October 22, 2008, LUARC Commission Meeting

Flag Salute.

Roll Call was Read.

LUARC Commission members present: John H. Fisher, III, Chair; Joseph V. Doria, Jr.; Marvin Reed; Robert F. Casey; Gary Passanante; Elizabeth Cervenak (for State Treasurer David Rousseau) Jane Kenny and Steve Cozza

On a motion by Commissioner Doria, seconded by Mr. Reed, the September 26, 2008, Minutes were approved with one abstention. Mr. Cozza abstained as he was not at that meeting.

Hannah Shostack, Executive Director: Reported

- Four topics which will be discussed at upcoming LUARCC meetings: Health, Emergency Dispatch, Administration of Justice and Construction Code Enforcement;
- The School of Public Affairs and Administration (SPAA) at Rutgers, Newark, received the contract to do the literature review for the Commission.
- LUARCC is continuing its efforts with regard to data collection. Commission will pursue opinion polling down the road.
- LUARCC will be holding a meeting on October 31 at 9:30 a.m. which will include a follow-up on the Health discussion and a broader discussion of our research agenda.

The Chairman indicated that the Commission will publicize the Sunshine Notice.

On a motion by Mr. Reed seconded by Ms. Kenny, the Commission voted to change the November 26 date to November 17 and the December 23 date to December 22 - approved unanimously.

Four presentations were given:

1. David Gruber, Senior Assistant Commissioner, Division of Health Infrastructure Preparedness and Emergency Response, Department of Health and Senior Services (See Attachment A).

    - Outlined current public health infrastructure, the administrative responsibilities of the State Department of Health relative to the

local public health offices, the services provided, and the possible impact of consolidation;

- The State does not contribute significantly to local public health spending and that most of the financial responsibility is with the local units that provide the service;
- Any savings that might accrue through any consolidation or sharing would accrue to the local units that finance public health operations;
- Based on the State study of Local Public Health service provision published in April 2008, recommendations could not be advanced that would restructure the existing system to achieve cost savings because the data are not available to support such conclusions;
- Although the State is responsible for overseeing the provision of the ten essential public health services, there is no check on the system to ensure that these services are being provided;
- Mr. Casey commented that the 2008 study was interesting when looking at the table regarding Cost vs. Services Rendered. Implication that economies of scale are reached when larger areas are providing the services.
  Mr. Gruber indicated that in the information he has provided to the commission, the answer to question 12 regarding the correlation between service activities and costs would answer Mr. Casey's questions.

- Mr. Reed said that he couldn't find a significant difference in per capita cost, but there was a difference in the level of services.
  Mr. Gruber indicated that no one is being short changed, based on the number of complaints.

2. Pete Tabbot, current President of the New Jersey Public Health Officers Association (a League affiliate).

   - Mr. Tabbot noted that 92% of municipalities are already involved in shared health arrangements and offers public health as a template for sharing of other municipal services.

   - There are serious workforce issues with regard to the provision of public health services, among them understaffing given resource scarcity and the age profile of the public health officer workforce.

   - Mr. Tabbot indicated that the focus should be on functional regionalization. There is a national move toward accreditation, which the State local health officers welcome, however, guidelines are still being developed nationally. (See Attachment B).

- Mr. Casey asked if there is a minimal size for a municipal department (population based)?
  Mr. Tabbot does not know of a magical number, depends on demographics.

- Mr. Casey wanted to know if the issue is not with per capita cost, isn't the issue related to services rendered?
  Mr. Tabbot doesn't know if there are services that we should be providing.

- Mr. Cozza asked about Accreditation of Health Departments and was told that they are working on the National accreditation.

- Mr. Casey said that the focus should be on functional regionalization.

- Mr. Cozza wanted to know why the per capita costs of service provided by County Health Departments tend to be higher than service provided by other entities?
  Mr. Tabbot said that the County Health Department provides more services and constituent towns may have different needs.

3. Cheryl Sbarra, Massachusetts Association of Health Boards.

- Massachusetts and Kansas are undergoing regionalization studies under the auspices of the Robert Wood Johnson Foundation. Currently, Massachusetts has only local health offices and does not provide these services on a regional basis. Motivated primarily by equity concerns, the State has been conducting a long-term reevaluation of service delivery, which could provide valuable insights for us in examining our own system.

- The MAHB, in conjunction with other private nonprofit health-based organizations had prepared a needs assessment about ten years ago which revealed major imbalances in the level of public health services provided across the State.

