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State, Tribal, Local, and Territorial Workgroup Recommendations to Advisory Committee to the Director Centers for Disease Control and Prevention

Topic: Health Department of the Future

Prepared by the Office for State, Tribal, Local and Territorial Support (OSTLTS)

Contents

Introduction

The State, Tribal, Local, and Territorial (STLT) Workgroup was charged by the Centers for Disease Control and Prevention's (CDC) Advisory Committee to the Director (ACD) to produce recommendations on how CDC can support health departments as they adjust to a changing economic and policy climate. STLT health departments are subject to growing demands, decreasing resources, and evolving system changes that call for planning greater efficiencies as well as new approaches to protecting the health of the public. Furthermore, the implementation of the Patient Protection and Affordable Care Act (ACA) is leading to a growing demand to examine how to more efficiently and effectively continue support for public health.

Methodology

To identify ways CDC can support the "health department of the future," the STLT Workgroup developed Subworkgroups to focus its analysis and recommendation efforts on four specific areas:

1. Clinical care and public health linkage options
2. Core services in public health
3. Shared services-regionalization options
4. Workforce development needs for public health

Each subworkgroup was tasked with developing high-level recommendations that could inform and advise CDC about possible options to address these challenges. Each recommendation is intended to

- Be feasible for CDC to address;
- Promote improvements that respond to the current economic environment and optimally have a large-scale public health impact; and
- Have an identifiable outcome beyond additional processing (e.g., another committee).

Subworkgroups included STLT Workgroup members with expertise in public health practice, representing various STLT public health departments and organizations. In addition, a CDC subject matter expert (SME) served on the subworkgroups as a resource for each group.

In July, each subworkgroup held two conference calls, along with additional electronic interactions, to develop proposed recommendations. In August, the four subworkgroup chairs, along with STLT workgroup leadership, held a conference call to review the proposed recommendations for each area. At its September meeting, the STLT Workgroup reviewed all the recommendations in preparation for delivering them to the ACD in October 2012.

This report is organized into four sections to present the recommendations provided by each subworkgroup. Each section summarizes the discussions, lists the recommendations, and provides a rationale for each recommendation.

A. Clinical Healthcare and Public Health

The Clinical Healthcare Subworkgroup was charged with defining recommendations on how CDC can support efforts to integrate clinical care and public health as a critical element of the "health department of the future." As indicated in the recent Institute of Medicine report (*Primary Care and Public Health: Exploring Integration to Improve Population Health,* March 2012), such integration could "enhance the capacity of both sectors to carry out their missions and link with other stakeholders to catalyze a collaborative, intersectoral movement toward improved population health." As the healthcare system in the United States evolves, healthcare costs increase, and public health departments face shrinking resources, a strong partnership between these two parts of the larger health system has become increasingly more critical for the support of population health. In light of these circumstances, the role of health departments in the direct provision of clinical care must be revisited. Likewise, clinical care must grow its role in supporting population health services that may previously have fallen under the jurisdiction of public health. ACA provides an opportunity to better engage healthcare in public health functions, such as community health assessments, that serve as a basis for addressing the most critical population health issues. CDC is well-positioned to help STLT health departments identify ways to strengthen their relationship with clinical care in their communities with the goal of improved population health. This section offers three recommendations, which are followed by supporting rationale.

Recommendation #1: Public Health role in non-profit hospital requirements for community health needs assessment/strategies

To ensure maximal community benefit, CDC should: (a) continue to work with the IRS to strengthen the requirements for hospitals to work with health departments, and (b) provide guidance to STLT health departments that will enable them to demonstrate their added value in helping hospitals meet IRS-mandated corporate compliance requirements regarding community health needs assessment and implementation strategies.

Rationale

The ACA established new federal requirements for tax-exempt hospitals under section 501(r) of the Internal Revenue Code. These changes impose new requirements on each charitable hospital, beginning in the tax year two years after the passage of the ACA, to conduct a community health needs assessment and adopt an implementation strategy that addresses the identified needs. Toward that end, the Internal Revenue Service (IRS) began working with CDC to develop technical guidance to inform the development of regulations pertaining to changes to the Internal Revenue Code. Particular interest was expressed in identifying best practices in the field, and examining challenges and opportunities associated with their implementation. To address this recommendation, CDC can help health departments identify ways to assist hospitals in their communities fulfill their IRS requirements while maximizing the public health benefit of their actions. Noteworthy is the 2011 IRS definition of "community building" activities to include those that "improve the community's health or safety," some of which may meet the definition of community benefit (e.g., housing rehabilitation such as removing lead; community support for violence prevention or disaster readiness/emergency preparedness; improving the environment to address environmental hazards; coalition building that addresses health and safety issues; workforce development to recruit health care providers to underserved areas)

