissioned Corps. For each of fiscal years 2010 through 2014, $5 million is authorized for recruitment and training and $12.5 million for the Ready Reserve Corps.

Grants to promote the community health workforce. The CDC director will award grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers. Community health workers will provide outreach related to health problems prevalent in underserved communities, provide guidance regarding effective strategies to promote positive health behaviors, identify and refer underserved populations to community-based programs and provide maternal and prenatal home visitation services. Such sums as may be necessary are authorized to be appropriated for each of fiscal years 2010 through 2014. (Sec. 5313)

Expanding public health fellowship training opportunities. The Secretary is authorized to expand existing CDC public health training fellowships in epidemiology, laboratory science and informatics, the Epidemic Intelligence Service (EIS), and other related training programs. For each of fiscal years 2010 through 2013, $24.5 million is authorized for EIS fellowships and $5 million each for epidemiology, laboratory and informatics fellowships. (Sec. 5314)

United States Public Health Sciences Track. The Secretary will establish a U.S. Public Health Sciences Track to award degrees that emphasize team-based service, public health, epidemiology and emergency preparedness and response by training students of medicine, dentistry, public health, behavioral and mental health, physician assistance and pharmacy. The Surgeon General is tasked with negotiating with institutions to support the science track and can provide students with funding if they serve for a period of two years in the Commissioned Corps for each year of support. Beginning in fiscal year 2010, the Secretary is required to transfer such sums as may be necessary from the Public Health and Social Services Emergency Fund to carry out these functions. (Sec. 5315)

Training in general, pediatric and public health dentistry. The Secretary is authorized to make grants to entities to support training and provide financial assistance in general dentistry, pediatric dentistry or public health dentistry for dental students, dental residents, dental hygienists, practicing dentists or dental faculty. PPACA also creates a

faculty loan repayment program for specific fields of dentistry; permits eligible entities to partner with schools of public health to allow dental residents or dental hygiene students to receive master's level training in public health; and takes additional steps to expand dental training. In fiscal year 2010, $30 million is authorized to be appropriated for these activities. For each of fiscal years 2011 through 2015, such sums as may be necessary are authorized. (Sec. 5303)

Evidence-based coverage of Medicare preventive services. Beginning in 2010, the Secretary has the authority to modify or eliminate Medicare coverage of certain preventive services to ensure consistency with the recommendations of the U.S. Preventive Services Task Force. (Sec. 4105)

2011

National Prevention, Health Promotion and Public Health Strategy. By March 23, 2011, the National Prevention Council will release a National Prevention, Health Promotion and Public Health Strategy with specific goals and timelines for improving health through federally-supported prevention, health promotion and public health programs. (Sec. 4001)

Prevention and Public Health Fund. In fiscal year 2011, $750 million is appropriated to the Prevention and Public Health Fund to expand and sustain a national investment in prevention and public health programs. (Sec. 4002)

Medicare personalized prevention plan. Beginning in 2011, Medicare will cover personalized prevention plans that include health risk assessments. Personalized prevention plans may include review and updating of family and medical histories, screening schedules and referrals based on the U.S. Preventive Services Task Force recommendations, and a listof risk factors and treatment options. Plans also may include referral to health education or preventive counseling programs or community-based lifestyle interventions to reduce health risk and promote self-management and wellness. Beneficiaries are eligible for the personalized prevention plan benefit once a year without cost-sharing. (Sec. 4103)

Removal of cost-sharing for Medicare preventive services. Effective in 2011, Medicare will cover 100 percent of the costs for most preventive services, including personalized prevention plans, the initial Medicare preventive physical examination and those covered preventive services that are recommended with a grade of 'A' or 'B' by the U.S. Preventive Services Task Force. (Sec. 4104)

Medicaid incentives for prevention of chronic diseases. Beginning in 2011, the Secretary will award grants to states to test the use of incentives in Medicaid to encourage healthy lifestyles. The Secretary will develop program criteria using resources such as the Guide to Community Preventive Services, the Guide to Clinical Preventive Services and the National Registry of Evidence-based Programs and Practices. Programs will have to have demonstrated success helping individuals quit smoking, lose weight, lower cholesterol and/or blood pressure, or prevent the onset of or assist in the management of diabetes. PPACA appropriates $100 million for the program for a five-year period. (Sec. 4108)

Nutrition labeling of standard menu items at chain restaurants. Within one year of enactment of PPACA, the Secretary will promulgate proposed regulations requiring nutrition labeling for standard menu items in chain restaurants or food establishments with 20 or more locations. These entities must disclose the number of calories in standard menu items and other required nutritional information. Vending machine operators that own or operate 20 or more machines must disclose the number of calories in each food item in a way that makes the information available before purchase. The Secretary will provide quarterly reports to Congress regarding progress on finalizing regulations. (Sec. 4205)

National Health Care Workforce Commission. Beginning in 2011, the PPACA created 15-member National Health Care Workforce Commission will make annual reports to Congress and the Administration on its review of health care workforce supply and demand issues and its recommendations for national priorities and policies. High priority areas for the Commission include public health care workforce capacity at all levels. Such sums as may be necessary to carry out these activities are authorized. Further, PPACA establishes competitive health care workforce development grants for states. HRSA will administer the program in consultation with the Commission. Planning grants are authorized at $8 million for fiscal year 2010 and such sums as may be necessary for each subsequent fiscal year. Implementation grants are authorized at $150 million for fiscal year 2010 and such sums as may be necessary in each subsequent year. (Sec. 5101 and Sec. 5102)