- Realized that the budgets didn't match needs
  Due to regional differences & competition for limited municipal dollars

- There has been a lack of consistency in education of public health providers and huge disparity in the level of service provided within Massachusetts.

- Workforce Crisis, 18% eligible to retire in the next 2 years

- Equitable delivery of services, the goal is not to save money. It's more about improving the quality of health

- The guiding principles:
  -Home Rule
  -Regionalization will be voluntary
  -Different Models
  -Needs funding

- For Fiscal Year 09': 1.) Health directors will be grandfathered 2.)Optimal size is 50K and based on geography according to a study conducted by Patrick Bernet for the State.

- For Fiscal Year 2010: 1.) Finalize plan to establish performance standards

- Strengthen MDPH Regional Operations 1.) Coordinate service delivery through regional office 2.) Promote workforce development

4. Jim Pearsol, Association of State and Territorial Health Officials (ASTHO) (See Attachment C). ASTHO is a national membership organization representing State Health Officers (ours is the State Commissioner of Health).

   - Mr. Pearsol provided testimony to place New Jersey's public health serviced in a more national perspective and help us understand what other models exist for provision of local public health services.

Adjournment unanimously approved.

ATTACHMENT A

Testimony before the Local Unit Alignment Reorganization and Consolidation Commission
David Gruber, Senior Assistant Commissioner
Division of Health Infrastructure Preparedness and Emergency Response
Department of Health and Senior Services
October 22, 2008

Good morning Chairman Fisher, and members of the Committee. Thank you for the opportunity to speak today about opportunities to provide the best public health service to the citizens of New Jersey. My name is David Gruber, Senior Assistant Commissioner, at the Department of Health and Senior Services. I supervise the Division of Health Infrastructure Preparedness and Emergency Response at the Department. The Division of Health Infrastructure Preparedness is responsible for our state's local and regional health departments. On behalf of Commissioner Heather Howard, I am here to address any issues you may have regarding New Jersey's public health system. I've been asked to describe our current public health infrastructure, its administrative responsibilities, services, and the impact of consolidation.

In support of this testimony, I will first describe our public health system, discuss the results of a DHSS study focusing on local health operations and finances, provide an overview of the different options available to jurisdictions, and finally address specific questions advanced by the LUARC Commission.

<u>The New Jersey Public Health System</u>

DHSS has the statutory authority to promulgate minimum standards for local public health services. These are contained in the rule: Public Health Practice Standards of Performance for Local Boards of Health in New Jersey (NJAC 8:52) and based on the nationally accepted Ten Essential Public Health Services listed below:

1. Monitor of community health status;
2. Protect people from health problems and health hazards;
3. Give people the information they need to make healthy choices;
4. Engage the community to identify and solve health problems;
5. Develop public health policies and plans;
6. Enforce public health laws and regulations;
7. Help people receive health services;
8. Maintain a competent public health workforce;
9. Evaluation and improve programs; and
10. Contribute to and apply the existing body of knowledge regarding public health.

Included in these services are the core services of communicable disease investigation, inspection, and emergency response.

The Practice Standards set forth minimum standards for local health departments (for example, minimum qualifications for staff) but are not prescriptive as to the services to be performed by each health department. Recognizing that there are significant differences in the populations served by local health departments and their needs, the Practice Standards require that each local health department "assure", not "provide" these services. The local health department may provide certain services itself, contract with another agency, or determine that a particular need is adequately met by other health care providers or agencies.
Outside of the Practice Standards, there are a number of other State statutes and/or rules that delegate to the local health departments the responsibility for addressing particular public health problems. This set of rules, referred to as the State Sanitary Code, include investigation of communicable diseases, immunization of school-age children, and oversight over a number of environmental and sanitary public health concerns, such as restaurants and other retail food establishments, private wells and septic systems, public bathing places, campgrounds, youth camps, and lead-based paint. However, because the regulated facilities under the Code are not present in all communities, not all local health departments perform these functions.

Organizational Structure of Public Health Services

Municipal government has the primary responsibility for local public health services and the municipality may meet this requirement by:

- maintaining a municipal health department;
- a shared services agreement with another municipality;
- participating in a regional health commission; or
- agreeing to come under the jurisdiction of, a county health department.

This has resulted in a diverse structure of 111 local health departments covering the State's 566 municipalities. [Note: this number is different than in our report, due to a recent consolidation.]

