

The Changing Public Health Landscape

Findings from the 2015 Forces of Change Survey

June 2015

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Economic forces and health reform are among the greatest contributors changing the public health landscape

Since 2008, the National Association of County and City Health Officials (NACCHO) has periodically surveyed local health departments (LHDs) to assess the impact of the economic recession.

For the last two years, NACCHO has expanded the survey to address more generally the forces that are affecting change in LHDs, including health reform and billing for services.

This new, expanded survey is called the Forces of Change survey.

LHDs face challenges and opportunities as the public health and clinical care environments evolve due to the Patient Protection and Affordable Care Act (ACA). The Forces of Change survey helps to identify these challenges and new opportunities.

Some LHDs are adapting to the changing clinical care environment by reducing their clinical services or expanding their population-based prevention services; others continue to sustain clinical services by exploring ways to be reimbursed for those services through billing third-party payers.

The ACA has also presented new opportunities for collaboration with community partners, including non-profit hospitals and primary care providers. LHDs are exploring these new partnerships.

Though the economic situation is improving for many LHDs, nearly one-quarter reported a lower budget in 2015 than 2014. These budget realities have also forced LHD leaders to value budget management skills as crucial for their professional public health staff.

NACCHO uses these findings to raise awareness of these issues among leaders in Congress, federal departments, and other organizations involved in public health funding and policymaking.

Methods

NACCHO distributed the Forces of Change survey to a statistically representative sample of 948 LHDs in the United States from January to February 2015. The sampling strategy allows state-level and national estimates if sufficient response was received from a state.

A total of 690 LHDs completed the survey (response rate of 73%).

NACCHO generated national statistics using estimation weights to account for sampling and non-response.

All data were self reported; NACCHO did not independently verify the data provided by LHDs.

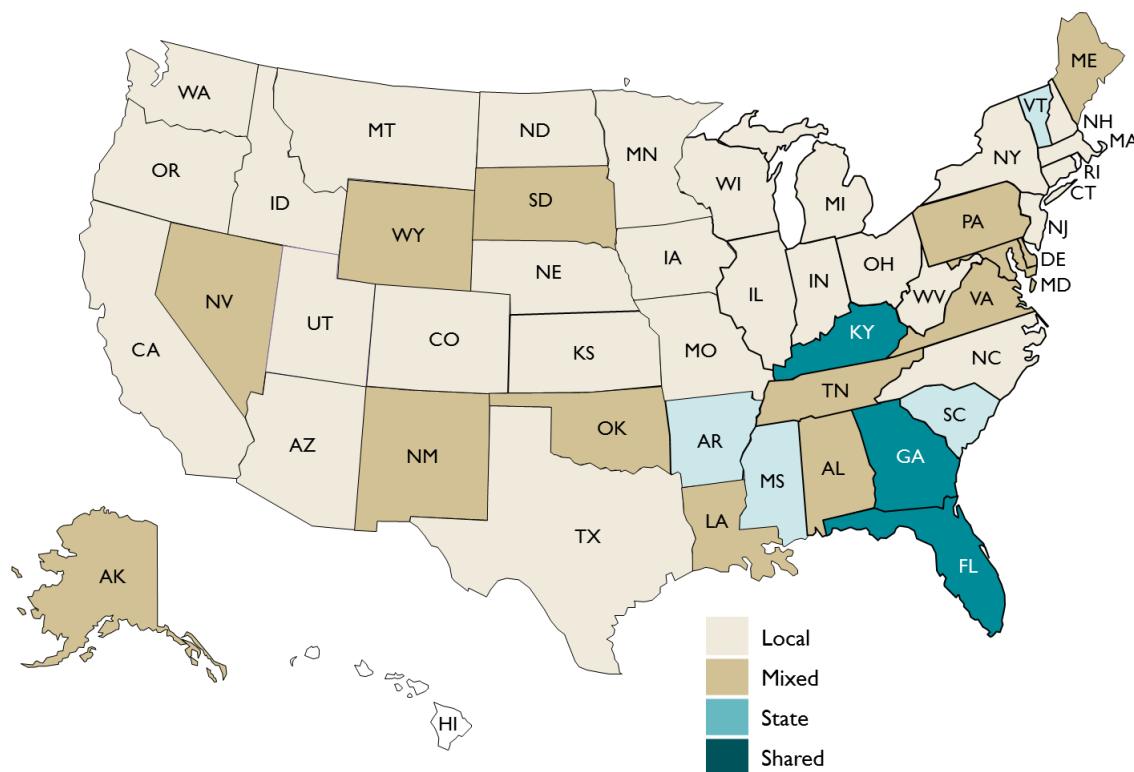
A detailed description of survey methodology is available on NACCHO's Forces of Change webpage at www.nacchoprofilestudy.org/forces-of-change

Government authority of LHDs

LHDs vary in their relationship to their state health department

Throughout this document, data are analyzed by type of governance. This means data are grouped by LHDs' relationship to their state health department.

LHDs vary in their relationship to their state health department. Some are agencies of local government (referred to as locally governed). Others are local or regional units of the state health department (referred to as state-governed). Some are governed by both state and local authorities (called shared governance). Finally, some states include LHDs with more than one governance type (shown as mixed on this map).



Varying sizes of LHDs

LHDs serve different size jurisdictions across the United States

Throughout this document, data are also analyzed by the size of the population served by the LHDs. This means statistics are compared for subgroups of LHDs defined by the number of people living in the LHD jurisdiction.

Small LHDs serve populations of less than 50,000 people



Medium LHDs serve populations of between 50,000 and 500,000 people



Large LHDs serve populations of 500,000 or more people



Budget Cuts and Job Losses

01

Economic forces continue to affect local health departments

Findings from NACCHO's surveys have consistently demonstrated local health department (LHD) funding challenges and the negative impacts on LHD infrastructures.

The effects of the Great Recession continue to pose major challenges for some LHDs. Substantial funding cutbacks from federal, state, and local sources have undermined the ability of LHDs to provide essential services to their communities.

Since 2008, NACCHO has administered Web-based surveys to LHDs across the United States to assess the impact of economic forces on LHDs.

Results have consistently demonstrated LHDs' funding challenges and the negative impacts on LHD infrastructures. While the proportion of LHDs reporting budget cuts and job losses has decreased in recent years, LHDs have not kept up with the general economic recovery and continue to face financial hardships. Some improvements have been seen, but the cumulative effect of budget cuts and job losses experienced during the recession continues to affect LHD capacity.

This chapter describes budget cuts and workforce reductions among LHDs in 2014.

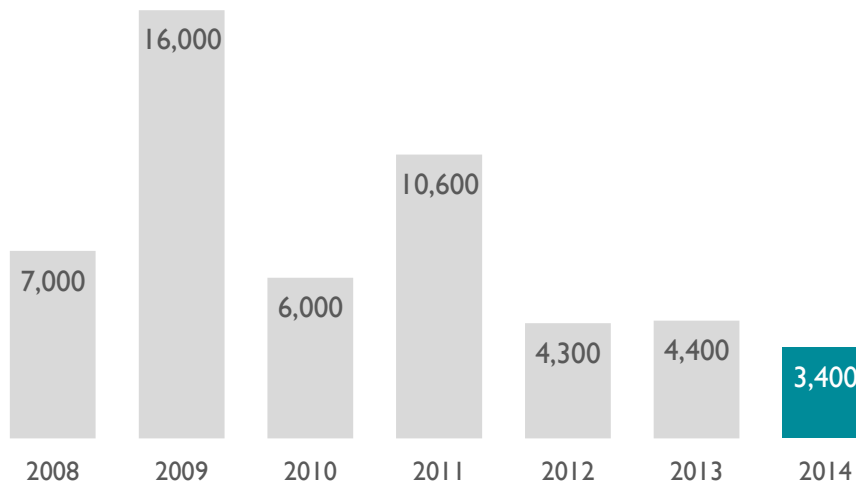
LHDs have eliminated 51,700 jobs since 2008

Since 2008, LHDs have eliminated 51,700 jobs due to layoffs/attrition because of hiring freezes or budget cuts.

LHDs reported 3,400 jobs lost in 2014 (1,300 due to layoffs and 2,100 due to attrition), lower than all previous years.

LHDs have eliminated approximately 51,700 jobs since 2008
The fewest jobs were lost in 2014

Number of jobs lost



Most large LHDs are still reporting job losses

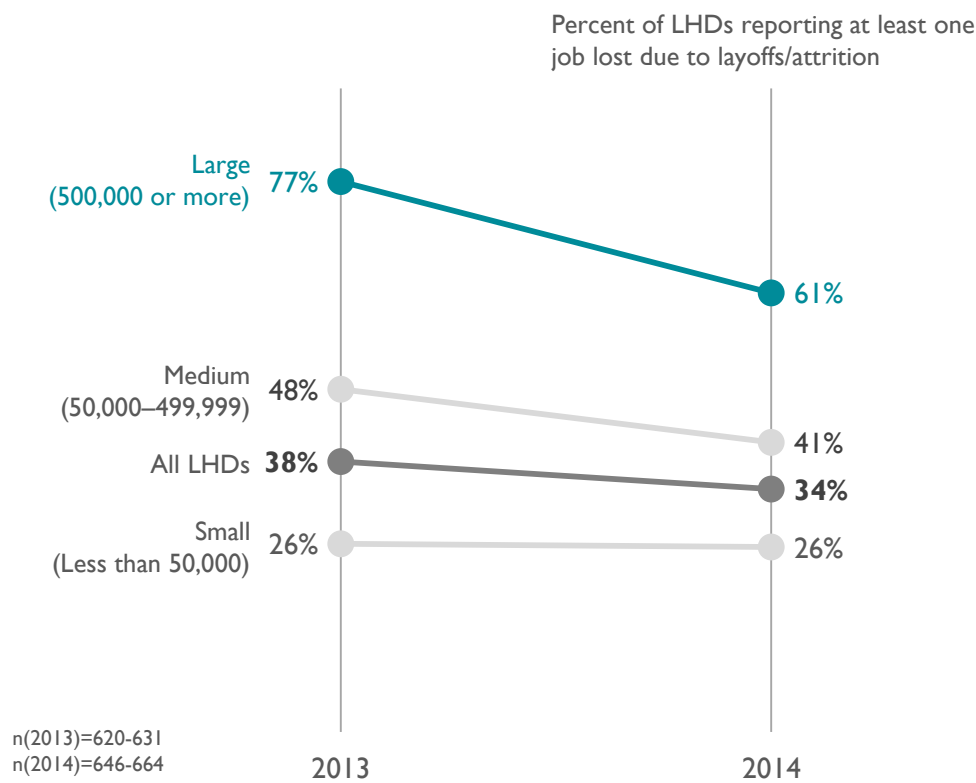
One-third of LHDs lost at least one position due to layoffs/attrition.