Health promotion media campaign. By March 23, 2011, the CDC will implement a national science-based media campaign on health promotion and disease prevention to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the five leading killers in the U.S., and secondary prevention through disease screening promotion. Every two years, the campaign is to be evaluated and the Secretary is to report to Congress

on its effectiveness. In addition, the Secretary, in consultation with the Institute of Medicine, will develop a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the lifespan. Further, the CDC director will develop a Web site resource on disease prevention that allows individuals to determine their own disease risk. (Sec. 4004)

Obesity and Medicaid. The Secretary will provide guidance to states and health care providers on preventive and obesity-related services available to Medicaid enrollees. States are to design awareness campaigns to educate Medicaid enrollees about coverage of these services. The Secretary is to report to Congress by January 1, 2011 and every 3 years thereafter on the status of these efforts and states' actions. (Sec. 4004)

Health risk assessments. The Secretary will establish publicly available guidelines for health risk assessments and standards for telephone and Web-based risk assessment tools. Within 18 months of enactment of PPACA, the Secretary will make a health risk assessment model publicly available. (Sec. 4103)

Preventive medicine and public health training grant program. The Secretary, acting through the HRSA administrator and in consultation with the CDC director, will award grants or enter into contracts with eligible entities: 1) to plan, develop, operate or participate in an accredited residency or internship program in preventive

medicine or public health; 2) defray the costs of practicum experiences; and 3) establish, maintain or improve academic administrative units in preventive medicine and public health or programs that improve clinical teaching in preventive medicine and public health. For fiscal year 2011, $43 million is authorized to be appropriated. Such sums as may be necessary are authorized to be appropriated for each of fiscal years 2012 through 2015. (Sec. 10501)

Workplace wellness program grants. The Secretary will award grants to eligible employers to provide comprehensive workplace wellness programs over a five year period. Eligible employers employ less than 100 employees. The Secretary will develop program criteria consistent with the Guide to Community Preventive Services and the National Registry for Effective Programs. For the period of fiscal years 2011 through 2015, $200 million is authorized. (Sec. 10408)

2012

Prevention and Public Health Fund. In fiscal year 2012, $1 billion is appropriated to the Prevention and Public Health Fund to expand and sustain a national investment in prevention and public health programs. (Sec. 4002)

Oral healthcare prevention education campaign. By March 2012, the Secretary will initiate a five-year national, public education campaign focused on oral healthcare prevention and education. Such sums as may be necessary are authorized for these activities. (Sec. 4102)

CDC and employer-based wellness programs. The CDC director will provide employers with technical assistance, consultation and other resources to evaluate workplace wellness programs. Not later than two years after the date of enactment of PPACA, the director also will conduct a national worksite health policies and programs survey to assess employerbased health policies and programs. (Sec. 4303)

Better diabetes care. The Secretary, in collaboration with the CDC director, will prepare on a biennial basis a national diabetes report card, including to the extent possible, report cards for each state. Report cards will include aggregate health information related to diabetes and pre-diabetes, including preventive care, risk factors and outcomes. The Secretary will also act through the CDC director to promote the education and training of physicians on the

importance of birth and death certificate data, including the collection of this data for diabetes, and work with states to re-engineer their vital statistics systems, including improvements in diabetes mortality data. Such sums as may be necessary to carry out these activities are authorized. (Sec. 10407)

2013

Prevention and Public Health Fund. In fiscal year 2013, $1.25 billion is appropriated to the Prevention and Public Health Fund to expand and sustain a national investment in prevention and public health programs. (Sec. 4002)

Medicaid preventive services for adults. Effective January 1, 2013, the Medicaid state option to provide certain screening and preventive services is expanded to include any clinical preventive service recommended with a grade of ‘A’ or ‘B’ by the U.S. Preventive Services Task Force and to include adult immunizations recommended by the

CDC's Advisory Committee on Immunization Practices. States that cover these services with no enrollee cost-sharing will receive an increase in their federal Medicaid match for these services of one percentage point. (Sec. 4106)

Secretarial plan for community-based prevention and wellness programs for Medicare.

By September 30, 2013, the Secretary will submit to Congress a report that includes recommendations for legislative and administrative action to promote healthy lifestyles and chronic disease self-management for Medicare beneficiaries. The recommendations will be based on an evaluation of community-based prevention and wellness programs, including those sponsored by the Administration on Aging, and an evidence review of the literature and best practices. The Secretary will fund these evaluation activities by transferring a total of $50 million from the Medicare Part A and Part B Trust Funds to the Centers for Medicare and Medicaid Services. (Sec. 4202)

2014

Prevention and Public Health Fund. In fiscal year 2014, $1.5 billion is appropriated to the Prevention and Public Health Fund to expand and sustain a national investment in prevention and public health programs. (Sec. 4002)

Essential health benefits package. All new health plans in the individual and small group markets and all qualified health plans that participate in the new health insurance exchanges, will be required to cover "preventive and wellness services and chronic disease management" to be defined by the Secretary. No deductible can apply to services graded 'A' or 'B' by the U.S. Preventive Services Task Force; immunizations recommended by the CDC's Advisory Committee on Immunization Practices; preventive care and screenings for infants, children and adolescents included in HRSA guidelines; and, additional preventive care and screenings for women not described by the U.S. Preventive Services Task Force but included in HRSA guidelines.