521 municipalities (92%) participate in some form of shared services arrangement for local public health services. Only 45 municipalities, many of which are large cities, have stand-alone municipal health departments.

Counties are authorized, but not required, to establish county health departments.

- Twenty of the 21 counties have some form of county health department (Who Doesn't)

- In fifteen counties the county health department provides the same core public health services as are provide by municipal health departments within that county

- In 8 counties, the county health department covers the whole county; these are all in the formerly rural areas in the Northwest and South Jersey.

- In 7 counties, the county health department covers some municipalities, while local health departments cover the remaining municipalities.

- All county health departments also perform specialized environmental services under the authority of the County Environmental Health Act (CEHA).

Study Results

As noted in my opening statement, DHSS conducted a study of local health department operations and finances during CY2006-07. Local health departments self-reported data elements either through the DHSS required Annual Report or surveys, therefore, our conclusions are limited by the constraints of self-reported data.

The cost per capita of providing public health services varies widely among local health departments with differences appearing to be related to the number and complexity of the services provided rather than to the size or the organizational structure of the local health department. There is not a strong correlation between the size of local health department and its operating cost per capita. The correlation is between the cost and the number of provided services.

Based on this data, we were unable to determine any clear evidence that consolidation of local health departments into larger units will guarantee a reduction in the cost per capita of providing services.

There are significant differences in the services provided by local health departments, depending upon local needs and the preferences of local elected officials. Local governing bodies frequently direct local health departments to perform tasks other than the core public health services. Which services a local health department provides directly affects costs.

Local government revenues are the sole or primary funding source for most local health departments, particularly municipal health departments. In the case of smaller municipal local health departments, the limited revenues available impact their ability to provide services and the quality of those services.

The primary finding of this study is that the "home rule" philosophy of government in New Jersey and the reliance on local tax revenue as the primary source of funding has resulted in a local public health system that is largely determined by, and responsive to, the needs of local communities and the priorities of local government officials.

The Department does view with concern how to effectively coordinate the activities of this structure so that it functions as a cohesive system in responding to public health challenges that are not local, but regional or statewide in scope.

Comparison with other States

Public health services in most other States are organized at the county level, with municipal health departments primarily in large cities.

In addition to New Jersey, only Connecticut and Massachusetts have public health services provided primarily at the municipal level. Both States have initiated efforts to consolidate single municipality health departments into larger regional units. As in New Jersey, the primary concerns driving these initiatives have been reducing the cost of services and better coordination of response to public health emergencies and other large scale events. Both States are looking to create structures similar to the regional health commissions that are already an option here in New Jersey.

Regarding funding, a comparison of NJ data to a 2005 NACCHO survey of local health departments that indicated NJ local health departments are more dependant on local revenues that in any other State. State funding has been the primary mechanism used in other States to ensure compliance with uniform standards. For example, the way that Connecticut is promoting regionalization of local health departments is by providing a higher per capita rate of State aid for regional health departments than for single municipality health departments.

Potential Options for New Jersey's Public Health System

1. Make public health a county responsibility
    - Where they exist, county health departments have proven to be an effective means to provide public health services.
    - Potential cost savings due to economies of scale, particularly through consolidation of management and administrative functions.
    - Countywide tax base can equalize disparity among municipalities in ability to raise funds to support services
    - Historically, county health departments have been more successful than municipal health departments in attracting outside (State/Federal) funds, thus reducing burden on local tax base.
    - Would require repeal/revision of multiple statutes

   Concerns
    - Capability of county health departments to meet the needs of the largest municipalities.
    - Some urban counties – Essex, Hudson, and Union – currently do not have full-service county health departments. It will take time and significant political will to develop effective county health agencies in these counties, whereas municipal and regional health departments in these counties are already functioning well in most cases.

2. Provide additional incentives to promote consolidation and shared services contracts
    - Funding for a "SHARE"-like program, specifically for public health, to support studies and/or implementation of local health department consolidation into county health departments, creation of new regional health

commissions, or expansion of shared services agreements among municipalities
- Revision of funding standards to promote larger public health agencies. The current minimum population to receive State Aid (Public Health Priority Funding) is 25,000 – unchanged since 1956.

Concern
- Planning for regional sharing of services needs to done in such a way as to promote effective provision of public health services, not simply to save money. The current system of inter-local agreements has promoted competition among local health departments to attract municipalities away from other health departments in order to increase their revenue base, which creates conflicts that inhibit collaboration among local health departments to meet regional public health challenges.