More than half of large LHDs, those serving populations of 500,000 or more, were still reporting job losses in 2014.

Large LHDs serve nearly half of the United States population. The substantial proportion of large LHDs still reporting job losses threatens the health and safety of these communities.

Small LHDs, those serving populations of less than 50,000 people have seen less improvement in the number of jobs lost than medium and large LHDs since 2013.

Sixty-one percent of **large LHDs** reported job losses in 2014
One-third of all LHDs lost at least one position due to layoffs/attrition in 2014

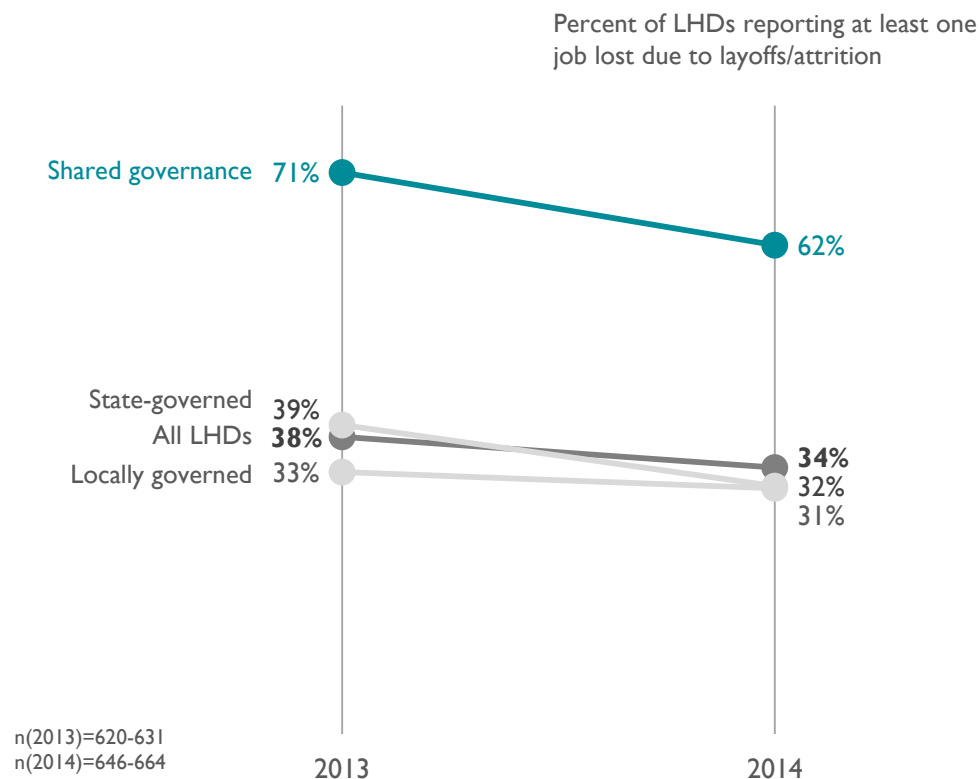


Most LHDs with shared governance are still reporting job losses

More than half of LHDs governed by both state and local authorities (shared governance), reported job losses in 2014.

Similar to small LHDs, locally governed LHDs have seen less improvement in the number of jobs lost than state-governed LHDs or those with shared governance.

Sixty-two percent of LHDs with **shared governance** reported job losses in 2013

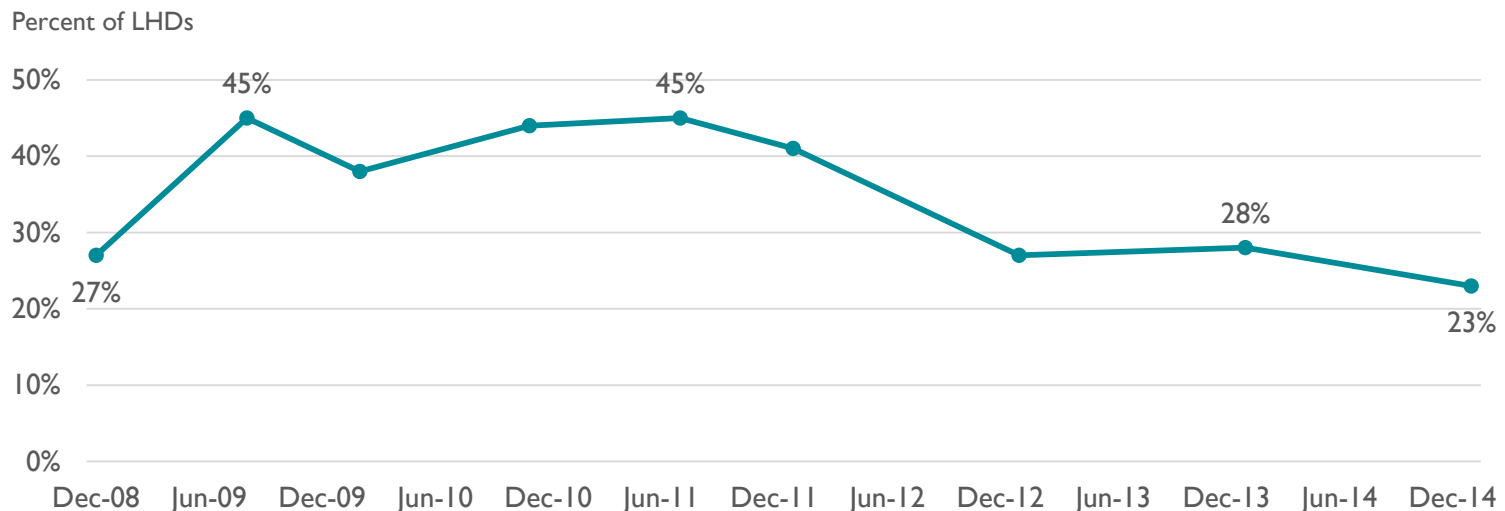


Budget cuts have tapered since 2008 but continue to affect almost one in four LHDs

NACCHO has tracked budgets cuts at LHDs since 2008. In surveys conducted in 2009 and 2011, between 40% and 45% of agencies reported having made cuts. While fewer agencies have reported cuts in recent years, almost one in four is still affected by cuts today.

These cuts are undermining the work of LHDs and are jeopardizing the safety of the food we eat, the water we drink, and the ability of communities to be prepared for and respond to public health emergencies.

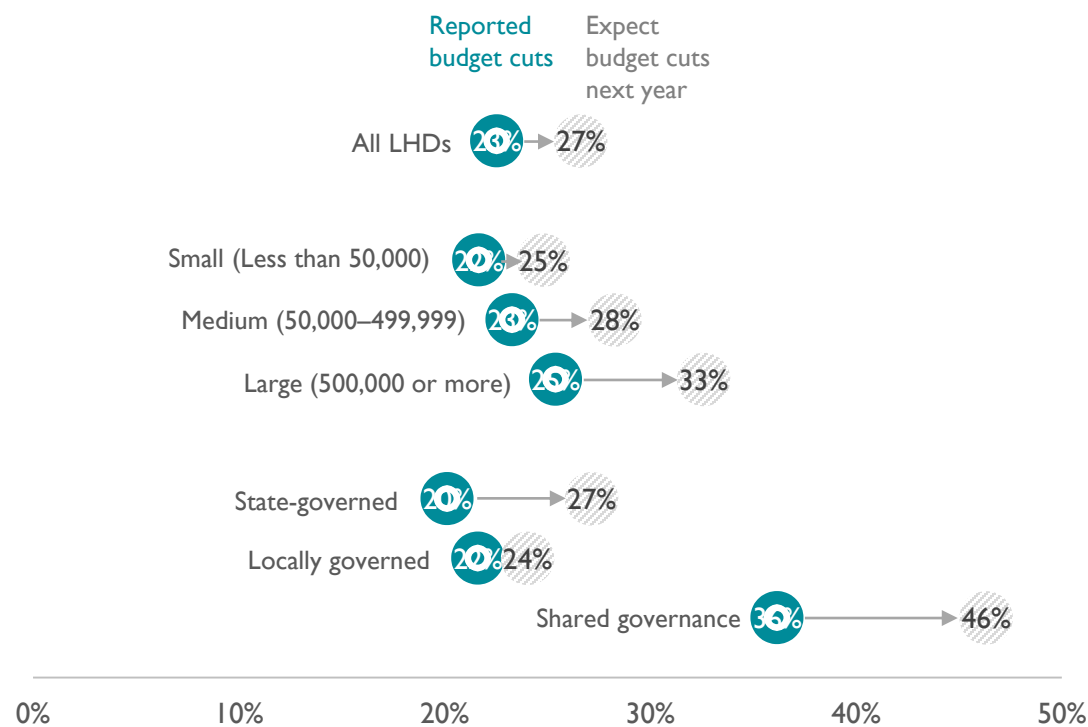
Budget cuts have tapered since 2008 but continue to affect almost one in four LHDs



Some LHDs expect budget cuts next year

A greater proportion of LHDs expect budget cuts next year than reported cuts this year

23% of LHDs reported **budget cuts this year**; 27% expect cuts in their next fiscal year



Some LHDs still see budget cuts ahead. Almost one-quarter of LHDs reported budget cuts in 2014 and more expect budget cuts in their next fiscal year. This could be for a variety of reasons, such as ongoing funding shortages or a known decrease in the amount of grant funding awarded.