2015 and subsequent years

Prevention and Public Health Fund. In fiscal year 2015 and each fiscal year thereafter, $2 billion per year is appropriated to the Prevention and Public Health Fund to expand and sustain a national investment in prevention and public health programs. (Sec. 4002)

Additional provisions

Research on optimizing the delivery of public health services. The Secretary, acting through the CDC director, will fund public health research examining evidence-based prevention practices, including comparing community-based public health interventions in terms of effectiveness and cost, translating interventions from academic into real world settings and identifying effective strategies for organizing, financing or delivering public health services in community settings. The Secretary will make an annual report to Congress on this research. (Sec. 4301)

Effectiveness of federal health and wellness initiatives. The Secretary will conduct an evaluation of federal health and wellness initiatives as they relate to changes in the health status of the American public, specifically the federal workforce. Topics include absenteeism, productivity, rate of workplace injuries, as well as medical costs incurred by

employees, workplace fitness, healthy food and beverages and incentives in the Federal Employee Health Benefits Program. The Secretary will submit a report to Congress on the evaluation. (Sec. 4402)

Health promotion and disease prevention evaluations. The Secretary of Health and Human Services and the Comptroller General will conduct periodic reviews (at least every 5 years) and evaluations of every federal disease prevention and health promotion initiative, program and agency. (Sec. 4001)

Individualized wellness plans and community health centers. The Secretary will establish a pilot program to test the impact of providing at-risk populations who use community health centers with individualized wellness plans designed to reduce risk factors for preventable conditions. The pilots will support up to 10 community health centers and focus on weight, tobacco and alcohol use, exercise rates, nutritional status and blood pressure. Such sums as may be necessary are authorized for these activities. (Sec. 4206)

Attachment B. Public Health Leaders Consulted for this Report

Listed in alphabetical order by last name

Name	Title	Organization
Terry Allan, MPH	Health Commissioner	Cuyahoga County Board of Health (OH)
Kaye Bender, PhD RN	Director	Public Health Accreditation Board
Jay Bernhardt, PhD MPH	Distinguished Consultant	Centers for Disease Control and Prevention
Carol Brown, MS	Senior Advisor	National Association of County & City Health Officials (NACCHO)
Donna Brown, JD, MPH	Government Affairs Counsel and Senior Advisor for Public Affairs	National Association of County & City Health Officials (NACCHO)
Susan Buckley RN, MPH	Director	Humboldt County Department of Health & Human Services (CA)
Ron Chapman, MD MPH	County Health Officer, Deputy Director	Solano County Health and Social Services Agency (CA)
Andrew Deckert, MD MPH	Health Officer	Shasta County Health and Human Services Agency (CA)
Leah Devlin, DDS MPH	Former State Health Director, former ASTHO President	North Carolina Department of Health and Human Services (NC)
Barbara Ferrer, PhD MPH MEd	Health Commissioner	City of Boston (MA)
David Fleming, MD	Director	Seattle-King County (WA)
Jean Fraser	Chief	San Mateo County Health System (CA)
Brad Gilbert, MD	Medical Director	Inland Empire Medi-Cal Health Plan (Riverside and San Bernardino Counties in CA)
Grace Gorenflo, RN MPH	Project Director	National Association of County & City Health Officials (NACCHO)
Mark Guarino, MPH	Former County Health Director	Bergen County Health Department (NJ)
Eric Handler, MD MPH	Deputy Agency Director and Health Officer	Orange County Department of Public Health (CA)
Mark Horton, MD MSPH	Director	California Department of Public Health (CA)
Joe Iser, MD DrPH MsC	Health Officer	Yolo County (CA)
Tony Iton, MD	Senior Vice President, Healthy Communities	The California Endowment (CA)
Joe Kimbrell, MSW	Director	Louisiana Public Health Institute (LA)

Michelle Larkin, JD MS RN	Team Director and Senior Program Officer	Robert Wood Johnson Foundation, Public Health Program
Pat Libbey	Former Executive Director	National Association of County & City Health Officials (NACCHO)
Anne Lindsay, MD	County Health Officer	Humboldt County Health and Human Services (CA)
Anthony T. Lo Sasso, PhD	Associate Professor	School of Public Health (University of Chicago)
Nick Macchione, MS MPH FACHE	Director	County of San Diego Health and Human Services Agency (CA)
Judy Monroe, MD FAAFP	State Health Commissioner and Immediate Past President	Indiana State Dept. of Health and the The Association of State and Territorial Health Officials (ASTHO)
Ed Moreno, MD MPH	Director and Health Officer	Fresno County Department of Public Health (CA)
Poki Namkung, MD MPH	County Health Officer	Santa Cruz County Health Services Agency (CA)
Carmen Rita Nevarez, MD MPH	Medical Director and Vice President of External Relations	Public Health Institute
Jim Pearson, DrPH BCLD MPH	Director	The Virginia Division of Consolidated Laboratory Services, Virginia Department of General Services (VA)
Bobby Pestronk, MPH	Executive Director	National Association of County & City Health Officials (NACCHO)
Bruce Pomer	Executive Director	Health Officer's Association of California (HOAC) (CA)
Robert Prentice, PhD	Director	Bay Area Regional Health Inequities Initiative (BARHII) (CA)
Eduardo Sanchez, MD MPH	VP & Chief Medical Officer	Blue Cross Blue Shield of Texas
Rita Scardaci, RN BSN/ PHN MPH	Director and Foundation Board Member	Sonoma County Department of Health Services (CA) and The California Endowment
Lillian Shirley RN, MPH, MPA	Director	Multnomah County Health Department, Portland (OR)
Mike Skeels, PhD	PH Laboratory Director	Oregon Health Division (OR)
Torney Smith	Director	Spokane Regional Health District (WA)
William Walker, MD	Director	Contra Costa County Health Services (CA)
Laura Wedemeyer	Director	Public Health Detailing Program in the Bureau of Chronic Disease Control, NY City Dept. of Health (NY)
Carol Woltring	Executive Director	Public Health Institute's Center for Health Leadership & Practice
Wilma Wooten, MD MPH	Public Health Officer	San Diego County Health and Human Services Agency (CA)