Recommendation #2 -- Exchange of EHRs across Clinical Care and Public Health Systems

CDC should work across the agency and in collaboration with key partners that can impact local level practice (e.g., Center for Medicare & Medicaid Services, hospitals, primary care providers) to build state and local health department capacity to exchange information with clinical electronic health record (EHR) systems or health information organizations/exchanges. Such collaborations would aim to improve population health surveillance and timeliness of data, preventive services delivery, and preparedness and response by using funding, shared technology solutions and technical assistance in synchrony with evolving federal standards (e.g., "meaningful use", EHR incentive programs). As part of this effort, CDC should partner with appropriate entities inside or outside of the agency to break down some of the legal barriers, both real and perceived, that clinical systems have in sharing information with public health.

Rationale

Interoperability or integration of EHR/Health IT systems across clinical care and public health will more effectively support population health. For example, when both clinical care and public health systems are able to receive and send electronic information, clinics and hospitals will have improved capacity to deliver evidence-based care during outbreaks and emergencies and public health will have higher epidemiological capacity to support necessary interventions. Across the country, there are many independent users of various EHR systems. Furthermore, many of the current surveillance systems are quickly becoming outdated and need to build capacity to use national industry standards for EHRs as they evolve, such as those becoming standard in hospitals, out-patient clinics, and other private provider practices, to ensure meaningful use and optimize efficiency.

Systems of interoperability between public health and clinical medicine have begun to demonstrate improved population health and preventive services:

1. The *New York City Primary Care Information Project* has allowed physicians to improve preventive service delivery with the help of electronic health records. In addition, the health department can query aggregate data and view, for example, how many children are receiving corticosteroids as part of asthma treatment and how many people with STDs are receiving the appropriate antibiotics. This type of access to health data empowers the healthcare provider to promote quality care and also helps the health department promote population health.

2. The *Beacon Community Initiatives* serve as a model for building health information exchange between primary care and public health. Tulsa, one of the Beacon communities, uses a system (MyHealth Access Network) that allows sharing of health records electronically to promote quality and coordinated care.

3. The *EHR Incentive Program* has accelerated electronic reporting to immunization information systems through immunization registries. These will help improve individual and population immunization rates by providing lifetime immunization histories and immunization decision support to clinicians using the electronic health record.

Recommendation #3 -- Financing for Population Health

CDC should collaborate with the Health Resources and Services Administration (HRSA), CMS and private insurance to develop strategies that support financing for population health, and encourage and support collaboration between public health and clinical medicine in the development of Accountable Care Organizations (ACOs).

Rationale

Collaboration with HRSA, CMS and private insurance can build strategies that support population, not just individual, health. Health departments need options for how they can bill for services and how they can expand the types of services (e.g., prevention services) that receive coverage.

B. Core Services in Public Health

The Core Services Subworkgroup was charged with defining recommendations on how CDC can help STLT health departments define core or a minimal package of public health services that will help define the "health department of the future." Governmental public health departments at all levels—local, state, tribal, territorial, and federal—face budget cuts and significant resource constraints. In addition, across the country, changes in the nature of preventable disease and illness are affecting people's health. These conditions require difficult decisions about which programs to protect, to eliminate, and/or to scale back. Part of the decision-making process involves an assessment of the current situation and future potential with regard to the assumption of these efforts by other governmental or non-governmental entities. CDC is the governmental public health agency that could have the greatest impact through its consideration of these matters. This section offers two recommendations, which are followed by supporting rationale.

Recommendation #1 -- Current Practice and Thinking regarding Core Public Health Services

CDC should gather and analyze information from STLT partners regarding the current practice and thinking regarding core public health services.

Rationale

There is insufficient information regarding the range of viewpoints and current practices throughout various STLT departmental jurisdictions. It is clear that there is wide variability with regard to the assessment of core public health programs. This variability is, in part, a reflection of the diverse environmental, budgetary, and historical factors in different locations. To address this recommendation, CDC should consider summarizing the information already available and collecting additional information, as resources and time allow, to ensure a sufficient evidence base to support deliberations for the stakeholder process detailed in the recommendation below.

Recommendation #2-- Stakeholder Process for Guidance on Core Public Health Services

CDC should create a stakeholder process to provide guidance to CDC and STLT health departments facing decision-making about future services and programs. Stakeholders should include members of the STLT Workgroup, as well as key non-governmental partners and those outside the public health arena. The group should attempt to answer the following questions:

1. What core public health services and programs do governmental public health agencies need to ensure are provided in every jurisdiction?
2. Which such services and programs will likely require governmental funding if they are to exist?
3. Are there structural models for governmental public health—such as shared services and regionalization—that increase the likelihood that such services and programs will reach all populations?
4. Are there models that demonstrate a sound infrastructure within public health for billing for services or contracting out such services the health department is not able to provide, with the ultimate goal of directing shrinking public health dollars to areas that cannot be reimbursed or provided by others?