Once again, large LHDs, those serving 500,000 or more people, may be the most affected: one-third of large LHDs expect budget cuts in their next fiscal year.

Similarly, more than a third of LHDs with shared governance, governed by both state and local authorities, reported cuts in 2014; almost half (46%) expect budget cuts in their next fiscal year.

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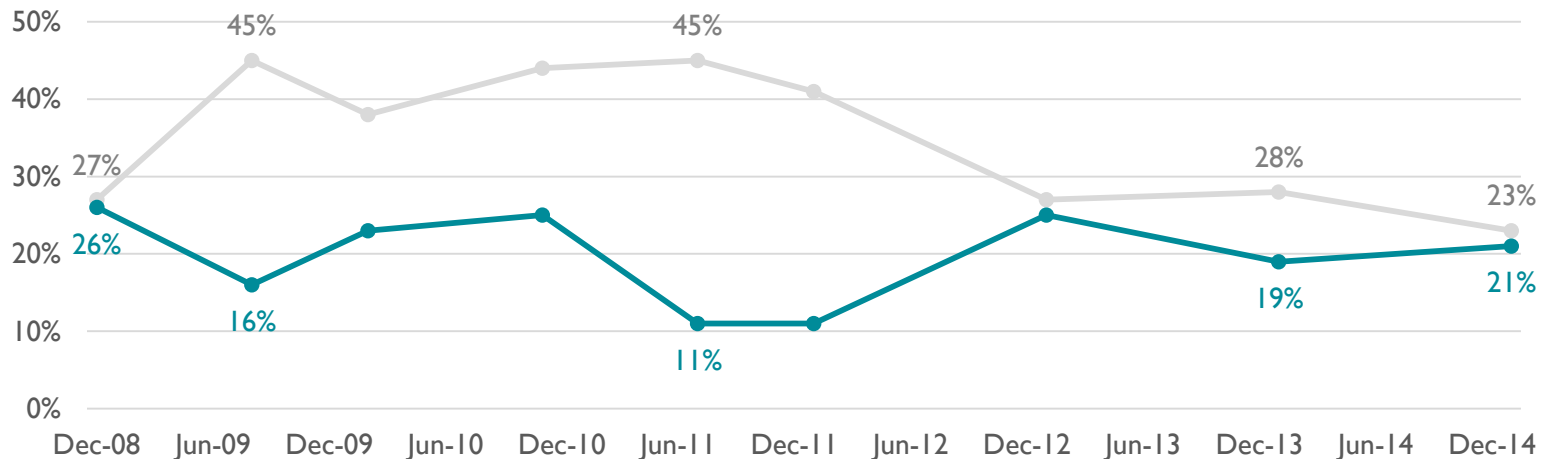
Most LHD budgets are not growing

Even though most LHDs did not report a lower budget in 2015, LHDs also did not report a budget increase. Since 2008, between 11% and 26% of LHDs reported a greater budget than the previous fiscal year.

Since NACCHO started collecting these data, fewer LHDs have reported a greater budget than a lower budget.

Fewer LHDs reported **their budget increased** than reported their budget decreased

Percent of LHDs that reported a lower budget
Percent of LHDs that reported a greater budget



Fewer large LHDs reported a greater budget

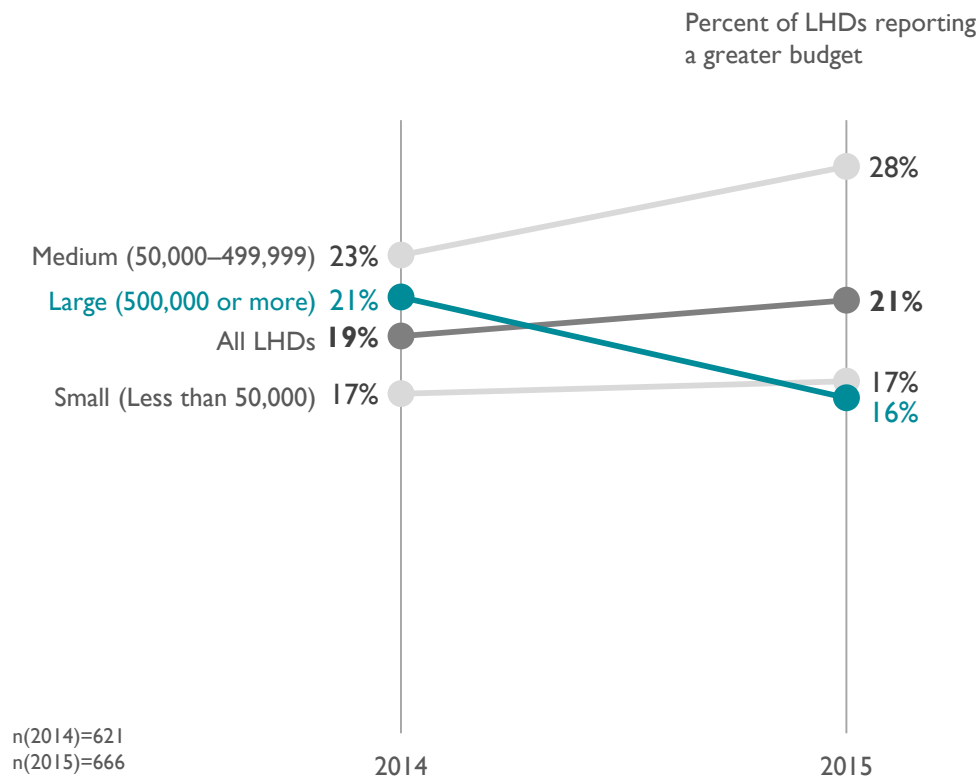
While some LHDs have seen improvements in recent years (one in five LHDs reported a greater budget in 2015), not all LHDs have seen their budgets increase.

Fewer large LHDs, those serving populations of 500,000 or more people, reported a higher budget in 2015 compared to 2014. While 21% reported a higher budget in 2014, only 16% reported a higher budget in 2015.

Small LHDs, those serving populations of less than 50,000 people, reported minimal improvement compared to last year: The same proportion of small LHDs reported a greater budget in 2014 and 2015.

Fewer **large LHDs** reported a greater budget in 2015 compared to 2014

One-fifth of all LHDs reported a greater budget in 2015



The cumulative effect of budget cuts threatens LHDs ability to provide basic services people depend on

Ongoing budget cuts and resulting staff layoffs are jeopardizing the safety of the food we eat, the water we drink, and the ability of the community to be prepared and respond to disasters and public health emergencies.

A sizeable proportion of LHDs were still affected by budget cuts in 2014. While the proportion of LHDs reporting budget cuts is lower now than when the recession first began, almost one in four LHDs continues to be affected by budget cuts. While fewer jobs have been lost in 2014, collectively LHDs have lost 51,700 jobs since 2008.

Despite economic recovery in other sectors of the United States, many LHDs still face financial hardships. While workforce reductions and program cuts may have slowed in some areas of the country in 2014, on the whole, LHD budgets have not kept pace with the general recovery.

LHDs make it easier for people to be healthy and safe. Ongoing budget cuts and resulting staff layoffs jeopardize the safety of the food we eat, the water we drink, and the ability of the community to be prepared and respond to disasters and public health emergencies, such as Ebola.

The cumulative effect of these cuts since 2008 threatens the ability of LHDs to prepare for and respond to emergencies and to provide basic services that people count on.

Lost LHD jobs due to budget cuts, layoffs, and attrition mean reductions in services offered—ranging from reducing maternal and child health clinic hours to ending substance abuse treatment programs.

Sufficient and consistent funding is critical to ensure LHDs' ability to address various health needs in their communities.

Changes in Services

02

Local health departments continue to adapt the type and scope of services to their communities

Local health departments (LHDs) are involved in various activities that contribute to the goal of creating and maintaining healthy environments and communities.

Several factors, such as shrinking budgets, the implementation of the Patient Protection and Affordable Care Act (ACA), and changing community health needs, affect the type and scope of services provided at LHDs.

LHDs are changing their services gradually. Some LHDs have decreased direct preventive clinical services to focus on population-based health activities, while others continue to provide these services in their communities.

LHDs must carefully evaluate the needs of the communities they serve and the availability of healthcare providers when deciding whether to increase or reduce their clinical operations.

This chapter describes changes to LHD services, including clinical service operations, from 2014 to 2015.

Notes on methods

In the survey, LHDs first selected the types of services or functions they provided at any time during calendar year 2014. Then respondents qualitatively characterized changes in overall service delivery (reduced, little or no change, expanded) for each service they provided. They did not indicate how much the service changed.

In the findings that follow, the percentage of LHDs that reported changes in services are based on those LHDs that provided that particular service (which ranged from 255 for diabetes screening to 657 for immunization and 657 for emergency preparedness).