Attachment C. Significant Literature on Public Health Systems Issues

A number of forces are reshaping local public health systems including state and national health reform debates and legislation, the economy, national security, and infectious disease concerns. Centers for Disease Control and Prevention (CDC) and other federal health partners can provide leadership to help the public health system survive and thrive in this challenging environment. This project identifies the challenges and opportunities the current environment may bring to different types of public health departments, and also addresses some of the actions that CDC may consider in order to help the public health system better serve the nation.

Public health groups have dedicated a great deal of effort to building national consensus on the mission, scope, and strategies of public health. The Institute of Medicine (IOM) has published two important studies on the future of public health in support of this effort, emphasizing the importance of adapting the public health system and its strategies to the health threats in the current environment. (IOM 1&2) With globalization of the economy, extensive movement of people and goods around the world and the threat of natural and man-made disasters, the public health system must respond with new strategies, partnerships and wider collaborations.

Following the 9/11 attacks, some analysts, writing from the perspective of homeland security, recommended that the entire public health system be restructured around the needs of national security. (Salinsky) Others emphasized the need to support and strengthen the core public health functions of assessment, policy development and assurance including increased use of performance and outcome measures. (Relman, Lotstein, Lurie) Historian Elizabeth Fee describes the nation's long history of ambivalent relationships between the medical care system and the public health system, characterizing the relationship as reactive, political, and episodic at best. (Fee) Others have emphasized the need for the public health system to take the initiative in improving its collaborative relationships with both the medical care sector and with non-profit community organizations, in order to address underlying determinants of health and achieve population health goals. (Baker)

Relatively little attention has been given to public health infrastructure from the standpoint of organizational theory and organizational change. A recent paper by Glen Mays addresses this with a framework for evaluating system performance and outcomes, with a proposed research agenda to further this approach. (Mays)

The diversity of local public health agencies has been documented and quantified in a series of annual 'profiles' issued by the National Association of County and City Health Officials (NACCHO). NACCHO's

surveys reveal striking regional differences in the size, capacities and priorities of local health departments, as well as significant diversity in the structures, functions, and resources across organizations. The majority of LHDs (64%) serve jurisdictions with populations under 50,000 (representing 12% of the U.S. population); 5% of LHDs serve populations over 500,000 that represent 46% of U.S. residents. LHDs in 29 states had local governance (counties, cities or Boards of Health), whereas six states plus Washington, DC had state governance and 13 states had mixed local and state governance.

In some parts of the country, particularly in larger urban areas, health departments perform both medical care delivery (operating hospitals and clinics) as well as public health functions. Larger departments often include mental health services, alcohol and drug programs, and a variety of other community support services. Many smaller departments provide only preventive clinical services and emphasize the 'core functions' of public health. For years the public health profession has debated (without consensus) whether it should continue to provide medical care services. The current economic downturn has increased the demand for publicly provided medical care and health reform with its expansion of insurance coverage is likely to amplify that. Decision-making power on the direct provision of medical care services rests with locally elected officials, and is naturally impacted by local circumstances.

The essential legal and political reality is that the nation's public health system is organized at the state level, often with further delegation of responsibility to the local level. Funding comes from a wide variety of sources with significant variation in per capita financial support across the country. Attachment D contains the latest 2008 LHD Profile with more details on LHD services, funding, staffing, use of technology and capacities.

The current economic downturn has had dramatic impacts on funding for public health in most regions, with reductions in programs, staffing, and services reported. (NACCHO/Willard reductions) Assessments of epidemiologic capacity have revealed major deficiencies (CSTE 2009) and reviews of workforce capacity and training also call for major reform. (Gebbie 2006) Advocacy groups continue to document the pressures on basic public health services. (Levi 2010 and Abramson 2009)

As a result of these trends, several initiatives have been proposed to improve the efficiency and effectiveness of the public health infrastructure. Regionalization has been recommended, especially for states with hundreds of small departments; however, given the political difficulties of achieving regionalization, other options may be shared service arrangements, informal collaboration, and inter-agency agreements. (Libbey – communication) A national accreditation initiative led by the Public Health Accreditation Board (PHAB) is now in the beta testing phase with the ultimate goal of establishing performance standards and improving capacities of all types of local health departments. If successful, these two initiatives, accreditation and regionalization, will have significant impacts on local public health systems.