3. Allow current trends to continue to evolve
   - The number of local health departments has been decreasing in recent years – from in 115 in 2004 to 111 in 2008.

Concerns
- This trend has not been entirely in the direction of fewer/larger health departments. During this same period, two new single municipality health departments were created.
- Same concern as for #2 above. The current system promotes competition for municipalities (which health department can provide the service for less) that can result in cost savings but undermines collaboration on responding to critical public issues.

With your permission, I'd now like to address some specific questions that have been passed to the Department in advance of this testimony.

1. Status of DHSS efforts (Study and CDC Performance Appraisal Tool)

The Department has reached an agreement with PHACE – the Public Health Associations Cooperative Effort – an organization representing all of the statewide public health professional organizations, to collaborate in conducting the State Public Health System Performance Assessment. A steering committee has been formed to direct this effort. The current plan is to convene a statewide meeting to complete the CDC assessment instrument during the 2nd quarter of CY2009.

The Department has also begun working on the other studies recommended in the report. Stakeholder committees have been formed review the *Practice Standards* and the Health Officer licensure rules. We are in process of obtaining approval of an outside contractor to advise us on revision of the Local Health Evaluation Report. Staff from the Office of Public Health Infrastructure has begun conducting site visits to evaluate local health departments.

2. Correlate Practice Standards with actual LHD activities (Study Table 7, 10).

Table 7 lists all the services that are covered either by the *Practice Standards* or the State Sanitary Code. These are the services that a local health department is responsible for making sure are available in each community, if needed. But not all communities need every one of these services. For example, not every community has a public beach or swimming pool. And a local health department may not need to directly perform a particular service (for example, counseling pregnant women) if the communities need is already being met by someone else. Therefore, data will not necessarily match requirements and actually LHD performed activities. There will be a match between requirements and assurance of requirements.

3. Explain why Table 7 "13 core activities and Table 8 list of activities correlated to the "core activities" are not identical.

The question about the required core activities is addressed under the question above.

Table 8 was developed from a national survey performed by the National Association of County and City Health Officials (NACCHO). The 60 services listed represent the services commonly provided by local health departments across the United States. This list, which goes far beyond the services covered by New Jersey's *Practice Standards* and Sanitary Code, illustrates the diversity among local health departments across the country. For example, in some parts of the country, the local health department is the primary provider of primary care medical services, particularly in rural areas; with the large number of medical providers in NJ, very few local health departments NJ provide direct medical care. Another example, in some cities the health department runs the emergency medical services; EMS in NJ is provided by other public and private agencies and not by health departments.

There is no national standard as to what are the "core activities" of local health departments. Where States do have standards, they differ from State to State. The closest thing to a national consensus is the "Operational Definition of a Local Health Department", developed by NACCHO. Our NJ *Practice Standards* align very closely with the Operational Definition, which contains recommendations for the organizational structure of the department.

4. Who is responsible for ensuring a local department "contracts" for services that they do not provide?

Many local health departments do contract, either formally or informally, with other entities that provide public health services. It is the responsibility of the local Board of Health, which represents the local community, to see to it that affected clients are informed of what is available to them and where to access it. With the current reporting system, it is difficult for the Department to track and verify these arrangements. However, as part of our auditing procedure, we have begun to assess

this type of information and, with a new reporting system; we have increased our ability to collect this information.

5. Table 10 list "services provided" as determined by local health officers. Again, are these correlated to "required activities" and if so, then why the wide variation in performance?

Table 10 was compiled by the New Jersey Health Officers Association. It is meant to be a comprehensive list of all NJ local health departments' activities, but no local health department does everything on this list. The extent of the services included goes far beyond the services addressed in State statutes or rules. This list demonstrates the great variety in the kind of services that local officials believe are needed from their local health department.

6. How can a local department be said to be providing "local public health services" given the fewness of activities provided by some departments as delineated in tables 8 and 9?

There are small local health departments serving a single municipality or a small number of municipalities in affluent suburban or rural areas that have only the most basic public health needs and are able to meet the minimum requirements of the *Practice Standards* by addressing only those needs.

Since the report primarily focuses on the cost of local public health in NJ, these tables show only those services directly provided by the local health department. There are likely to be other services that these local health departments have arranged for through contracts with other entities, or that the local health department has identified are already done by some other provider.