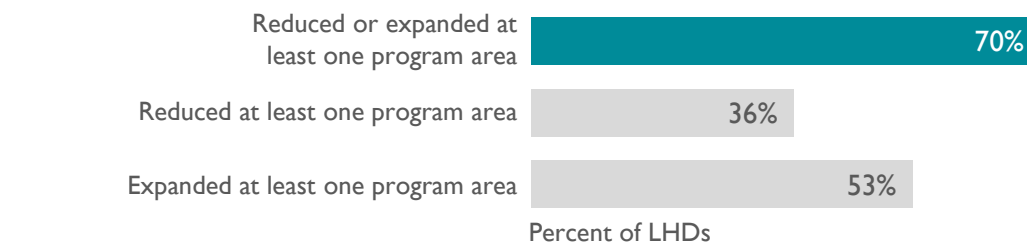
Most LHDs made some changes to their services

More than two-thirds of LHDs reported at least some change in their service delivery. Thirty-six percent reported reducing at least one program area and 53% reported expanding at least one program area.

However, the percentage of LHDs that did not report any change in their service delivery varied by program area: 88% of LHDs did not reduce or expand services in epidemiology and surveillance, while 68% did not reduce or expand services in tobacco, alcohol, and other drug prevention.

This finding suggests that, despite external fiscal and economic factors impacting LHDs, changes to LHD services are happening gradually and not in all service areas.

Most LHDs reported some changes to their programming



LHDs were more likely to reduce their clinical services

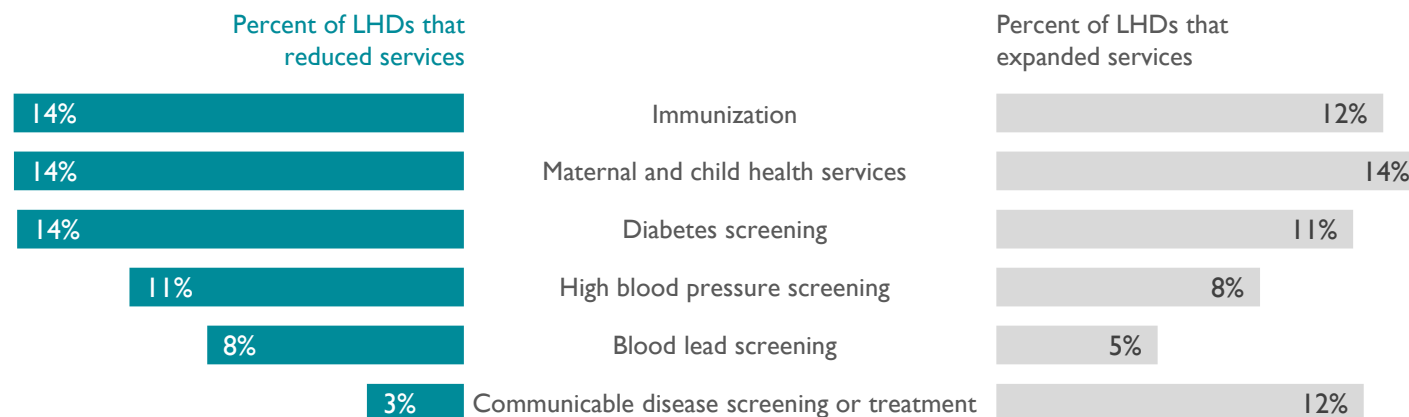
Among LHDs that reported a change in their service delivery, more LHDs reported reducing their clinical services (such as immunization, diabetes screening, and high blood pressure screening) than expanding those services.

In contrast to most clinical services, fewer LHDs reported reducing their communicable disease screening or treatment services than expanding those services.

The same proportion of LHDs reported reducing and expanding maternal and child health services, which are typically a mix of clinical and population-based services.

More LHDs reduced clinical services than expanded services in the previous calendar year

An exception was communicable disease screening or treatment



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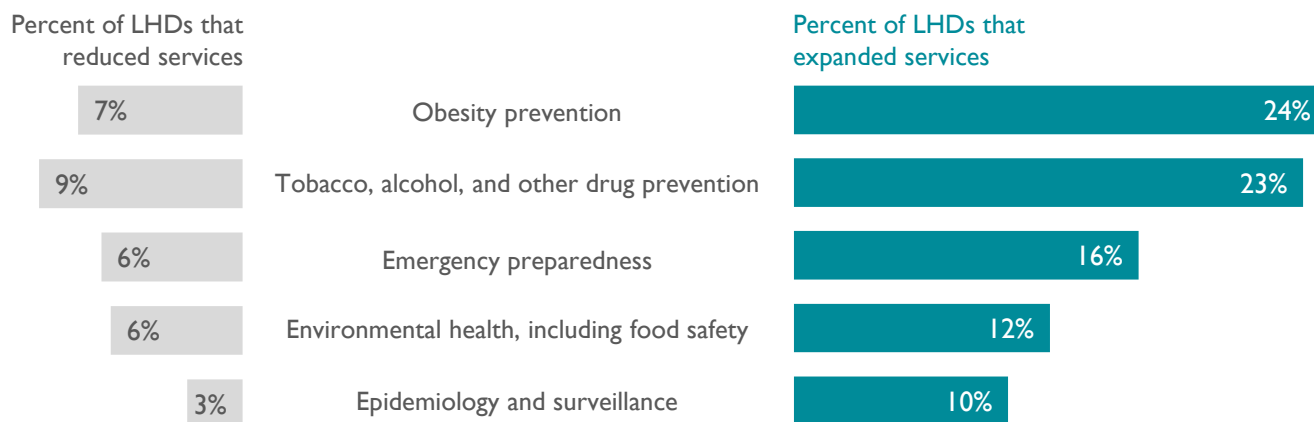
LHDs were more likely to expand their population-based services

By contrast, among LHDs that reported a change in their service delivery, more LHDs expanded their population-based services (such as obesity prevention and tobacco, alcohol, and other drug prevention) than reduced those services.

Almost one in four LHDs reported expanding obesity prevention and tobacco, alcohol, and other drug prevention services—a much larger percentage than reported expanding other population-based prevention services.

This shift toward population-based services continues a decades-long evolution for LHDs, reinforced by implementation of the ACA.

More LHDs **expanded population-based services** than reduced services in the previous calendar year



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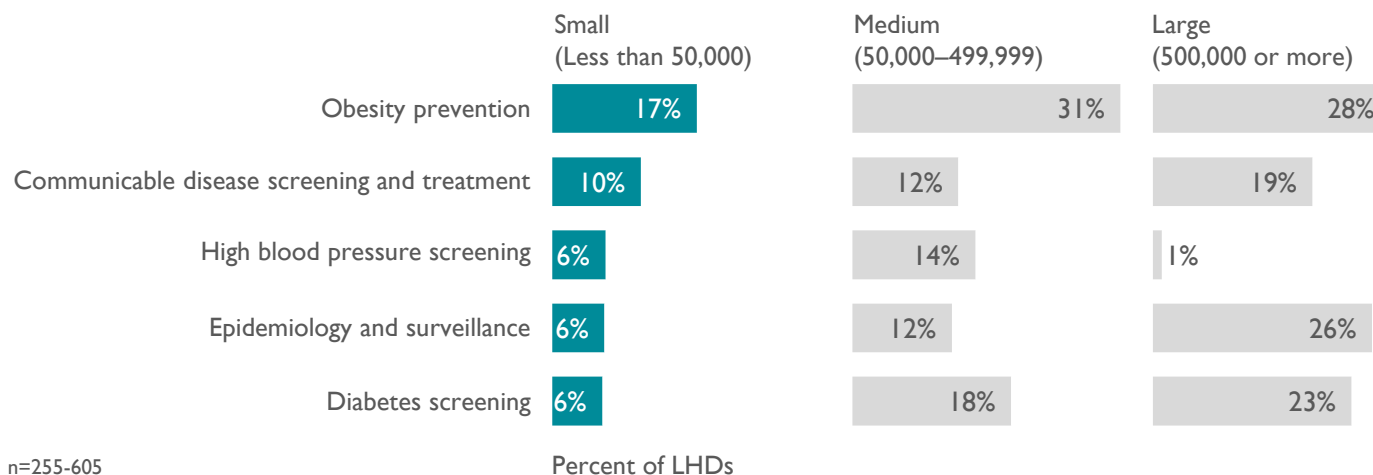
Small LHDs were least likely to expand services

Forces of Change findings show that small LHDs were less likely to expand services in a variety of program areas (both clinical and population-based). Most notable, only 17% of small LHDs expanded their obesity prevention services, compared to 31% of medium-sized LHDs and 28% of large LHDs.

As shown in Section 1, small LHDs also had little change in their budgets: fewer small LHDs reported a higher budget or a lower budget. This may be for a variety of reasons. For example, small LHDs may have less flexibility to reallocate and adjust funding and staffing across programs and services.

Small LHDs also have smaller overall budgets, so expanding programming by adding staff to a specific area may require a substantial proportional increase in a budget.