KEY REFERENCES

Comprehensive studies on the nation's public health system, including two Institute of Medicine reports:

1. Institute of Medicine. (2002). The Future of Public Health in the 21st Century. National Academy Press, Washington, DC.
2. Institute of Medicine. (1998). The Future of Public Health. National Academy Press, Washington, DC.

The 1993 JAMA paper by Baker, et al, written during a time of intense interest in health care reform, focused on the need for public health leaders to engage in wider community partnerships to address new and evolving health concerns:

3. Baker, E. et. al. (1994). Health Reform and the Health of the Public – Forging Community Health Partnerships. JAMA 272: 1276-1282.

Following terrorist attacks on New York, some experts recommended a major reorganization of the public health system along the lines of homeland security, while others emphasized the need to strengthen the core functions of public health:

4. Relman, D.A. (2006). Bioterrorism. Preparing to Fight the Next War. NEJM 354: 113-115.
5. Salinsky, Eileen, and Gursky, Elin. (2006). The Case For Transforming Governmental Public Health. Health Affairs 25(4):1017-1028.
6. Lotstein et. al. Using Quality Improvement Methods to Improve Public Health Emergency Preparedness: PREPARE For Pandemic Influenza. Health Affairs. July 15 2008. http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.5.w328v1.
7. Lurie et. al. (2006). Public Health Preparedness: Evolution or Revolution? Health Affairs 25(4): 935-945.

An excellent review of the longer history of public health in the United States emphasizes the reactive, political, and episodic nature of support for a strong and proactive system for the protection and promotion of health of the entire population:

8. Fee, Elizabeth, and Brown, Theodore M. (2002). The Unfulfilled Promise of Public Health: Déjà vu All Over Again. Health Affairs 21(6):31-43.

The recent resurgence of disease outbreaks (SARS, Bird Flu, H1N1) and the renewed push for medical care reform have led to new interest in creating better coordination between the health care system and public health initiatives, goals, and values:

9. Association of State and Territorial Health Officials. (2009). Public Health, An Essential Component of Health Care Reform.

10. Meyer, J., and Weiselberg, L. (2009). County and City Health Departments: The Need for Sustainable Funding and the Potential Effects of Health Care Reform on Their Operation. A report prepared by Health Management Associates for the Robert Wood Johnson Foundation and the National Association of County and City Health Officials.
11. Trust for America's Health. (2008). Germs Go Global - Why Emerging Infectious Diseases Are a Threat to America. Washington, DC.

Additional attention has been given to conducting research on the public health infrastructure as a delivery system:

12. Mays GP, Smith SA, Ingram RC, Racster LJ, Lamberth CD, and Lovely ES. (2009). Public Health Delivery Systems. Evidence, Uncertainty and Emerging Research Needs. American Journal of Preventive Medicine, 36(3), pp.256-265.

CHALLENGES AND FORCES IMPACTING LOCAL PUBLIC HEALTH DEPARTMENTS

Among the many reports on the impact of the economic crisis on the public health system, the following provide specific examples and data on the effects:

13. Abramson, Susan S. (2009). Holes in the Net: Surveying The Impact of the Current Economic Recession on the Health Care Safety Net. American Public Health Association.
14. Council of State and Territorial Epidemiologists. (2009). National Assessment of Epidemiologic Capacity in Public Health: Findings and Recommendations. Atlanta, GA.
15. Gebbie, K.M. Turnock, BJ. (2006). The Public Health Workforce, 2006: New Challenges. Health Affairs 25(4):923-33.
16. Levi, J., et al. (2010). Shortchanging America's Health. Trust for America's Health and The Robert Wood Johnson Foundation.
17. Willard, R. (2009). Local Health Department Job Losses and Program Cuts. National Association of County and City Health Officials.

STATE RESPONSES TO HEALTH CARE ISSUES

In spite of the difficult environment, many states have forged ahead with reforms designed to impact access to coverage and care:

18. Fernandez, Bernadette. (2009). State Health Reform Strategies. Congressional Research Office.
19. Long, Sharon K, and Masi, Paul B. (2008). Access and Affordability: An Update on Health Reform in Massachusetts. Health Affairs Web Exclusive, May 28, 2009, w578-w587.
20. The Kaiser Commission on Medicaid and the Uninsured. (2009). States Moving Toward Comprehensive Health Care Reform. The Henry J. Kaiser Family Foundation.

21. The Kaiser Commission on Medicaid and the Uninsured. (2009). Massachusetts Health Care Reform: Three Years Later. The Henry J. Kaiser Family Foundation.
22. States In Action Newsletter. (2009). Feature: Public Health in the State Reform Spotlight. The Commonwealth Fund.