7. What specific services/activities (not generalized responsibilities) are actually required in NJ to assure reasonable public health safety? What authority does the Department have to determine and require these essential services/activities? How can the Department insure that in fact the "core public health functions' are being provided to the citizenry of the state?

The Department has statutory authority to set "minimum standards" for local boards of health. The specific services required by the Sanitary Code are each authorized by separate statutes.

The Department ensures that local health departments are providing these services through a number of mechanisms: a) local health departments submit an annual Local Health Evaluation Report, b) enforcement of the Sanitary Code requirements are reported to the various Divisions of the Department responsible for each specific requirement, and c) the Department has begun making site visits to evaluate local health departments.

8. Assuming all local health departments provide services directly or indirectly (through a publicized contract or inter-local service arrangement) do they provide a specific report to the State on why such services / activities are not required in their geopolitical area?

Local health departments must provide or ensure services either directly or indirectly. With respect to services which are not required in a geopolitical area, each health department is required to participate in a regional (county-based) process which assesses the public health needs of the communities therein and make recommendations for best meeting those needs.

9. Why LINCS?

LINCS deals primarily with public health emergency preparedness and response, not routine public health services. It is an acknowledgement that public health emergencies are not likely to be limited to a particular municipality, and therefore separately developed plans for each municipality would not be adequate to address a widespread emergency incident. The other intent of LINCS is to provide specialized expertise not otherwise available to all local health departments. Both LINCS and the Governmental Public Health Partnerships were established to promote improved coordination and collaboration between local health departments on areas of common concern. They are not necessarily a judgment on the ability of local health departments to provide local services to their own communities.

10. Is state law is in an impediment to redesigning the public health delivery system?

We have been told on numerous occasions that the current statutes have been an impediment to consolidation of local health departments. According to the Local Health District Act of 1951, if a health department is absorbed or consolidated with another LHD, all FTEs are guaranteed comparable duties and compensation. These statutory provisions were originally adopted to address concerns of local health department employees regarding their job security so as to gain their support for a previous initiative to promote larger public health jurisdictions. This guarantee that the employees would not lose their jobs if consolidation occurred was intended to gain the employee's acceptance of consolidation. This has in many cases resulted in the opposite affect as absorbing LHDs cannot afford or are not willing to accept these costs and additional employees.

11. Why the huge variation in the local department performance of core public health activities?

The differences reflect both variances in community needs and variances in public officials' perceptions of their community's needs, and what they are willing to fund. This variance is the inevitable result of a system based on "home rule."

12. What is the correlation between the service activities and costs?

A comparison of local health department costs in relation to services received by the community is potentially misleading. While small and larger municipalities may not be getting the same amount of services, they also are not paying for unnecessary services. For example, childhood lead poisoning prevention is a "core" public health service, but communities with low lead poisoning rates don't need the same level of services as communities with high rates.

13. The report implies that larger scale organization, serving larger population bases (or land areas) are providing needed services in a far more cost effective manner than many small departments. If this is so, should the State be forcing the creation of these larger more cost effective and service response agencies as the preferred mechanism?

Many previous studies of public health in New Jersey, going back to the 1930s, have reached this same conclusion. But there has never been a politically viable consensus as to what the "larger scale organization" is, or how it would be funded.

Any major reorganization of the public health structure in New Jersey will have to include a reassessment of the underlying statutes and funding mechanisms. Currently, the municipality has the primary responsibility for identification of services and is the primary funding source. In most other States, State government is either the direct provider of public health services through local offices of the State Health Department, or the State provides a substantial percentage of the funding for local public health services, and thereby has greater control over what they do. Any increase in State oversight of local health departments to ensure that particular services or being performed and/or that they are meeting any other requirements will require increased spending at the State level to monitor their performance.

ATTACHMENT B

Testimony before the Local Unit Alignment Reorganization & Consolidation Commission
Peter N. Tabbot, President
New Jersey Health Officers Association

John H. Fisher, Chairman
Joseph V. Doria, Jr., Commissioner
Mayor Gary Passanante
Local Unit Alignment, Reorganization and Consolidation Commission

Chairman Fisher, Commissioner Doria, Mayor Passanante & Commission Members:

Good morning. My name is Peter Tabbot and I am President of the New Jersey Health Officers Association. Thank you for the opportunity to speak with you this morning about New Jersey's local public health system, which has a rich and successful history of regionalization, and is perhaps the best example of a shared service among New Jersey's municipalities.