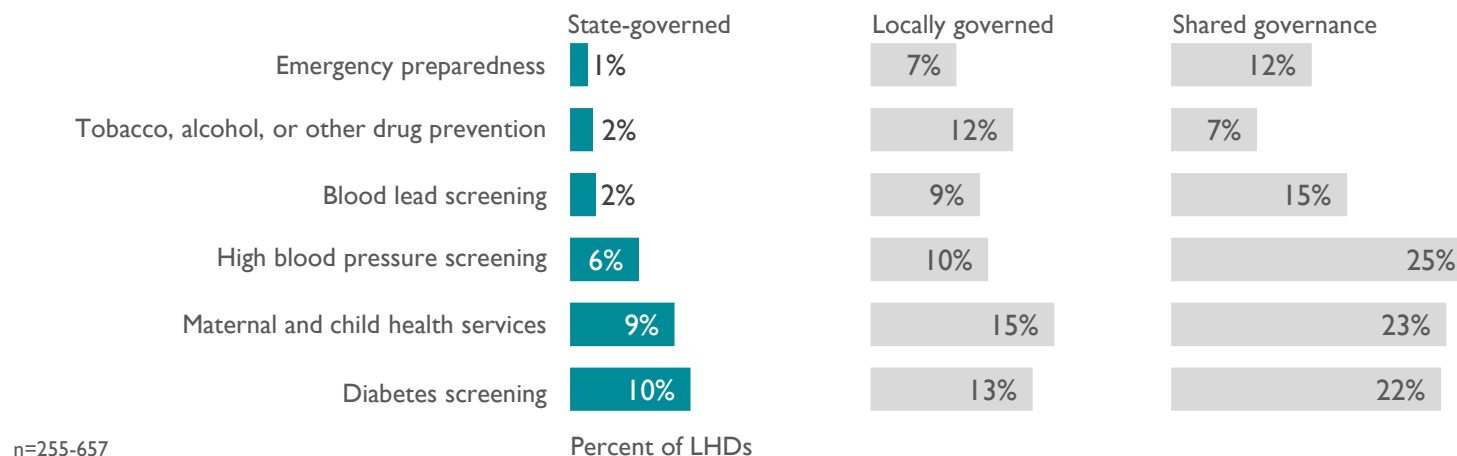
A smaller proportion of small LHDs expanded services in most program areas



State-governed LHDs were least likely to reduce services

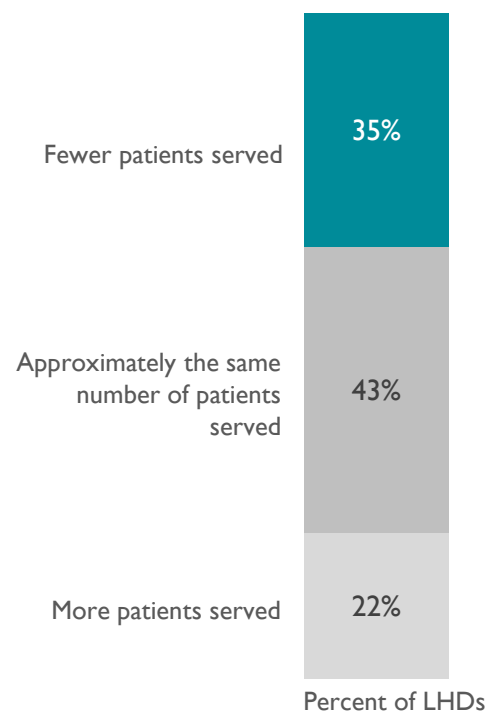
State-governed LHDs were much less likely to reduce services in most program areas. A similar finding was reported in NACCHO's 2014 Forces of Change survey. Notably, only 6% reduced high blood pressure services, compared to 25% of LHDs with shared governance.

State-governed LHDs were less likely to reduce services in most program areas



Some LHDs are serving fewer patients in clinics

More than one-third of LHDs reported serving **fewer patients** in 2014 compared to 2013



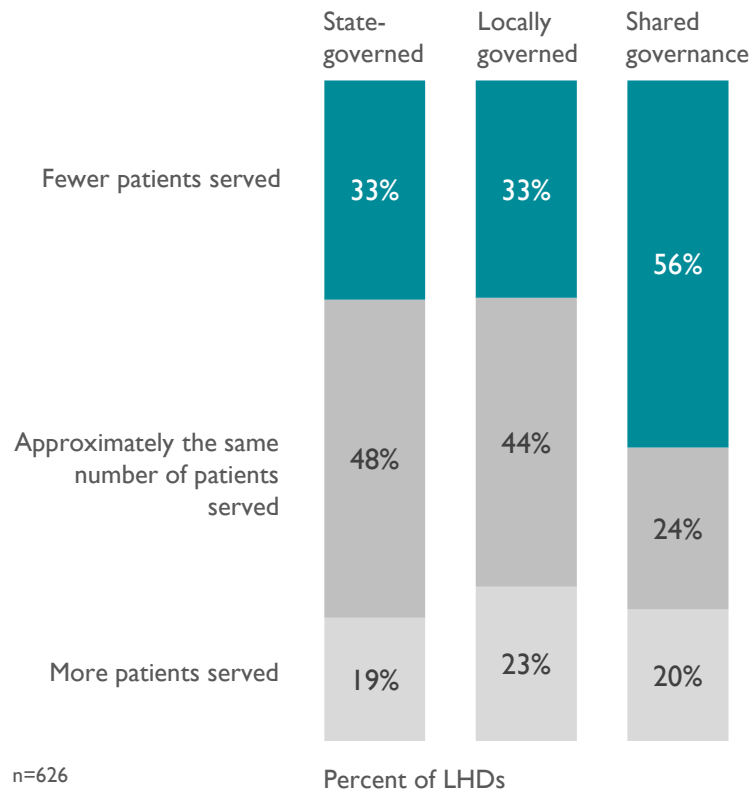
n=626

Not only are LHDs reporting a reduction in clinical services, they are also reporting a reduction in the number of patients served in their clinics.

Thirty-five percent of LHDs reported serving fewer patients compared to 22% that reported serving more patients than the previous calendar year.

More than half of LHDs with shared governance are serving fewer patients

More than half of LHDs with shared governance reported serving **fewer patients** in 2014 compared to 2013



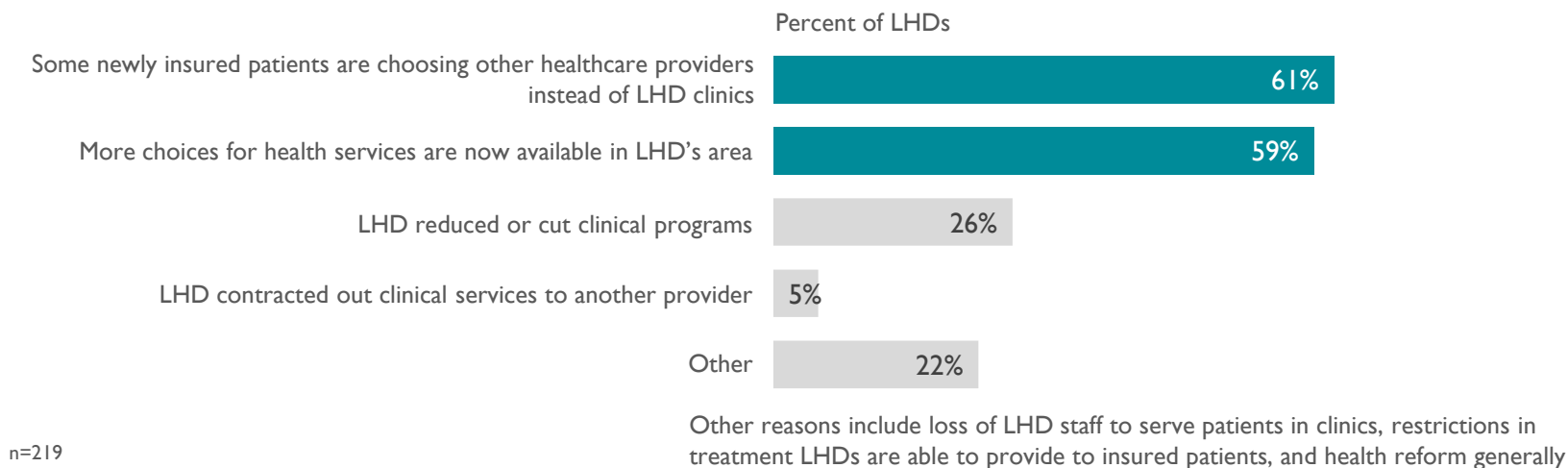
LHDs with shared governance (those governed by both state and local authorities) were most likely to report serving fewer in patients in LHD clinics. More than half of LHDs with shared governance reported serving fewer patients, compared to one third of state-governed and locally governed LHDs.

Clinical services are now also available elsewhere

When asked why LHDs were serving fewer patients in their clinics, most LHDs reported that newly insured patients are choosing other healthcare providers and that more choices are now available in the area.

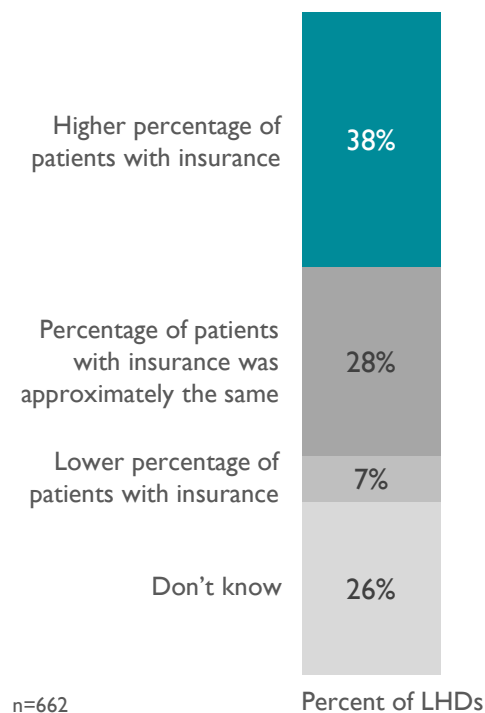
This finding likely reflects in part the growing healthcare marketplace since the advent of the ACA and trends toward alternative providers (such as pharmacy and urgent care clinics) that pre-date the ACA.