OPPORTUNITIES FOR THE PUBLIC HEALTH SYSTEM

The following articles address changes in the role, functions, and financing of local health departments:

23. American Public Health Association. Washington, DC. (2010). APHA 2009 Agenda for Health Reform.
24. Association of State and Territorial Health Officials. (2008). A Transformed Health System for the United States in the 21st Century.
25. California Health Policy Forum (2007). Regionalization in Local Public Health Systems.
26. Exploring Accreditation Steering Committee (2007). Exploring Accreditation: Final Recommendations for a Voluntary National Accreditation Program for State & Local Health Departments (Full Report).
27. French, Molly. (2009). Shifting the Course of Our Nation's Health: Prevention and Wellness as National Policy. American Public Health Association.
28. Minnesota Department of Health. Community Engagement Web Site. Available at http://www.health.state.mn.us/communityeng, Accessed April 23, 2010.
29. National Association of County and City Health Officials. (2008). 2008 National Profile of Local Health Departments.
30. Taylor, Tia. (2009). The Role of Community-Based Public Health Programs in ensuring Access to Care Under Universal Coverage, American Public Health Association.
31. McGinnis JM, Williams-Russo P, Knickman JR. (2002) The Case for More Active Policy Attention to Health Promotion. Health Affairs 21(2):78-93.

This article addresses the role of community health centers and their relation to LHDs:

32. Lo Sasso, Anthony T., and Byck, Gayle R. (2010). Funding Growth Drives Community Health Center Service. Health Affairs 29(2):289-296.

Attachment D: National Association of County and City Health Officials Profile

NACCHO's 2008 Profile of local health departments ("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.") describes their structure, function, and capacities, looks at the funding, staffing, governance, and activities of LHDs, and understands how patterns vary across the country and by size of the population served by the LHD. The survey, which was administered electronically through a Web-based survey, had a response rate of 83% (n=2,794). LHDs jurisdiction types, population sizes, and governance structures vary significantly from state to state and within states. It is important to recognize the significant diversity in the structures, functions, staffing patterns, and funding sources of local public health systems and local public health activities and services. Formal performance improvement and accreditation (are relatively new to local public health, but LHDs are entering into these areas in order to strengthen the activities and services they provide.

Jurisdiction and Governance

- 64% of LHDs serve jurisdictions with populations under 50,000 (representing 12% of the U.S. population) versus 5% serving jurisdictions of more than 500,000 (46%).
- LHDs in 29 states had local governance, whereas six states and Washington, DC, had state governance and 13 had mixed governance.
- The frequency of local boards of health decreased with increasing jurisdictional size, ranging from 87% of LHDs serving a population of less than 10,000 to 38% of LHDs serving more than one million.

Financing

- Revenue sources are predominantly local (25%), followed by state direct sources (20%) and federal funds that pass through state agencies to LHDs (17%).
- The median annual expenditure for all LHDs was $1.12 million (25% under $500,000 and 17% more than $5million) and median per capita annual expenditure was $36 (range of $32-$42).
- The smaller the population of the jurisdiction served, the greater the proportion of revenues from Medicaid and Medicare (18% for under 25,000 versus 9% for populations of over 500,000).

Leadership and Workforce

- The education level of top agency executives in LHDs serving populations of 500,000 was predominantly at the doctoral degree level (57%), whereas 11% of LHDs serving populations less than 25,000 had a top executive with a doctoral degree.

- LHDs employed approximately 155,000 FTEs, with 38% employing fewer than 10 FTE worker and most (89%) employing less than 100.
- More than 90% of LHDs in most population size categories employed administrative or clerical personnel (95%), nurses (94%), and managers and directors (91%).
- More than 50% of all LHDs employed environmental health workers (80%), emergency preparedness coordinators (57%), health educators (56%), and nutritionists (51%).

Emergency Preparedness

- With public health agencies placing increased emphasis on emergency preparedness since September 2001, 62% of LHDs had hired additional FTEs during 2008 using funding from the CDC preparedness cooperative.
- LHDs serving urban areas received lower per capita funding than LHDs serving suburban or rural areas.$1.59 was the median per capita funding that LHDs received from the CDC preparedness cooperative agreement.
- 89% of LHDs had written or updated a Pandemic Flu Preparedness Plan, 86% of LHDs had participated in table top emergency drills or exercises, and 85% had conducted staff training on emergency preparedness.

Activities and Services

- Over three-quarters of LHDs provided direct services related to immunizations (for adults and children), communicable and infectious disease surveillance (including tuberculosis), and food service establishment inspection.
    - 35% of LHDs provided screenings for cardiovascular disease; 45% of LHDs provided screenings for diabetes.
    - 72% of LHDs provided treatment for tuberculosis; 57% of LHDs provide treatment for sexually transmitted diseases.
    - 62% of LHDs provided WIC services; 54% provided family planning services.
    - 70% of LHDs provided tobacco use prevention services; 12% provided mental illness prevention services.
- The percentage of LHDs offering other public health activities was 50% or less for each activity. Outreach and enrollment for medical care, including Medicaid (50%), vital records (50%), and school health 40 (40%) were the three leading LHD activities within this group.
- Laboratory services were the most frequent activity and service contracted out by LHDs (13%), followed by STD, HIV/AIDS and Cancer screening (7%).
- Animal control, land use planning, and specific emergency response activities (hazardous materials and emergency medical services) were provided by other local governmental agencies for more than half of LHDs.

Community Health Planning and Health Disparities

- More than 60% of respondents reported that a community health assessment (CHA) had been completed in the last three years. Just under half (49%) reported that community health improvement planning (CHIP) had been conducted in the last three years, more than 90% of which were based on CHAs.
- Resources most often cited for use in CHAs and CHIPs, and implemented as a reference, in collaboration with other tools, or independent of other tools, included Healthy People 2010 (79%), the Operational Definition of a Local Health Department (53%), and Mobilizing for Action through Planning and Partnerships (MAPP; 33%).
- Schools were the most common partnership of any type (99%) through the use of shared personnel and/or resources, or written agreements, followed by emergency responders (98%), hospitals (97%), physician practices (94%), other healthcare providers (93%), and community-based non-profits (91%) and community health centers (90%).
- More than 80% reported routine referrals to health care services in their jurisdiction, more than 70% provided clinical services, and almost 70% collaborated with community partners to fill gaps or reduce barriers.