The New Jersey Health Officers Association represents the 111 Health Officers who serve our state's local health departments, and through our allied organizations, the public health workforce of New Jersey. As an organization, we have never opposed consolidation and regionalization, where appropriate. In fact, we recognize and embrace current regulations that already allow for and encourage the regionalization of public health services. By statute, municipalities may participate in regionalization by sharing costs through interlocal municipal agreements, by participating in a regional health commission, or by contracting for services with a county health department. In fact, 92% of New Jersey's municipalities have already formed agreements under current statute to provide consolidated health services, resulting in the provision of public health services to 566 municipalities by only 111 health departments. By this evidence alone, there may be no greater example of successful regionalization in New Jersey.

The success in public health regionalization reflects natural partnerships based largely on homogenous populations, contiguous borders and the intelligent sharing of costs. Because New Jersey is such a diverse state, even within Practice Standards of Performance for Local Boards of Health in New Jersey, health departments are given some flexibility in assessing the needs of the jurisdiction and providing services accordingly. These same Practice Standards are aligned with national guidelines for public health service delivery, and also require municipalities to collaborate on a countywide basis through partnerships that assure regional planning. We are not 566 municipalities providing the same services across the board, but are 111 agencies that provide population based services through collaborative community partnerships.

Unlike the majority of other government services, the New Jersey public health community is already taking several steps to examine the capabilities and efficiencies – or lack thereof – of the state's public health system. The state's comprehensive May 2008

Study of New Jersey's Local Public Health System reveals some interesting information about the regionalization of public health services in the state. The data emerging from this document indicates the following:

- County health departments have an average per capita cost of $25.99, while municipal health departments have per capita costs of $24.39.

- In fact, if one removes single municipality health departments (of which there are only 45) from the data, per capita costs for municipal health departments are $15.44. Per capita costs for Regional Health Commissions are $12.75.

- There will be a decrease in services with no clear net savings to taxpayers through strict countywide regionalization of services.

Clearly, the data in this statewide report does not show any evidence that further regionalization of local health departments into larger units will result in reduction in the cost per capita. In fact, in its report, the NJDHSS concluded that an analysis of the data "does not provide a compelling case for recommending significant structural changes to the organization of local public health in New Jersey." Given the lack of sound data to support structural change, the aggressive pursuit of consolidation at this juncture would seem imprudent.

In speaking with you about the regionalization of local public health, I would be remiss if I did not discuss the potential negative effect of consolidation on the public health workforce. As public health professionals, we are concerned that further reduction in the number of health departments will result in a critical diminution in New Jersey's public health workforce. The importance of having a well-trained, experienced public health workforce cannot be overstated. Besides having experts in place who may aptly respond to the health needs of communities, emergencies such as pandemic flu and biological attacks are felt first at the local level. It is the local health department to whom residents turn for guidance during such events, and where a response must be generated.

Statistics from the national Association of State and Territorial Health Officials show an alarming trend, citing a rapidly aging public health workforce that will experience high rates of retirement over the next five years. There is no clearly identified source of qualified employees to fill this void in knowledge and experience when threats surface. ASTHO concludes that our nation's public health system is in a legitimate preparedness crisis. Locally, the reduction in experienced public health personnel would severely cripple our ability to handle pandemic influenza, provide vaccinations and distribute medication. Experience from past pandemics tells us that during such an event, upwards of 30% of our workforce may be unable to report because they could be sick, dead or caring for homebound/ill family members. Even with a full response of all governmental public health professionals in New Jersey, it would be difficult, at best. Anything that could reduce this vital workforce must be avoided.

There has been some debate that savings could perhaps be achieved if administrative functions performed by Health Officers were placed at the county level. Please remember

that most Health Officers do not only administer programs but also provide oversight and support for well over 100 different services, many of which exceed traditional public health programs and emergency preparedness activities.

Simply stated, the amalgamation of health departments and the termination of Health Officers will result in the elimination of vital, experienced local public health leadership, will impair the ability of municipalities to perform their work in a variety of program areas, and will irreparably compromise the workforce. To remove local staff will not only squander local expertise, but will compromise many local programs. Worse still, local governing bodies will have to backfill positions for the performance of other critical and state-mandated programs that health officials customarily oversee. This cannot result in a savings of tax dollars.