Rationale

There is no consensus or uniform guidance on which programs are considered core or essential. Similarly there is an uneven understanding of the possibilities for the provision of such core services by other entities. The situation can become further complicated when services are mandated or believed to be mandated. It is important that shrinking public health dollars not be used for services that can be paid for by third parties. In contrast, certain services critical to protecting the public health that are not focused on individuals (e.g., protecting the environment, surveillance, food-borne outbreak containment) will likely continue to require public resources. CDC, as the leading governmental public health agency, can play a leadership role in providing guidance to health departments to move through this critical decision-making process.

C. Shared Services-Regionalization

The Shared Services-Regionalization Subworkgroup was charged with defining recommendations on how CDC can support the "health department of the future" in addressing resource constraints while providing quality services to communities. As STLT health department budgets shrink, sharing, consolidating, and collaborating on services across STLT jurisdictional boundaries could increase efficiency, reduce redundancy, and maximize use of resources. With several new initiatives being funded through the Center for Sharing Public Health Services (CSPHS) and the University of Kentucky's National Coordinating Center for Public Health Services and Systems Research (PHSSR), CDC can rely on these or similar projects to share critical information and science related to shared services and regionalization. This section offers three recommendations, which are followed by supporting rationale.

Recommendation #1-- Shared Services Clearinghouse

CDC should establish a clearinghouse of program practices that demonstrate how shared services work in the field.

Rationale

Anecdotally, there are examples of creative state and local health department efforts to share services (e.g., shared STD testing services in Oregon, Alaska, North Dakota, and Idaho; shared newborn screening consortiums in Oregon and Massachusetts; New Hampshire's collaborative model; proposed models for regional laboratory centers of excellence). However, no systematic, overarching collection of information exists. Establishing a clearinghouse will provide up-to-date resources for health departments to easily access information regarding existing collaborations focused on shared services. To address this recommendation, CDC can consider the following activities:

- Survey STLT health departments to collect their sharing program practices and making these available to others
- Assess whether sufficient work volume exists that will ensure quality and expertise (e.g., poison control center, newborn screenings)
- Identify departments and core services that logically can be centralized without losing quality or efficiency
- Provide practical examples and documents that can be adapted or contribute to developing shared program services (e.g., agreement templates, sample methodologies)

Recommendation #2-- Encourage/Incentivize Use of Shared Program Services

CDC should identify ways to encourage use of shared program services including but not limited to incentives built into funding opportunity announcements (FOAs).

Rationale

Leveraging existing financing and cooperative agreements will help motivate different jurisdictions to find ways to work together and optimize efficient use of ever-shrinking public health resources and services. To address this recommendation, CDC can consider—as part of the agency's next steps in its current FOA re-design effort—reviewing available CDC financing and cooperative agreement mechanisms that would support incentivizing shared or regionalization of services. CDC could also consider using the regional HHS structure to encourage shared service opportunities.

Recommendation #3--Support and Add Value to Existing Shared Services Initiatives

CDC should continue to partner with existing efforts to promote shared services (e.g., CSPHS in Kansas and PHSSR at the University of Kentucky, others) to identify added-value opportunities for collaboration, especially related to promotion of promising practices and development of tools/technical assistance, thus encouraging their implementation and ensuring the success of these initiatives.

Rationale

In an effort not to duplicate efforts being conducted by other partners in the field, CDC should support the current efforts and collaborate with these partners to both add value and help ensure success.

D. Workforce Development

The Workforce Development Subworkgroup was charged with defining recommendations on how CDC can support public health workforce needs as they relate to the "health department of the future." The current public health workforce is both aging and potentially misaligned with the needs of the 21st century health department. Public health leaders recognize that there is a lack of the right number of people with the right skills in the right place at the right time. Factors impacting these gaps include the composition and number of workers, their competency, the larger contextual environment, and the workplace environment. CDC's fishbone diagram titled "Factors Affecting the Public Health Workforce" provides a graphic description of these factors (see appendix 2). Unlike any other HHS agency, CDC has the credibility and understanding of issues relevant to the public health workforce to play a needed leadership role in addressing today's challenges facing the public health workforce. This section offers four recommendations, which are followed by supporting rationale.

Recommendation #1-- Vital Public Health Workforce Gaps

CDC should lead a coordinated effort with active engagement by external and internal partners to address vital workforce gaps.