Quality Improvement and Accreditation

- Among LHDs with any formal performance or quality improvement activity in place (55% of LHDs participated in performance improvement activities), 76% had customer focus and satisfaction performance improvement activities in place. More than 50% reported related activities in management practices, public health capacity, data and information systems, health status, and human resource development.
- Among LHDs that had taken any formal quality improvement or performance improvement efforts in the past two years, 59% indicated that no specific framework or approach had been used. Among specific approaches, the Total Quality Management (TQM) strategy was most often mentioned.
- 77% of LHDs were familiar with voluntary national accreditation programs for state and local health departments, 54% expressed interest in seeking voluntary national accreditation, and 38% of LHDs planned to seek accreditation within the first two years of the program (2011–2012).

Information Technology and Management

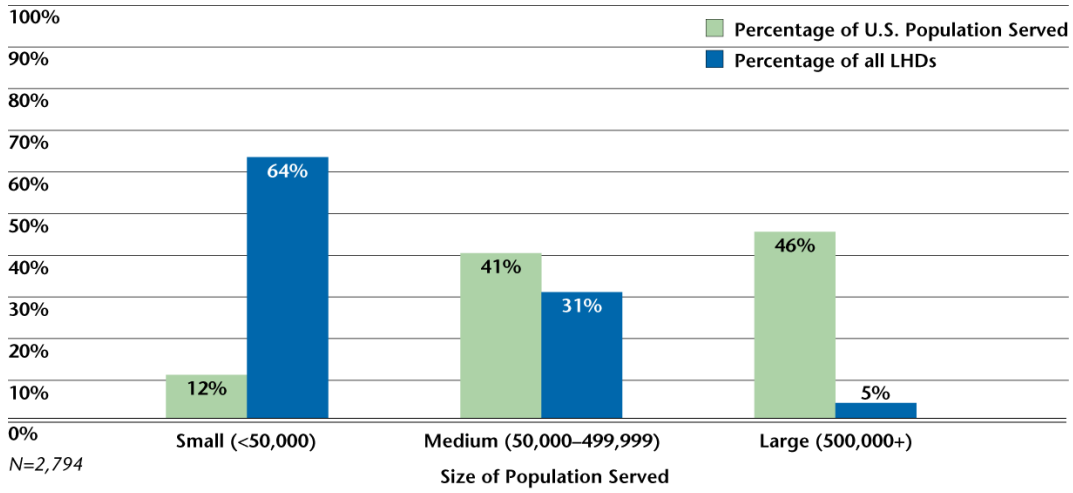
- Use of information technology in the field was the area most often implemented (50%), followed by wireless access to a network (37%), and IT disaster recovery planning (29%). Electronic health record use implementation was only reported by 19%.

- A shared database was the most common record keeping means for LHDs with related program activity for childhood immunization (87%), reportable diseases (68%), vital records (62%), laboratory reporting (58%), and outbreak management (54%).
- 57% of all LHDs shared resources (funding, staff, equipment) with one or more other LHDs on a continuous, recurring basis in emergency preparedness (77%), epidemiology or surveillance (56%), inspections (41%), clinical services (41%), administrative services (37%).

LHD Jurisdiction and Governance, Source: NACCHO 2008 Profile

LHDs in the United States served a variety of different jurisdiction types, with populations ranging from less than 1,000 to more than nine million. The majority served small populations, with 64% serving populations of less than 50,000, which account for only 12% of the U.S. population. Only 5% of LHDs served populations of 500,000 or more, which represent approximately 46% of the U.S. population.

Percentage of LHDs and Percentage of U.S. Population Served, by Size of Population Served

