**Assurance strategy 2: Helping to obtain fiscal resources to enable public health agencies at the State and local levels, and other organizations, to assure delivery of public health services and to enhance the capacity of the public health infrastructure**

**Office of the Assistant Secretary for Health (OASH)**

1. Facilitate the development of broad-based, often multidisciplinary, programs designed to reduce preventable conditions among minority populations (*Office of Minority Health*).
**1990–91**

2. Collaborate with commissions and offices of minority health within various States to provide a stronger foundation for State budget submissions (*Office of Minority Health*).
**1990–91**

3. Operate the Title X program to offer free or low-cost family planning services to a primarily low-income clientele (*Office of Population Affairs*).
**1990–91** **1992 and beyond**

**Indian Health Service (IHS)**

1. Develop resource allocation criteria and methodology.
**1990–91** **1992 and beyond**

2. Work with State and local governments to assure that access to State and local funded programs include consideration of American Indian and Alaskan Native health needs.
**1990–91** **1992 and beyond**

**Health Resources and Services Administration (HRSA)**

1. Increase or improve support for facilities, basic clinical services, and community-based program facilitating services. Substantial support is being provided to States and communities in their efforts to plan, organize, and deliver health care, especially to underserved and rural area residents, migrant workers, the homeless, mothers and children, and other groups with special needs.

• Develop an ongoing process to solicit input from State and local public health officials on how HRSA programs can deliver fiscal resources to State and local projects with necessary flexibility to increase the likelihood of more effective use.
**1992 and beyond**

• Target a share of any Community and Migrant Health Center Program expansion dollars available for helping existing facilities comply with life safety codes (*Bureau of Health Care Delivery and Assistance*).
**1990–91** **1992 and beyond**

• Work with the Farmers Home Administration, the National Cooperative Bank, and the Community Health Center Capital Corporation to assure financing for needed facilities (*Bureau of Health Care Delivery and Assistance*).
**1992 and beyond**

• Fund project grants for renovating and constructing nonacute care facilities to provide for the special health care needs of AIDS patients (*Bureau of Health Resources Development*).
**1990–91**

• Work with the Health Care Financing Administration to implement increased Medicaid reimbursement to Community and Migrant Health Centers and similar organizations, as required by the Omnibus Budget Reconciliation Act of 1989. Work with community health centers to help them derive maximum benefits from the funds (*Bureau of Health Care Delivery and Assistance*).
**1990–91**

• Work with the Health Care Financing Administration to improve public awareness of the Rural Health Clinics Act Program (*Office of Rural Health Policy*).
**1990–91**

2. Collaborate with State and local public health officials on ways to seek support from other Federal and State programs to financially support the delivery of sound primary care services for the disadvantaged.

• Support services such as case management services that facilitate health care availability. Specific plans include:

Expanding the Bureau of Health Care Delivery and Assistance perinatal initiative in FY90 to increase the range of case management and other support services at existing Community and Migrant Health Centers, and to reach more centers.
**1990–91**

Increased support for implementing network models of primary health care delivery, such as has been employed recently in Texas by the State health department and Community and Migrant Health Centers. In Texas, community health centers, in addition to providing onsite care, coordinate and case manage the receipt of care by other community-based providers, who accept referrals for basic primary care that they deliver in their own offices.

**1992 and beyond**

• Support the development of noninstitutional care by grants to States for demonstration projects to identify and assist HIV-infected persons to avoid institutionalization by using home health services, and to coordinate the provision of home health services and other long-term care services in the home.
**1990–91**

3. Develop a mechanism to identify novel and innovative ways of supporting public health services, such as using personnel provided "in kind," or volunteers; funding-offset arrangements; donations of goods, such as medications; and free rent for facilities.

**1992 and beyond**

**Centers for Disease Control (CDC)**

1. Work with State and local governments to secure fiscal resources needed to effectively address the high priority health problems.
**1990–91** **1992 and beyond**

2. Promote reimbursement strategies by private and public health insurers for effective preventive services, such as those recommended by the U.S. Preventive Services Task Force. Develop strategies to maintain the independence of persons with disabilities or chronic disease.

**1992 and beyond**

3. Prepare and propose a budget initiative to increase the capacity of the State and local public health system to carry out the assurance function. Representative actions would include activities required to assist States and localities to build capacity for Healthy People 2000 priorities and to increase the involvement of academic institutions in public health practice.

**1992 and beyond**

**Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)**

1. Assess the strengths and limitations of Medicare's diagnosis-related groups (DRG) for payment for alcoholism treatment in the private sector for those younger than 65 years (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91**

2. Review public and private sector policies bearing on liver transplants for alcoholics (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91**

3. Analyze the nature and extent of health insurance coverage for alcoholism treatment (*National Institute on Alcohol Abuse and Alcoholism*).
**1990–91**

4. Continue to administer the ADAMHA McKinney Mental Health Services for the Homeless Block Grant programs, which provide States with funds for direct services (*Office for Treatment Improvement*).
**1990–91** **1992 and beyond**

5. Provide technical assistance for potential grantees regarding availability of funding sources and proper mechanisms needed for obtaining funding (*Office for Substance Abuse Prevention*).
**1990–91** **1992 and beyond**

6. Convene a group of State Community Support Program coordinators to review fiscal incentives for providing community services and support for the severely mentally disabled (*National Institute of Mental Health*).
**1990–91**

7. Provide funding to State mental health agencies for local research demonstration projects focused on case management, psychosocial rehabilitation, and crisis assistance (*National Institute of Mental Health*).
**1990–91**

8. Conduct the annual review of State applications for funds under the McKinney Mental Health Services for the Homeless Block Grant; make grant awards for outreach, community mental health treatment, referral to health services; and substance abuse treatment, staff training, case management, and supportive and supervisory services in residential settings (*National Institute of Mental Health*).
**1990–91**

9. Issue a request for applications for human resource development grants to States and jurisdictional departments of mental health (*National Institute of Mental Health*).
**1990–91**

10. Fund Child and Adolescent Service System Program (CASSP) grants in all States and expand CASSP to the local level as a primary focus (*National Institute of Mental Health*).
**1992 and beyond**

11. Provide funding to State mental health agencies for local research demonstration projects on supported employment for the psychiatrically disabled (*National Institute of Mental Health*).
**1992 and beyond**

**Agency for Toxic Substances and Disease Registry (ATSDR)**

Continue assistance through grants, cooperative agreements, and contracts to States and local governments. Provide staff assistance to equip them with resources and skills required to implement needed activities.
**1990–91** **1992 and beyond**

- Regional representatives will continue to share with States examples of other States activities and experiences used to raise the level of priority of programs designed to minimize the threat of hazardous substances in the environment.

- Continue dialogue through the cooperative agreement with the National Governors Association to help raise the awareness of the various State Governors of the threat of toxic substances in their jurisdictions.

**Agency for Health Care Policy Research (AHCPR)**

Focus on linking and improving health care and insurance data bases and helping public health agencies use this information effectively.
**1990–91** **1992 and beyond**