LHDs reported serving fewer patients because patients are choosing other healthcare providers, and more services are now available elsewhere



LHDs are serving more patients with insurance

Almost two in five LHDs reported serving a higher percentage of patients with insurance in 2014 compared to 2013



Despite the fact that services might be available elsewhere in communities, patients with insurance are still visiting LHD clinics. Forces of Change findings show that LHDs also reported serving a higher percentage of patients with insurance in 2014 compared to 2013. Few LHDs reported serving a lower percentage of patients with insurance.

In states expanding Medicaid, 46% of LHDs reported serving a higher percentage of patients with insurance, compared to 29% of LHDs in states not expanding Medicaid.

A notable finding was that a quarter of LHDs did not know whether they were serving a higher percentage of patients with insurance. This might be because some LHDs do not ask about insurance status when serving patients in their clinics or because statistics on patient insurance coverage were not readily available to the survey respondent.

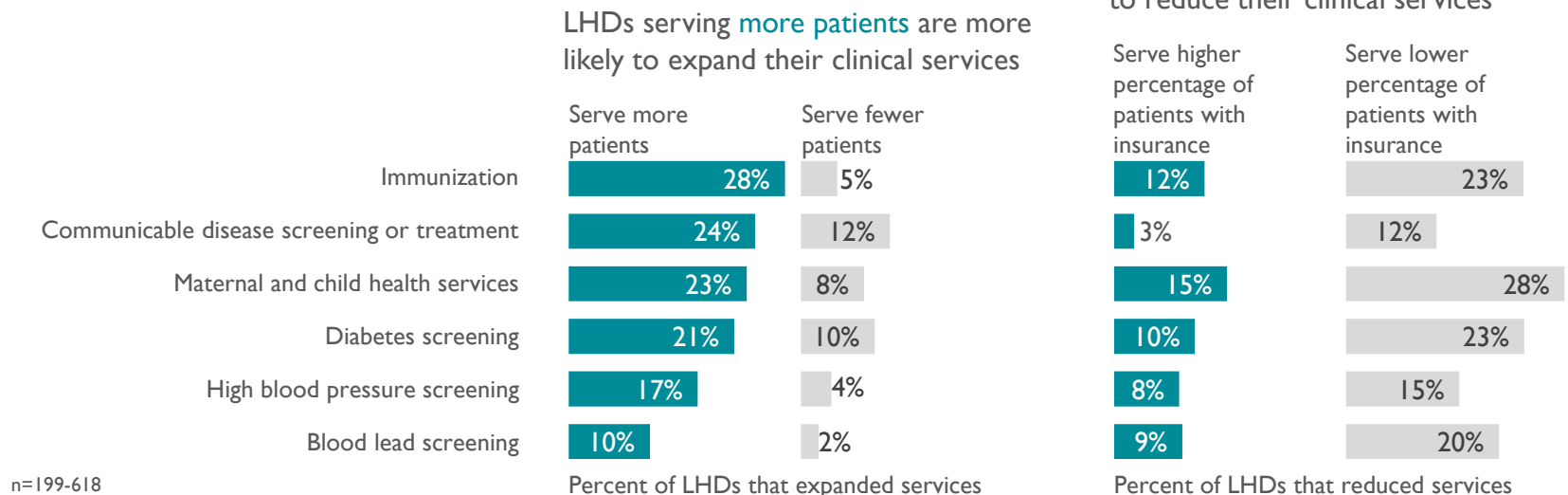
The number and insurance status of patients affect change in clinical service provision

LHD clinical service provision is affected by the number of patients served and the percentage of patients with insurance served in LHD clinics.

LHDs serving more patients in their clinics were more likely to expand clinical services; LHDs serving a higher percentage of patients with insurance were less likely to reduce clinical services.

This finding suggests that LHDs are evaluating their community needs and their patient population when deciding whether to expand or reduce clinical services.

The number of patients and percentage of patients served with insurance affect change in clinical service provision



LHDs are reducing their clinical services but still play a critical role in communities

Though a large majority of LHDs reported no change in the level of delivery for clinical services, LHDs were more likely to report reducing than expanding clinical services, including immunization and diabetes, high blood pressure, and blood lead screening.

Conversely, LHDs were more likely to report expanding than reducing services in population-based prevention areas, most notably in obesity and tobacco, alcohol, or other drug prevention.

However, the overall difference in the percentage of patients expanding versus reducing clinical services was only a few percentage points, indicating that this shift away from clinical services is happening slowly. For any particular clinical service, most LHDs reported no change in the level of service delivery.

These changes in service provision likely reflect both the differences in budget realities facing these LHDs and different choices LHDs are making about their role in the changing healthcare landscape. LHDs have to consider the context of their communities and what services are available elsewhere when deciding what services to continue to provide versus cut back.

While LHDs are serving fewer patients in their clinics, findings show that patients with insurance are still visiting LHDs for services. This could be the result of a variety of reasons, including confidentiality, provider preference, high co-pays, or high deductibles.

Despite the changing healthcare system and the availability of clinical services outside of the LHD, LHD clinics continue to play a crucial role in communities and are a safety-net provider for many.

Billing for Clinical Services

03

Local health departments are exploring alternative ways to sustain critical services

Local health departments (LHDs) face challenges and opportunities as the public health and clinical care environments evolve due to the Patient Protection and Affordable Care Act (ACA).

LHDs are facing shrinking federal, state, and local budgets. Although public health has traditionally been free, the cost of providing preventative and clinical services has been growing for health departments.

As described in the previous chapter, some LHDs have decreased direct preventive and clinical services to focus on population-based health activities, while others are exploring alternative ways to sustain these services.

Even with expanded insurance coverage, gaps will remain and LHDs will need to develop a way to provide services to insured patients and those left uninsured.

To continue to provide essential services that are not available elsewhere, some LHDs have developed the capacity to bill third-party payers (public insurance providers such as Medicare and Medicaid, and private insurers) for services provided in LHD clinics.

This chapter provides an overview of which third-party payers LHDs are billing for services and what factors influence their decision to bill for services.

More LHDs billed third-party payers in 2015

Ninety percent of LHDs reported billing third-party payers (including Medicaid, Medicare, and private insurers) in 2015, up from 86% in 2014. Although the 2015 Forces of Change survey did not ask about which services LHDs bill for, the 2014 survey indicated that LHDs were billing only for a subset of the clinical services they provide.

On the other hand, nearly one-quarter of LHDs reported billing public but not private payers. This could be a result of several factors. For example, LHDs may be more likely to serve a population insured by public payers, rather than private insurers.

In addition, LHDs have a history of working with public insurance providers, and some have found working with private insurers difficult. Administrative requirements might be more difficult, and private insurers may not understand what services LHDs provide.

Slightly more LHDs billed third-party payers in 2015 compared to 2014 Two-thirds of LHDs reported billing public and private payers in 2015



n(2014)=610
n(2015)=643

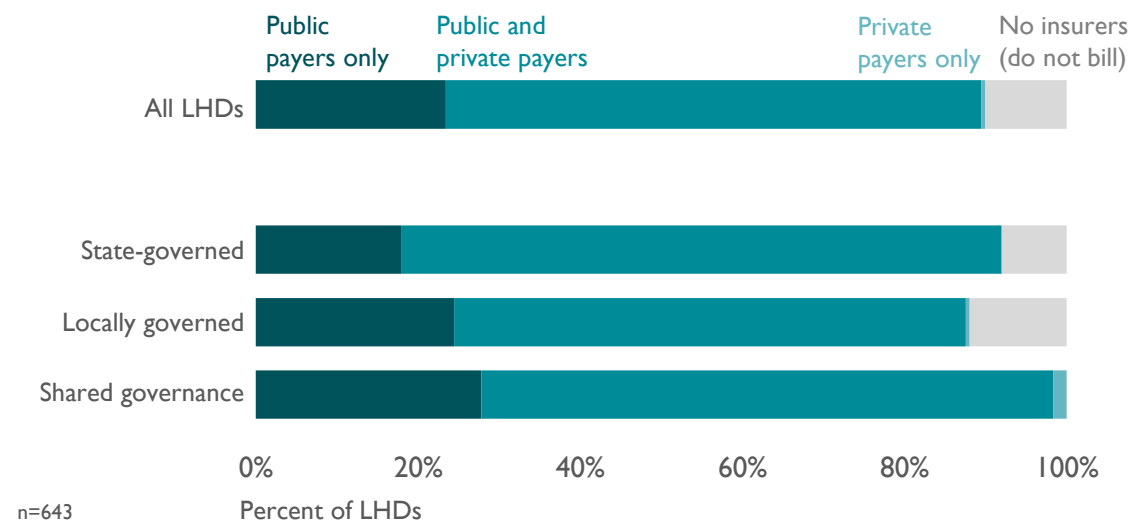
All LHDs with shared governance bill third-party payers

All LHDs with shared governance reported billing third-party payers. Most bill both public and private payers.

LHD governance can affect how LHDs enter into contracts with health insurers. Centralized or largely centralized states—those with mostly or all state-governed LHDs—are more likely to be able to take a unified approach and develop state-wide billing infrastructure to help LHDs bill third-party payers.