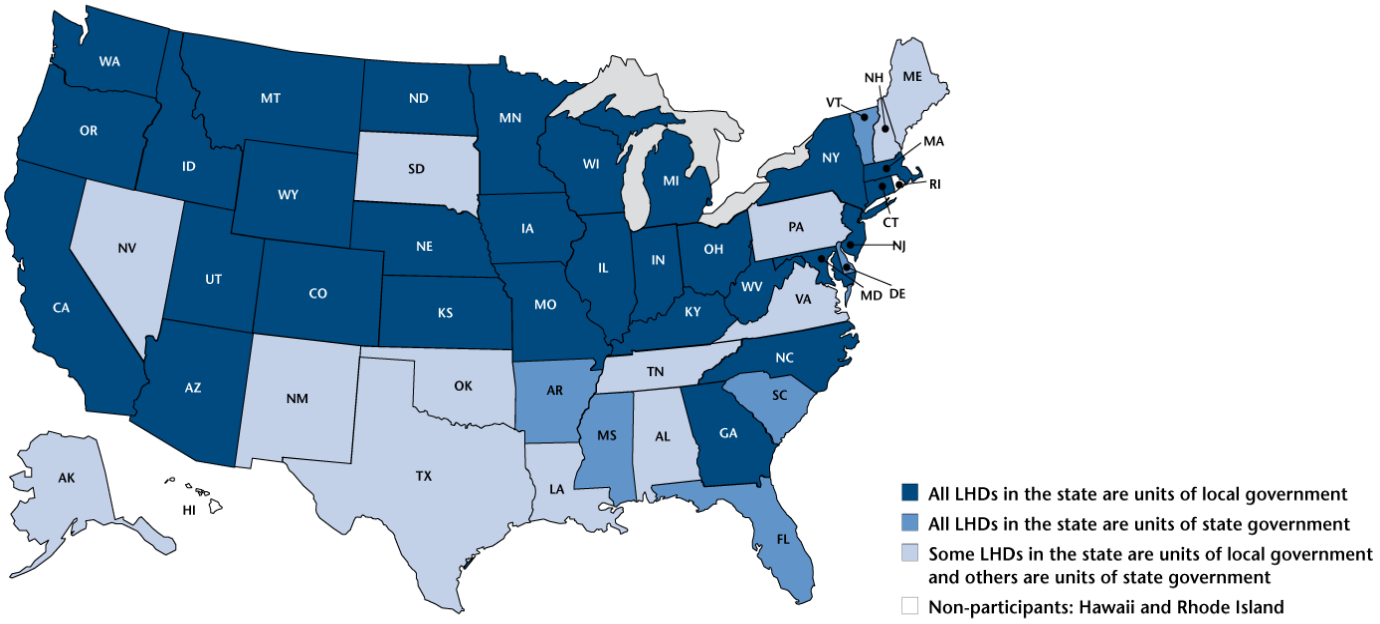


Source: 2008 National Profile of Local Health Departments

The governance of LHDs varied from state to state, and sometimes even within a state. Seveny-one percent of LHDs served a county (60%) or combined city-county jurisdiction. Seven percent were organized to serve cities and 11% were based in towns and townships.

On a state basis, a simplified governance categorization scheme for LHDs reveals the following distribution depending on whether a state was governed primarily by local authorities (e.g., local board of health, county or city elected officials) or by the state health agency, or both. In 29 states, all LHDs operated as units of local government, whereas six states and Washington, DC, had state governance and 13 mixed governance.

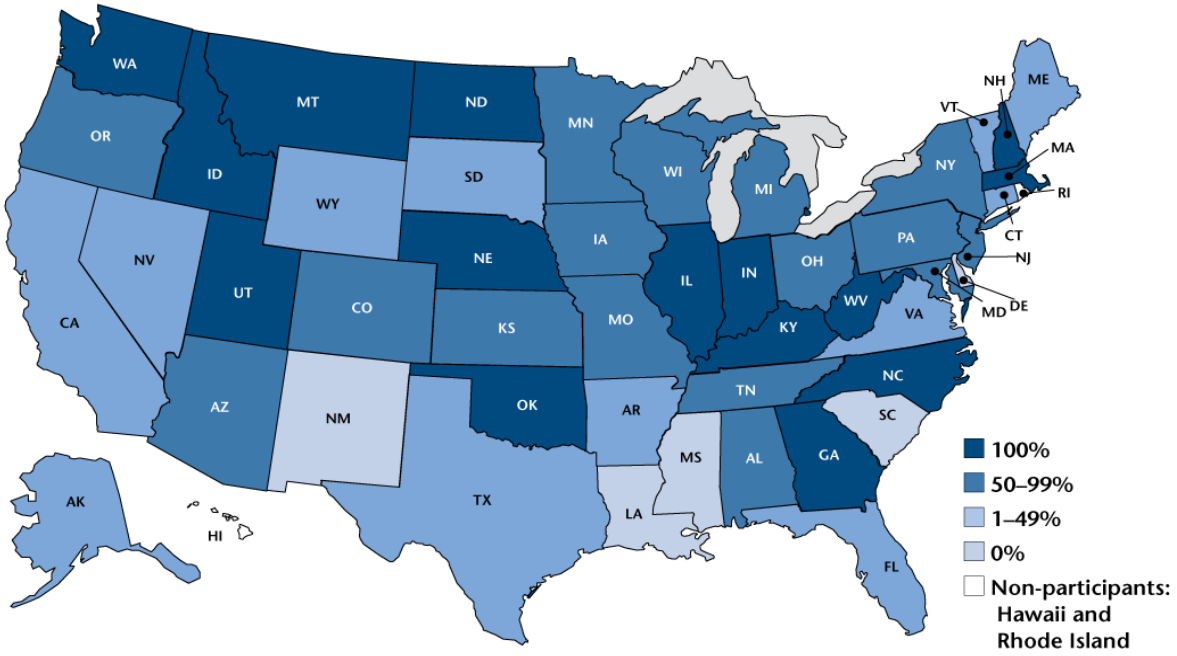
LHD Governance Type, by State (Map)



Source: 2008 National Profile of Local Health Departments

Approximately 80% of LHDs served a jurisdiction with a local board of health. The frequency of local boards of health decreased with increasing jurisdictional size, ranging from 87% of LHDs serving a population of less than 10,000 to 38% of LHDs serving more than one million. Adopting public health regulations (73%) and setting and imposing fees (68%) were the two most common functions of local boards of health.

Percentage of LHDs with a Local Board of Health, by State (Map)



Source: 2008 National Profile of Local Health Departments

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