

**NACCHO**

National Association of County &amp; City Health Officials

The National Connection for Local Public Health

## Recommendations of the National Association of County and City Health Officials to the Presidential Transition Team Concerning Health Policy and Health Reform Goals

### December 2008

**NACCHO's recommendations are designed to protect and improve health and well-being in our nation's communities. These recommendations will serve the incoming Administration's highest short-term priorities to preserve and create jobs and improve local infrastructure. They will also promote the longer-term success of health reform by strengthening our national capacities in prevention and public health.**

The National Association of County and City Health Officials (NACCHO) represents the nation's approximately 2,860 local public health departments. These are the governmental agencies that work every day in their communities to prevent disease, promote wellness, and protect health. They organize community partnerships and facilitate community conversations to create the conditions in which people can be healthy. NACCHO develops resources and programs and promotes national policies that support effective public health practice in communities across America. The work of local health departments and NACCHO improves economic well-being, educational success, and nation-wide competitiveness community by community.

NACCHO's broad goals with respect to national health policy are:

- 1) Building a 21<sup>st</sup> century United States health system that results in optimal health for all residents and makes the United States the healthiest nation in a healthier world. Such a system will place its highest priority on prevention, provide access to health care for every person, eliminate inequities in health status, and protect people and communities from emerging health threats (See Attachment A *United States Health System for the 21<sup>st</sup> Century*.); and
- 2) Improving and modernizing the governmental public health system, so that federal public health agencies and state and local governmental public health departments work effectively together, using the unique and complementary powers and capacities in each level of government to provide a seamless, efficient, and accountable system that improves health and quality of life.





## I. Short-Term Health Policy Priorities

### A. Fiscal Stimulus

The Obama-Biden health plan places a heavy emphasis on public health and prevention. An ideal way to recognize their importance is to **include a public health workforce and infrastructure component in fiscal stimulus legislation**. This would address the immediate problems of job loss, serious workforce shortage, and an outdated physical infrastructure in which this workforce serves the public and the technology and health records used to serve it. It would also lay essential groundwork for a health system that fully integrates public health with health care.

More than half of local health departments have already lost approximately 6,000 employees through lay-offs or attrition with over 84 percent of health departments serving jurisdictions with populations larger than 500,000 among those losing staff. More lay-offs and budgets cuts are expected in 2009. (See Attachment *NACCHO Survey of Local Health Departments' Budget Cuts and Workforce Reductions*.) An additional **one-time, no-year appropriation of at least \$300 million designated to sustain the state and local health department workforce** would help stem the tide of lay-offs. Similarly, health departments should be explicitly eligible for **\$500 million** in fiscal stimulus funds to rebuild physical facilities and replace equipment, as well as to improve electronic medical records. In addition, fiscal stimulus legislation should provide **immediate funding to implement a public health workforce loan repayment demonstration program** authorized in the Pandemic and All-Hazards Preparedness Act. Existing authorizing legislation, accompanied by appropriate conditions to ensure that the purpose of fiscal stimulus legislation is met, can be used. (See Attachment *NACCHO Recommendations for a Public Health Component to Fiscal Stimulus Legislation*.)

*A one-time appropriation of \$850 million would be required to implement public health fiscal stimulus recommendations.*

### B. Public Health Program and Funding Coordination

The new Administration can improve the efficiency and effectiveness of federal categorical public health programs by establishing immediately an **initiative to integrate and streamline categorical public health programs** in a way that incorporates the required categorical intent and statutory requirements but **eliminates duplication and inefficiencies** required of fund recipients. In particular, the top leadership of the Centers for Disease Control and Prevention (CDC) should require program integration among mid-level program officers in all Centers that provide funding to state and local health departments, with the goal of aligning program objectives and deliverables, requirements, and reporting. Inter-agency coordination is also needed. An example is to require that clinical records used in the Supplemental Feeding Program for Women, Infants, and Children (WIC program) be integrated with other clinical records so that stand-alone electronic record systems are eliminated.



*This initiative would require action by the HHS Secretary, the Secretary of Agriculture, and pertinent agency directors. No new legislation or appropriation is required.*

The new Administration also can foster greater constructive collaboration between state and local health departments by building on the success of the **concurrence requirement** applicable to the Public Health Emergency Preparedness cooperative agreements administered by CDC. This requires state grantees to demonstrate that local health departments in the state have agreed with the proposed plans and allocations of federal funds received by the states to support both state and local public health preparedness. A similar strategy should be applied to other public health programs intended to support the efforts of both state and local health departments, such as (but not limited to) grants for vaccine purchase and infrastructure made pursuant to Section 317 of the Public Health Service Act and the Preventive Health and Health Services block grant program.