ATTAHCMENT C

State Public Health
A Summary of National Survey Results
Jim Pearsol
Chief Program Officer
Public Health Performance
Association of State and Territorial Health Officials
October 22, 2008

Public Health as a Public Service

- Health in community and across the lifespan
- Population-based interventions and response
- Domains: prevention, emergency preparedness, disease (communicable, infectious, chronic, genetic, etc.), food, water, environmental, neglect, safety, monitoring (lab, data, case follow-up, etc.), communication, regulation and licensure, health education, clinics, science, etc.

Survey Background

- Survey Partners:
    - Robert Wood Johnson Foundation (RWJF)
    - Centers for Disease Control and Prevention (CDC)
    - Public Health Foundation (PHF)

- Goal: Define the purposes, functions, roles and responsibilities of state and territorial health (STHA) agencies.

Survey Subheadings

- Respondent Information
- Activities
- Organization for Federal Initiatives
- STHA Descriptors
- STHA Personnel
- State Organizational Structure
- Agency Mission
- STHA Scope of Work

- 75 + survey questions
- Web survey tool

- Planning and Quality Improvement
- Relationship with Local Public Health Agencies
- STHA Training
- Emergency Preparedness Infrastructure
- Partnership and Collaboration
- STHA Performance Activities
- STHO Qualifications and Experience

How are state public health agencies structured?

Structure of state health agencies:

58% Free-standing/independent agency

40% Under a larger agency

State health agencies have specific authority to:

- Collect health data: 100%
- Manage vital statistics: 98%
- Declare a health emergency: 79%
- Conduct health planning: 77%
- License health professionals: 63%

Prevention services provided by state health agencies:

- Tobacco control and prevention: 92%
- Obesity: 85%
- Injury control and prevention: 81%
- STD counseling/partner notification: 79%
- HIV: 77%
- Diabetes: 71%

More than **50%** of states report the following Emergency preparedness responsibilities became significantly stronger over the past 3 years:

- Communication and information systems
- Relationship with other local, state, or federal agencies
- Preparedness planning
- Access to laboratory services
- Epidemiology
- Public health surveillance
- State Health Agency Services

State health agencies regulate, inspect, and license**:**

- Labs: 77%
- Hospitals: 73%
- Food service establishments: 71%
- Swimming pools: 69%
- Hospice & long term care: 65%
- Lead inspection: 60%
- Campgrounds/RVs: 54%
- Public drinking water: 50%

Monitor health status STHA Epidemiology/Surveillance Activities (>83%):

- 100% Communicable Diseases
- 96% Vital Statistics
- 93% Cancer Incidence, Chronic Diseases, Injury, Perinatal events/risk factors

- 87% Behavioral Risk Factors
- 83% Syndromic Surveillance

STHA Electronic data exchange (>58% send and receive data):

- 92% Reportable diseases and Vital records
- 88% Lab reporting
- 81% Childhood immunizations and WIC
- 73% Outbreak management, Geo-coded data for mapping, and MCH reporting
- 58% Medicaid billing

STHA Exchange information of any type (>74%) with: LHDs, Hospitals, providers, CHCs, other HC providers, health insurers, cancer societies, EMR, EH orgs, coop ext, schools, parks and rec, transportation, CBOs/nfps, faith-based, universities, businesses and media

STHA created a state Health Improvement Plan (HIP) using a state health assessment (HA) (>56%)

STHA conducted an overall state health assessment (67%)

Protect people from health problems and health hazards
STHA has a stronger infrastructure due to emergency preparedness efforts (>85%)
98% Communication system, epi & surv, planning, surge
94% IS, WF, and relationships with other fed, state and local
89% Lab services
85% Legal basis for PH action

STHA engaged in preparedness activities (63%)
98% BT response
87% Natural disaster response and Nuclear disaster response
83% Chemical disaster response
63% Explosion disaster response

STHA environmental protection activities (>48%):
93% Food safety education
85% Environmental epidemiology
72% Radiation control and Toxicology
63% Radon control
50% Private water supply safety and Indoor Air
48% Vector control and Public water supply safety

Assuring preparedness for a health emergency (Rank #2, in priority activities planned for current fiscal year – Health reform was #1)

Provide people with health information

Media: STHA exchanged info (100%) or worked on joint projects (64%)

STHA increased collaboration & exchange information, last 3 years (>47%)
55% Business
53% health insurers
51% Community health centers
49% Community-based organizations and schools
47% Other health care providers and faith communities