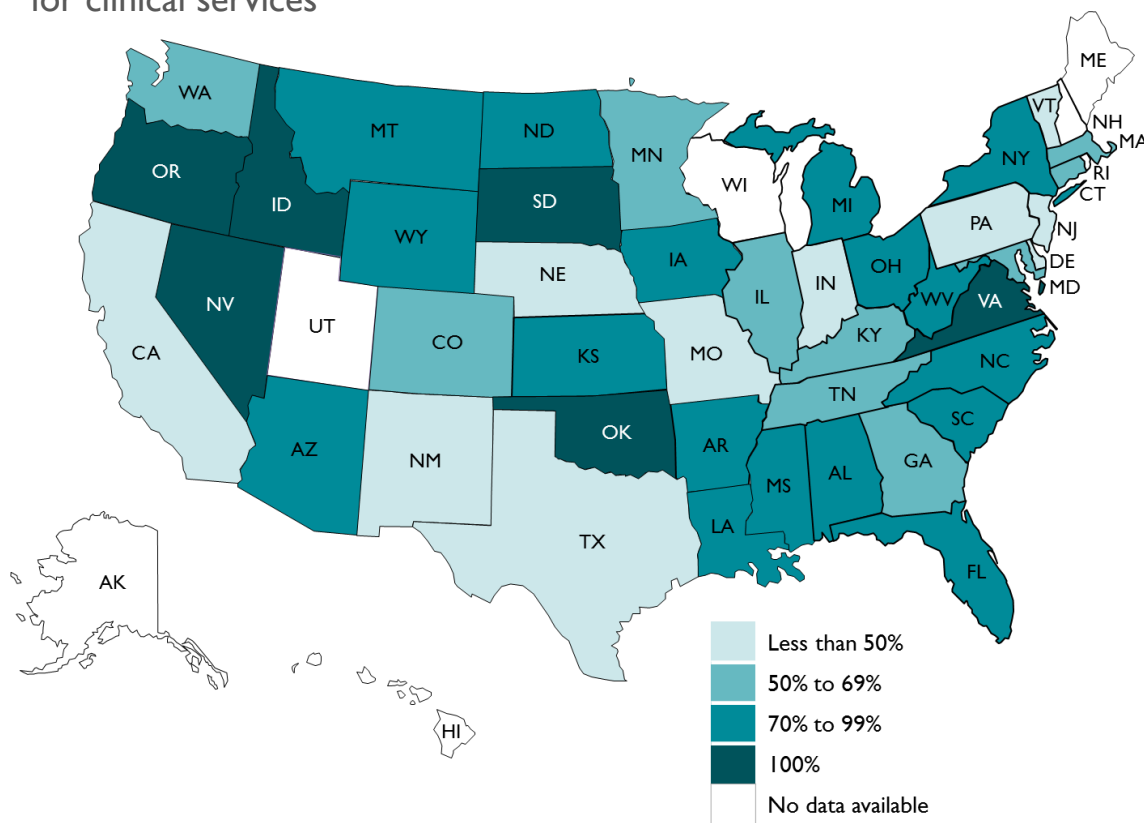
On the other hand, locally governed LHDs may face additional challenges negotiating contracts with insurers on their own and meeting ongoing administration requirements. Despite this challenge, Forces of Change findings show that some locally governed LHDs are billing third-party payers. LHDs that face challenges setting up a billing infrastructure, and other partners supporting LHD billing, could leverage this existing knowledge and resources.

Ninety percent of LHDs bill third-party payers for clinical services



Third-party billing varies in LHDs across the United States

All respondents in six states reported billing public and private payers for clinical services



All respondents in Idaho, Nevada, Oklahoma, Oregon, South Dakota, and Virginia bill both public and private payers for clinical services provided.

Virginia, Oklahoma, and Oregon have comprehensive care systems or accountable care models that are likely supporting LHD billing.

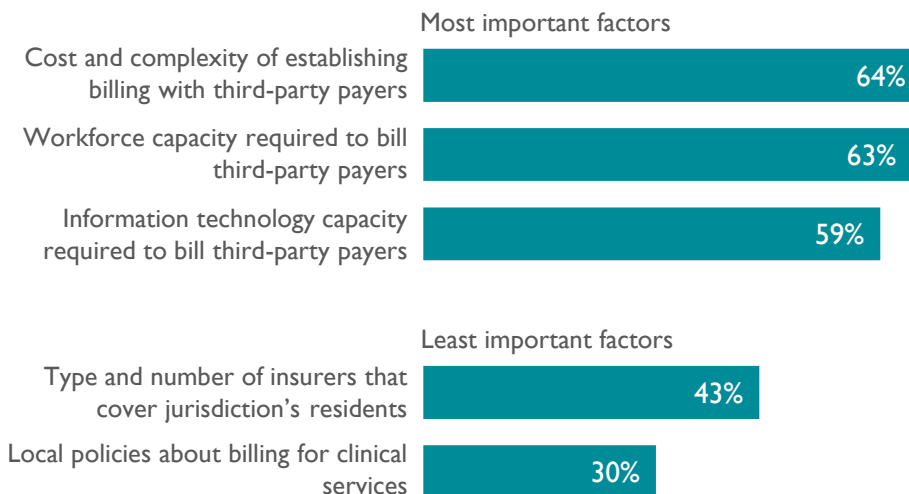
Internal LHD capacity influences LHDs' decisions to bill

When asked what factors influence LHDs' decisions whether or not to bill for clinical services, LHDs indicated that factors related to LHD capacity, including the cost and complexity of establishing billing, workforce capacity, and information technology capacity, were most important.

This finding supports the conclusion that the process of developing a billing infrastructure is time consuming and requires a high level of staff engagement and commitment. Thus, LHDs could benefit from additional training, technical assistance, and peer support to continue to bill third-party payers. Additional funding to support improved information technology and workforce capacity will also be needed.

Less than half of LHDs indicated that the type and number of insurers that cover a LHD jurisdiction and the local policies about billing were important factors in LHDs' decisions to bill third-party payers.

LHDs rated factors related to internal LHD capacity as the most important factors influencing LHDs' decision to bill third-party payers
Only 30% of LHDs rated local policies about billing as important in influencing their decisions to bill



Percent of LHDs that rated factor as a 6 or 7 on a 7-point scale (7 is most important)

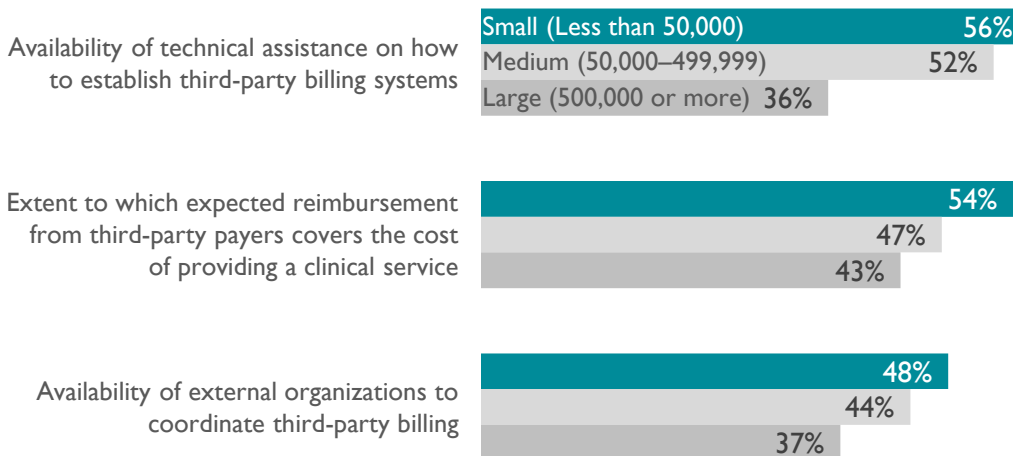
n=608-615

Small LHDs rated availability of technical assistance as most important

Small LHDs, those serving less than 50,000 people, rated the availability of technical assistance to establish billing, the extent to which third-party reimbursement covers the cost of providing a service, and the availability of external organizations to coordinate billing as among the most important factors influencing their decisions to bill.

This finding suggests that small LHDs—likely with the fewest resources—could benefit from external support to sustain the clinical services needed in their communities.

Small LHDs rated the availability of support an important factor



Percent of LHDs that rated factor as a 6 or 7 on a 7-point scale (7 is most important)

n=608-615

LHDs bill third-party payers to sustain essential services

Insurance payments provide revenue that helps LHDs continue to provide healthcare services for clients who remain uninsured.

While LHDs have traditionally provided services without regard to insurance status, findings from the Forces of Change Survey show that LHDs are adapting to the changing public health system and billing for some clinical services.

Internal LHD capacity, including workforce and technical capacity, and the cost and complexity of establishing billing are the most important factors influencing whether or not LHDs decide to bill for services. LHDs need additional training, technical assistance, and peer support to support billing capacity.

LHDs will also continue to serve uninsured patients despite the implementation of the ACA and the uneven uptake of expanding the Medicaid program across states. Some patients will remain uninsured and some will continue to seek care at LHDs for various other reasons (for added confidentiality, provider preference, or due to high co-pays or deductibles).

Budget cuts and the increased cost of providing preventive and clinical services have motivated LHDs to seek additional revenue streams to sustain essential public health services in their communities and remain viable safety-net providers.

Continued support—both technical and financial—is needed to ensure that LHDs can adapt to the changing healthcare system and continue to provide preventive and clinical services to their communities that might not be available elsewhere.

Collaboration with Non-Profit Hospitals

04

Health reform presents new opportunities for collaboration

The Patient Protection and Affordable Care Act (ACA) requires that non-profit hospitals conduct and report on a community health needs assessment (CHNA) every three years to maintain their tax-exempt status.