*Administrative action by the HHS Secretary or his designee would be required to implement this strategy.*

### C. HHS Regulations

The regulation concerning **Medicaid reimbursement for targeted case management** would exacerbate the financial stresses of those local health departments that now provide this service and is likely to diminish the quality of services received by vulnerable populations, including low-income pregnant women and infants, the disabled, and the elderly. Case management is typically provided by community health nurses who reach out to persons with special needs, visit them in their homes, and follow-up to ensure that all needed health and social services are being received.

The proposed HHS regulation concerning **provider conscience** is unnecessary and would significantly undermine patients' access to critical services and information to safeguard their health. It has the potential to exacerbate existing public health workforce shortages by further straining the ability of local health departments to attract a competent workforce.

*The new Administration should rescind the targeted case management rule before the legislated moratorium on its implementation expires and rescind the proposed provider conscience rule.*

## II. Long-Term Health Policy Priorities

### A. Assume Federal Leadership in Developing the 21<sup>st</sup> Century Public Health Workforce

1. **Expand Health Resources and Services Administration (HRSA) mission of health workforce** development to public health by using or expanding existing programs and authorities.



2. **Develop scholarship and loan forgiveness programs for public health professionals** or students who enter the local governmental public health workforce.
3. Establish both national and state-based centers to **enumerate the public health workforce**. The data these centers generated would inform priorities for developing and funding workforce “pipelines” for prospective public health workers including stimulating interest in these public service professions among young people and those who are presently laid off or changing careers.
4. **Identify which professions are in short supply** and in which jurisdictions
5. **Facilitate job recruitment and placement** in local health departments through cooperative arrangements among NACCHO, HRSA, and CDC.
6. HRSA, in collaboration with CDC and NACCHO, should also **develop competencies and curricula** that would equip health professionals to enter the public health workforce and implement them via virtual training centers or through local workforce development programs.
7. **Designate existing or new training funds** in local workforce development programs for public health workforce training.

*This initiative would require new budget authority and possible statutory revisions to HRSA’s authority.*

## **B. Establish 21<sup>st</sup> Century Systems to Manage Health Data and Measure Public Health System Performance**

1. **Develop the health information infrastructure in local health departments** (hardware, software, and professionals trained in public health informatics). These departments are the “front end” for population-wide surveillance of health and disease status. As the “DEW line” or sentinels for identifying incoming disease threats, they collect, aggregate, and interpret communicable and chronic disease levels for the community. No other local agency plays this role. Health care providers depend on them for this population-wide perspective. The development of an interoperable national system for electronic medical records and health information exchange should fully engage and integrate the local health department with its local health care professionals.
2. **Conduct a comprehensive evaluation of the notifiable disease reporting process** in order to identify areas for improvement
3. Design and use federal disease surveillance systems to enable **improvements in real-time situational awareness needed to guide public health interventions**, as well as to identify long-term trends.
4. **Develop and fund an agenda for public health systems research**, complementary to the Agency for Health Quality and Research (AHRQ) health services research. Such a research program would examine the organization, financing, performance, and impact of public health systems – defined as the constellation of governmental and non-governmental actors that influence population health. Establish a program of grants especially for young investigators who are beginning their careers so that they are subsequently eligible for larger research grants.



*These initiatives would require some new budget and statutory authority. The recommendations concerning CDC-developed surveillance systems would require agency action only.*

### **C. Design and Implement a “Health in All Policies” Approach to Leverage Federal Resources to Improve the Health of the U.S. Population and Reduce Health Inequities**

Recognize and act on the knowledge that the health status of individuals and communities has many determinants outside the traditional health care system. Education, housing, nutrition, employment, and many aspects of the physical environment in a community exert powerful influences on an individual’s health and the decisions an individual makes.

**Policy development across the federal government should include an analysis describing the effect of each policy on population health and wellness.** The federal government has the ability to improve the health of the United States not only in the design of a better health care system, but also in its approaches to other dimensions of the quality of life in America. A deliberate effort to assess the health impacts of all federal policies, led by HHS and supported by the White House, would help the President and Executive agencies understand and leverage their potential to improve health and create wellness. Similarly, states and localities can be encouraged with positive incentives to use health impact assessment in their policymaking.