STHA primary prevention services (>54%)
93% tobacco prevention
87% Obesity
83% Injury prevention
80% STD counseling
78% HIV counseling
72% Diabetes
65% violence prevention
61% Hypertension and suicide
54% unintended pregnancy

Engage community to solve PH problems
STHA has a strategic plan (73%)
Used MAPP in some capacity (53%) – state, reference, or collaboration
State HIP: within 3 years (56%); 3 years ago (22%); no (21%)
Plan to update HIP in next 3 years (81%)
State HIP linked to LHD HIP- yes (25%); some (27%); no (15%)

State provides policy engagement (>66%)
81% EMR and LHDs
66% Hospitals and community –based organizations

STHA works together on activities/projects (>62%): Universities, schools, hospitals, community-based organizations, community health centers, cancer societies, faith-based, other health care providers, local health departments, health insurers, physicians, cooperative extensions, businesses, environmental and conservation groups, media, parks and recreation, and tribal.

Enforce PH laws and regulations
Authority to adopt public health laws and regulations (STHA, 47%)
85% State legislature
47% STHA
34% Governor
21% State board of health

Educate about laws and regulations (>51%)
79% Local health departments
77% Emergency responders
68% Laboratories
57% Hospitals
51% Community-based organizations

Regulation, inspection or licensing (>52%)
78% Laboratories
74% Hospitals
72% Food service establishment
70% Swimming pools
52% Public drinking water and tattoos
65% Hospice and long term care
63% Lead inspection
57% Campgrounds/RVs, assisted living, other h facility

Environmental protection activities (>48%):
93% Food safety education
85% Environmental epidemiology
72% Radiation control and Toxicology
63% Radon control
50% Private water supply safety & Indoor Air
48% Vector control and Public water supply safety

Other (>67%)
74% Veterinarian PH activities; 70% trauma system; and 67% IRB

Help people receive health services
Access to health care (>24%)
87% Health disparities
83% Minority health
67% Rural health
48% Certifying authority for federal reimbursement
46% Outreach and enrollment for medical insurance
39% EMS and oral health
28% SCHIP, pharmacy & substance ab
26% Tribal health
24% faith-based health programs

Created a state HIP using a state HA (>56%)
State HIP – last 3 years (56%); 3 years ago (22%); no (21%)
Plan to update HIP in next 3 years (81%)

MCH services (>22%)
67% CSHCN
48% WIC
41% Early intervention
30% Family planning/prenatal care
28% WIC nutrition counseling
28% School health (clinical)
22% EPSDT

Maintain a competent PH workforce
Sources of STHA workforce development (rank order)
STHA in-house training
Universities
Federal Government
National associations
Other state agencies
Health professional agencies
PH institutes

STHA has a designated training coordinator (62%)

STHA provides workforce technical assistance (>30%)
74% Local health departments
70% EMR
47% Hospitals
43% Community-based organizations
30% Laboratories

STHA oversees professional licensing (>22%)
26% Nurses; 24% Physicians and PAs; and 22% Dentists

See also ASTHO 2007 State Public Health Workforce Survey

Evaluate and improve PH programs
STHA maintains registries (>74%)
78% Birth defects
74% Cancer registry

Overall health assessments (67%)

STHA has its own quality improvement (QI) process in place
33% Fully or partially department-wide
59% Fully or partially in specific programs
19% No

STHA has a formal performance management program in place (standards, measures, progress reports, and QI process)
42% Fully or partially department-wide
35% Fully or partially in specific programs
27% No

Created a state HIP using a state HA (>56%)
STHA provides QI/Performance technical assistance (>62%)
81% LHDs; 79% Labs; 77% EMRs; 74% Hospitals; and 62% Community-based organizations

Manage resources
STHA has primary responsibility for federal initiatives (>50%)
90% Vital statistics and PHHS block grant
83% Cancer prevention and control and HPSA
81% HIV pharm (ADAP)
73% WIC
71% MCHBG
65% HRSA preparedness
58% CDC preparedness
56% HIV Title IV and FP Title X
54% Healthy people
50% Rural health

STHA sources of revenue
45% Direct federal funds
24% State GRF
15% Medicaid
8% Other (Inter-agency transfers, other dedicated or shared funds)
5% Federal pass through
3% Fees

STHA has authority to establish fees for services (62%)

STHA has a system for LHDs to report to state (71%)
Thank you….

- For more information, please contact: Jim Pearsol, Katie Sellers, or Michael Dickey at ASTHO
- www.astho.org or 202-371-9090