Rationale

The STLT Workgroup strongly believes in the need for CDC leadership in the arena of public health workforce. CDC has already demonstrated its credibility and understanding of issues relevant to the public health workforce. To address this recommendation, CDC can convene partners to develop a comprehensive workforce strategic plan that

- Includes the roles of various partners
- Assures coordination and communication among those active in this arena
- Increases the competency of the public health workforce
- Minimizes duplication of efforts

It is also hoped that CDC will continue to build a partnership with HRSA to leverage that agency's workforce efforts for public health.

Recommendation #2--Core Competencies in CDC Training Programs

CDC should redesign its training programs for both internal CDC staff and external STLT workforce to include the core competencies needed in the 21st century health department; such new content should be supported by a learning management system that facilitates access to training for all public health workers.

Rationale

The core competencies needed in the "new public health" are changing. For example, given the exponential increase in available data and technologic tools, there is a critical need for skills in data management and use of technology. It is hoped that CDC will ensure greater core scientific expertise among CDC staff who interact with STLT partners (i.e., an increased emphasis on technical assistance, scientific engagement, and teaching targeted to the specific local needs and less emphasis on "grants police" and rigid adherence to CDC grants guidance). Drastic budget cuts have also led to a need for accessible training, available at the worker's desk. To address this recommendation, CDC could develop

a curriculum available to all public health workers that addresses these new core competencies. CDC could work with the Public Health Informatics Institute to extend their work with the Public Health Informatics Academy to the broader public health workforce. In addition, CDC could lead the adoption of a common (or at least interoperable) Learning Management System or platform to ensure ubiquitous access to training for the public health workforce.

Recommendation #3 -- Public Health Workforce in Partnership with Healthcare System

CDC should facilitate the ability of the public health workforce to partner with the healthcare system.

Rationale

Given the burgeoning cost of the US health care system, there is a need now more than ever for public health and health care to work together to leverage their complementary contributions to the health of the population. To address this recommendation, CDC should continue to support integration of public health/population health into health professional education. CDC could consider supporting inter-professional education and development of a common curriculum for health professionals and public health. In addition, CDC could consider assignments of public health staff or fellows to work with the health care system to integrate population health into practice, as well as faculty or student and resident assignments within public health.

Recommendation #4 -- Realignment of Public Health School Curricula

CDC should partner with schools of public health (SPH), the Association of Schools of Public Health (ASPH), and the Council on Education for Public Health (CEPH) to realign public health school curricula with current health department needs.

Rationale

Few graduates of SPHs go into public health practice. There are multiple factors that contribute to this, including the lack of critical public health content in many curricula, as well as insufficient exposure to public health practice and role models. Furthermore, as a growing number of undergraduate programs grant degrees in public health, it is unclear if their training aligns with STLT public health jobs. Yet, STLT health departments might more easily afford to hire bachelor's level graduates if their training prepares them appropriately. To address this recommendation, CDC could work with practice partners and academics from SPHs to develop strategies for enhancing the appropriateness of preparation of the public health workforce and increasing the number of SPH graduates going into public health. They could further explore course requirements, including analytical skills, and career paths of people getting bachelor's degrees in public health and their alignment with STLT public health jobs. Such discussions could include model curricula, increased emphasis on informatics and policy skills in SPHs, more faculty with practice experience, and more practical public health experience for students. CDC could build into its work with ASPH, as well as ASPH's work on the education continuum, more efforts to address the pipeline of future public health workers (e.g., in elementary and secondary schools, colleges).

E. Next Steps

The Workgroup encourages CDC to develop a time-phased, measureable plan for implementing these recommendations. After the acceptance of these recommendations by the ACD, OSTLTS will prepare progress reports on the implementation of these recommendations for the STLT workgroup to review. These will be standing reports on the STLT workgroup calls and during in person meetings. CDC will develop a table of objective measures for the successful implementation of the recommendations for the STLT workgroup to review.

Appendix 1: Subworkgroup Members

Clinical Healthcare and Public Health	Core Services in Public Health	Shared Services-Regionalization	Workforce Development
▪ Bruce Dart (Chair)	▪ John Auerbach (Chair)	▪ Carol Moehrle (Chair)	▪ Paul Halverson (Chair)
▪ Tom Farley	▪ Jonathan Fielding	▪ David Lakey	▪ Dileep Bal
▪ Melissa Gower	▪ Mary Selecky	▪ Karen Remley	▪ Lillian Rivera
▪ Eduardo Sanchez	▪ Ann Whitting Sorrell	▪ Sally Smith	▪ Denise Koo (CDC SME)
▪ Greg Holzman (CDC SME)	▪ Janet Collins (CDC SME)	▪ May Chu (CDC SME)	

Appendix 2: Workforce Development Fishbone Diagram