*This initiative could begin with Administrative action by Executive Order, followed by such new budget and statutory authority as agencies determine are necessary.*

**Direct the incoming Surgeon General to develop a report on health equity and social justice** and their impact on the nation’s health. Just as Surgeon Generals’ reports on smoking and obesity constructively influenced the public discourse, such a report would turn our nation’s attention over time to consider and act on those factors which have the long-term potential to improve health and wellness, reduce medical costs, and improve productivity and educational attainment.

*The White House could require this initiative, which would require modest funding.*

Building on the documented successes of the STEPS and REACH programs and other community-based approaches to prevention, request that Congress establish and fund a new program that would provide **pilot grants to 100 local health departments in the amount of \$1.5 million each to implement proven strategies to improve health status.**

*This initiative requires new legislation and budget authority.*



## D. Recommendations Concerning Specific Public Health Programs

1. Eliminate federal requirements that public funds be used for **abstinence-only-until-marriage education**.
2. Eliminate bans on the use of federal funding for **syringe exchange programs**.
3. Standardize, improve and strengthen **preentry screening of immigrants, refugees and asylees for communicable diseases of public health significance**.  
Communicate and follow-up with local health departments regarding immigrants, refugees and asylees who have been identified during screening as having either a communicable disease or a potentially communicable disease (e.g., those persons classified as Class B1 tuberculosis status) of public health significance.
4. Conduct a review of **federal vaccine policy** that explicitly addresses mechanisms for preventing shortages and maldistribution of vaccines, for increasing demand for vaccines based on communication of accurate information on vaccine safety, and for distributing limited supplies of vaccine to high-risk individuals when shortages occur.
5. Expand the **Vaccines for Children** program by enabling public health clinics to provide VFC vaccines to under-insured children.
6. The federal government should assume full financial responsibility for **stockpiling and managing an adequate amount of influenza antivirals** for treatment of the ill and prophylaxis of critical public and private sector healthcare workers and first responders. To the extent that this is logistically undesirable, all state and local governmental public health departments and other public-sector agencies should have access to reduced purchase costs for influenza antivirals negotiated by the federal government. Barriers to the use of federal preparedness funds for the purchase and stockpiling of antivirals by governmental agencies should be removed.
7. Centralize and put on a fast track the development of **performance standards for public health emergency preparedness**, taking full account of the input of local health departments.
8. In concert with stakeholders and all relevant federal agencies, develop a **comprehensive science-based food safety system** that assures local public health department participation in all areas of food safety as a means to reduce foodborne illness, with particular attention to challenges such as imported food supply, new and re-emerging foodborne pathogens, changing demographics, and intentional contamination.
9. Disclose to state and local health departments the names and addresses of **retail and wholesale food establishments subject to voluntary product recall by the United States Department of Agriculture (USDA)**. This transparency is necessary to ensure that state and local health departments have the information necessary to provide to the public regarding possible exposure to potentially contaminated food products and to provide adequate measures of intervention and surveillance to contain the pathogen subject of the recall and assure no further propagation of disease.
10. Develop and fund methods for compensation or reimbursement from the federal government to local health departments for the expenses they incur in responding to special requests and assistance during **food safety recalls or foodborne-illness outbreaks**.



11. Reinstating the Department of Transportation requirement that states enact **motorcycle helmet laws** in order to receive U.S. Transportation road construction funds.
12. Enable local health departments to realize cost-savings by giving them access to **Federally Qualified Health Center prime vendors** for pharmacy supplies and vaccines.
13. Actively recruit and promote local health departments to serve as **Federally Qualified Health Center look-alikes** in underserved communities where the need exists.
14. Engage federal and private sector experts in environmental health in development of Administration **climate change** policy.



# NACCHO

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**08-01**

## STATEMENT OF POLICY

### A United States Health System for the 21<sup>st</sup> Century

#### Policy

The National Association of County and City Health Officials (NACCHO) believes that the United States should become the healthiest nation in the world. We are committed to building a 21<sup>st</sup> century United States health system that results in optimal health for all. Such a system will place its highest priority on prevention, provide access to health care for every person, eliminate inequities in health status, and protect people and communities from emerging health threats.

A transformed U.S. health system will be based upon promoting good health, rather than mitigating sickness, and will address the known determinants of health. In order to do so, it will connect and integrate the resources and knowledge of public health, health care delivery and research, and all private and public sector entities that influence health outcomes. It will assure that every community is served by a robust governmental public health system.

A transformed U.S. health system will measure and improve outcomes continuously. It will be accountable and transparent to the public. It will benefit from a standardized, integrated health information system, a workforce of requisite size and competency, and flexible, sustainable financing for key health system capabilities.

Ultimately, a 21<sup>st</sup> century health system will require different commitments and investments from both government and the private sector than now exist. Such a change in paradigm is realistic but will take time to achieve. Progress in transforming our health system will necessarily take place incrementally.

NACCHO urges all leaders and policymakers in the public and private sectors to take the critical initial step now by establishing a shared vision of a health system that ultimately will result in optimal health for all persons in the United States. Other first steps should include:

- 1) Responding to the public need and demand for universal access to comprehensive health care coverage. Such coverage should emphasize prevention and assist individuals in using existing health services and systems effectively;
- 2) Building the national commitment to prevention through enhanced support for individual and community-based interventions known to promote healthy behavior, create healthy environments, and/or reduce the incidence of chronic and infectious diseases;





3) Promoting collaboration between providers of medical care, the public health system, and their partners in the private and public sectors to create healthier communities and eliminate health inequities.

### **Justification**

The United States is one of the least healthy developed nations in the world. It ranks 44<sup>th</sup> in the world in life expectancy and 41<sup>st</sup> in the world in infant mortality.<sup>1</sup> The United States spends at least twice as much on health care per person than other industrialized countries,<sup>2</sup> but health outcomes are much poorer than should be expected for the money invested. Poor health outcomes in the United States are strongly associated with race and social class,<sup>3</sup> but those factors are not the sole reasons for our dismal global standing. The low global health status rankings of the United States and the inferior return on investment of our health care dollars are compelling reasons to rethink and rework how we approach medical and health care.

Moreover, there has long been a separation in the United States between the medical care system, which primarily cares for sick individuals, and the public health system, which is concerned primarily with disease prevention, health promotion, and addressing the determinants of health. The former has grown ever costlier, while the latter has eroded due to lack of public financing and support. In order to improve the nation's health outcomes, it is essential to refashion these disparate arrangements into one coherent system that combines the best of each. Such a conjoined system has two principal objectives - first to achieve optimal health for each individual, then to assure all persons care when they become sick.

The number of persons with no health insurance rose to 47 million in 2006.<sup>4</sup> The number of additional underinsured, or individuals with inadequate health coverage, was estimated at 16 million in 2003.<sup>5</sup> A growing public outcry to address the costs and availability of health insurance provides an opportunity to begin also transforming the system from one that provides only "health care" to one that creates "health" itself, thereby improving the well-being of every individual.

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<sup>1</sup> U.S. Census Bureau, International Data Base, <http://www.census.gov/ipc/www/idb>

<sup>2</sup> Congressional Budget Office, Technological Change and the Growth of Health Care Spending, January 2008. Retrieved from <http://www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf> on February 15, 2008.

<sup>3</sup> U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2007*, Executive Summary and Highlights.

<sup>4</sup> Davis, Karen. Census Data on Growing Number of Uninsured Make Clear: National Health Care Strategy is Needed. August 28, 2007. Retrieved from [http://www.commonwealthfund.org/General/General\\_show.htm?doc\\_id=519979](http://www.commonwealthfund.org/General/General_show.htm?doc_id=519979) on February 15, 2008..

<sup>5</sup> Schoen, Cathy, Doty, Michelle M., Collins, Sara R., and Holmgren, Alyssa L. Insured But Not Protected: How Many Adults Are Underinsured?, *Health Affairs* Web Exclusive, June 14, 2005 W5-289–W5-302. Retrieved from <http://www.commonwealthfund.org/publications/> on March 6, 2008.

### **Record of Action**

*Approved by NACCHO Board of Directors  
March 2008*



# NACCHO

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## NACCHO Recommendations for a Public Health Component to Fiscal Stimulus Legislation

**December 2008**

### Justification

The Obama-Biden health plan places a heavy emphasis on public health and prevention. Fiscal stimulus legislation is an ideal way in which to promote public health and set the stage for a greater national emphasis on public health while saving state and local government jobs, providing training and education in public health professions where serious shortages exist, and improving the physical infrastructure and information technology that supports the work of state and local governmental health departments.

### Saving Jobs—\$300 million

Provide funds to state and local governments to sustain their public health workforce, which is now subject to lay-offs and reductions through attrition due to the strains on state and local government budgets. This can be accomplished rapidly within the existing framework of the Preventive Health and Health Services block grant program, which provides formula grants to states for various public health programs. An additional one-time, no-year appropriation would help stem the tide of lay-offs and workforce reductions. Funds should be subject to the following conditions:

1. They may not be used to supplant state or local funds available to public health departments on the date of enactment;
2. They must be used for the salaries and related expenses of state or local public health department employees that support public health activities and programs;
3. Recipients of funds must report the number and type of positions subsidized by the funds; and
4. Each state must make funds available to local health departments within the state in a proportion equivalent to the ratio of full-time local health department employees within the state to the number of state health department employees, subject to additional criteria that the Secretary may determine.





### **Improving State and Local Infrastructure—\$500 million**

Include local health departments among eligible recipients of fiscal stimulus funding for physical infrastructure improvements and health information technology improvements.

Designate state and local health departments as Federally Qualified Health Centers for the purposes of qualifying for construction and equipment funds provided in fiscal stimulus legislation.

### **Replenishing the Public Health Workforce for the Near Future—\$10 million**

Provide funds to implement the public health workforce loan repayment demonstration authorized by the Pandemic and All-Hazards Preparedness Act.

### **Planning the 21<sup>st</sup> Century Public Health System—\$30 million**

Provide \$10 million to the Agency for Health Research and Quality (AHRQ) to institute a public health systems research program, complementary to AHRQ's health services research, that will examine the organization, financing, performance, and impact of public health systems—defined as the constellation of governmental and non-governmental actors that influence population health.

Provide \$20 million to the Health Resources and Services Administration to establish a Public Health Workforce Center to define the most critical public health workforce needs and establish training programs to meet those needs.



# NACCHO Survey of Local Health Departments' Budget Cuts and Workforce Reductions

## Background

The National Association of County and City Health Officials (NACCHO) surveyed 2,422 local health departments nationally in November–December 2008 to assess the impact of current economic conditions on local health departments' budgets and workforce. The survey, to which 1,079 local health departments distributed across 46 states responded, found that a majority of respondents are experiencing adverse impacts and expect those to continue next year.

## Jobs Provided By Local Health Departments are Dwindling

In 2008, more than half of local health departments have either laid off employees or lost them through attrition and have been unable to replace them due to budget limitations. About one-third predict layoffs in 2009. Among the largest health departments, 84 percent reduced their staff in 2008, and 45 percent expect to lay off staff in 2009. Extrapolating the survey results to all local health departments, there has already been an estimated total loss of between 3,000–6,000 local public health workers nationally, and those numbers will increase in 2009.

## Local Health Departments' Budgets are Eroding

Nationally, 27 percent of local health departments are working under a current budget that is less than the previous year, and 44 percent expect to do so next year. The impact falls disproportionately on health departments serving large jurisdictions, of which two-thirds expect next year's budget to be lower than this year's. For local health departments in large jurisdictions that experienced budget declines this year, the median budget reduction was \$1.5 million.

The burden of declining budgets also is falling disproportionately on health departments in certain states. More than 50 percent of the local health departments in nine states (Arizona, California, Florida, Georgia, Oklahoma, Pennsylvania, South Carolina, Virginia, and Vermont) have already experienced cuts. More than 80 percent in 10 states anticipate cuts next year (Arizona, California, Florida, Georgia, Idaho, Pennsylvania, South Carolina, Virginia, Vermont and Washington).

**TABLE 1: PERCENTAGE OF LOCAL HEALTH DEPARTMENTS REPORTING STAFF REDUCTIONS (BY JURISDICTION POPULATION)**

Jurisdiction Population	Percentage of Local Health Departments that:			
	Laid Off or Lost through Attrition in 2008	Laid Off Staff in 2008	Lost Positions through Attrition in 2008	Expect to Lay Off in 2009
All LHDs	53%	21%	46%	32%
<25,000	31%	15%	21%	21%
25,000–49,999	46%	15%	41%	25%
50,000–99,999	62%	19%	56%	40%
100,000–499,999	77%	34%	70%	51%
500,000+	84%	40%	83%	45%

**TABLE 2: PERCENTAGE OF LOCAL HEALTH DEPARTMENTS REPORTING DECLINING BUDGETS (BY JURISDICTION POPULATION)**

Jurisdiction Population	Percentage of Local Health Departments Reporting Declining Budgets	
	Current budget compared to prior year	Next year's budget compared to current year
All LHDs	27%	44%
<25,000	22%	38%
25,000–49,999	19%	38%
50,000–99,999	25%	45%
100,000–499,999	37%	55%
500,000+	44%	67%

# NACCHO

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Public Health

Prevent. Promote. Protect.

NACCHO is the national organization representing local health departments. NACCHO supports efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, seeking health equity, and supporting effective local public health practice and systems.

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