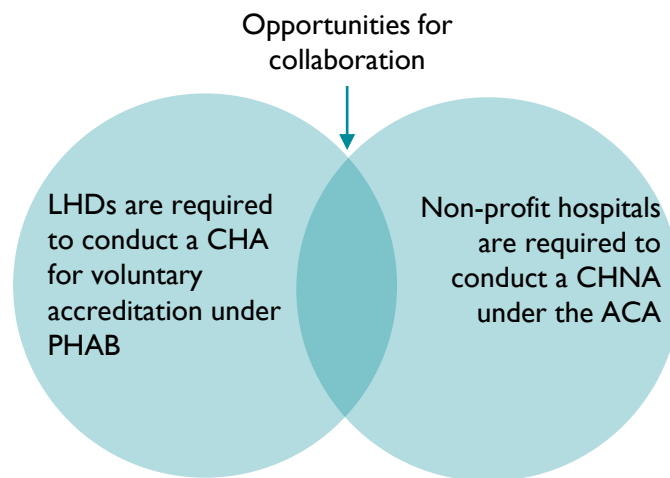
The ACA also requires that a CHNA take into account input from stakeholders that represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise in public health.

Depending on their capacity, local health departments (LHDs) may play an important role in this process and can be vital to developing the CHNA.

The ACA's CHNA requirement coincides with the launch of the national voluntary public health department accreditation process by the Public Health Accreditation Board (PHAB). To achieve accreditation, LHDs must conduct a community health assessment (CHA) every five years. While LHDs have been completing CHAs (a core function of public health) prior to the PHAB requirement, this new requirement adds further incentive to complete a CHA regularly.

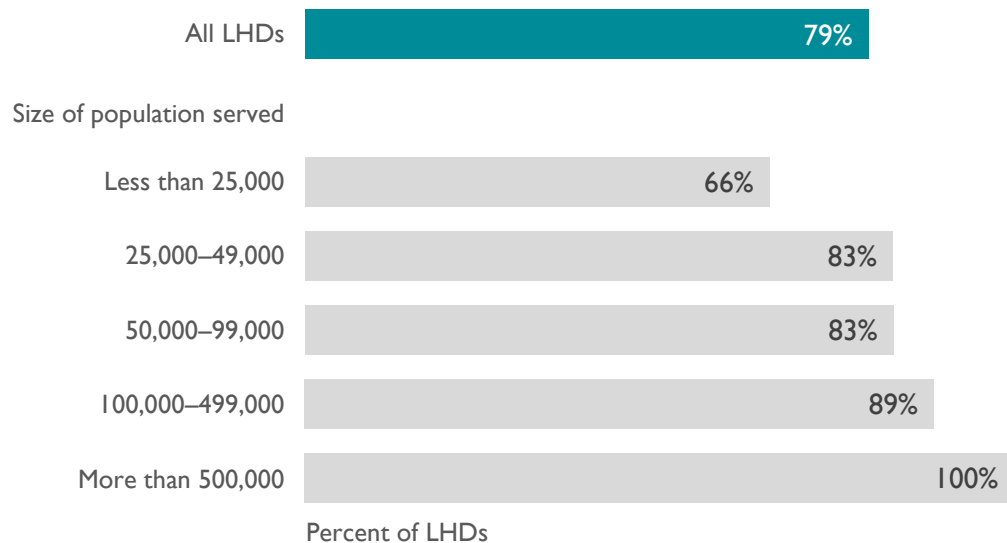
CHAs and CHNAs are based on some of the same kind of data. Thus, the requirement to conduct a CHNA presents an opportunity for LHDs and non-profit hospitals to collaborate on health assessments that benefit multiple stakeholders and the community-at-large.

This chapter presents information on how LHDs and non-profit hospitals are collaborating on these processes.



Four of five LHDs have a non-profit hospital serving their jurisdiction

Almost 80% of LHDs have a non-profit hospital in their jurisdiction
LHDs that serve smaller populations are less likely to have a non-profit hospital serving their jurisdiction



n=642

Most LHDs indicated they had at least one non-profit hospital serving in their jurisdiction.

However, small LHDs were less likely to report having a non-profit hospital. Notably, 40% of LHDs serving less than 25,000 people did not have a non-profit hospital in their jurisdiction.

In addition, one in four state-governed LHDs reported not having a non-profit hospital in their jurisdiction.

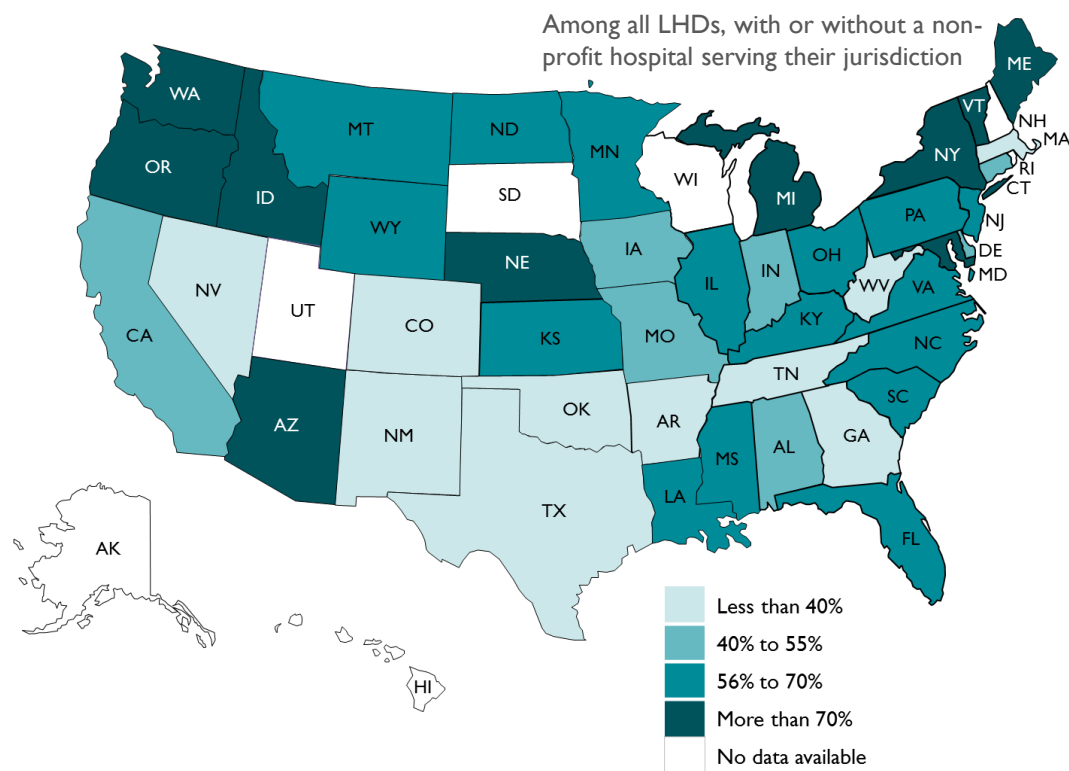
Thus, larger LHDs and locally governed LHDs might have more opportunities for collaboration than small LHDs or state-governed LHDs.

More than half of LHDs were collaborating with non-profit hospitals on a CHNA

Findings show that among all LHDs (with or without a non-profit hospital serving their jurisdiction) more than half of LHDs (58%) collaborated with non-profit hospitals on a CHNA. Nine percent of LHDs discussed collaboration and 12% were not engaged in discussion or collaboration.

States with state or local ordinances that encourage collaborations, such as New York and Maryland, help to create partnerships between LHDs and hospitals.

More than 70% of LHDs in 10 states collaborated with a non-profit hospital on a CHNA

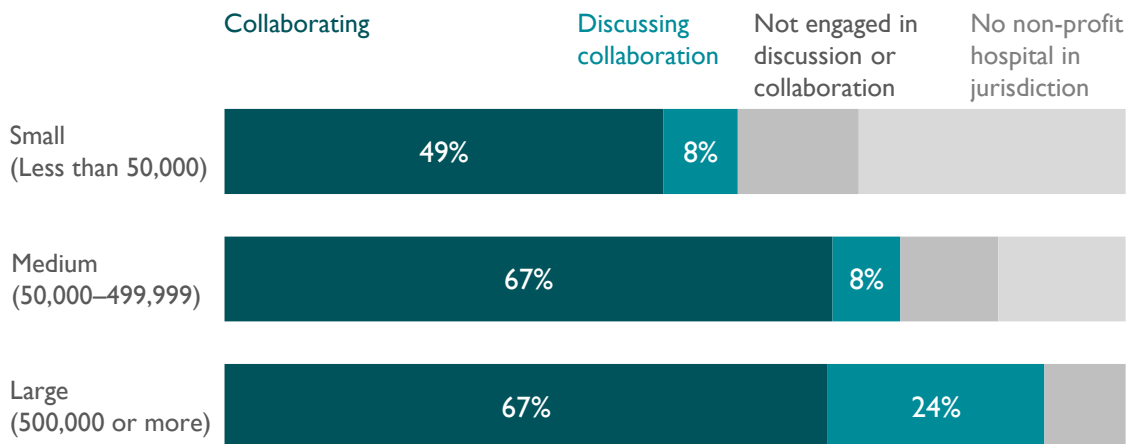


CHNA: Community Health Needs Assessment

Required for non-profit hospitals every three years to maintain tax-exempt status

Large LHDs were collaborating with non-profit hospitals on a CHNA

More large LHDs are collaborating or discussing collaboration with non-profit hospitals on a CHNA



n=621

Percent of LHDs

LHDs serving larger populations were more likely to collaborate on a CHNA than LHDs serving smaller populations. A larger proportion of large LHDs (those serving 500,000 or more people) reported collaborating or discussing collaboration with a non-profit hospital on a CHNA than small or medium LHDs.

As shown above, large LHDs were also more likely to have a non-profit hospital serving their jurisdiction, indicating that a larger proportion of large LHDs also might have more opportunity for collaboration.

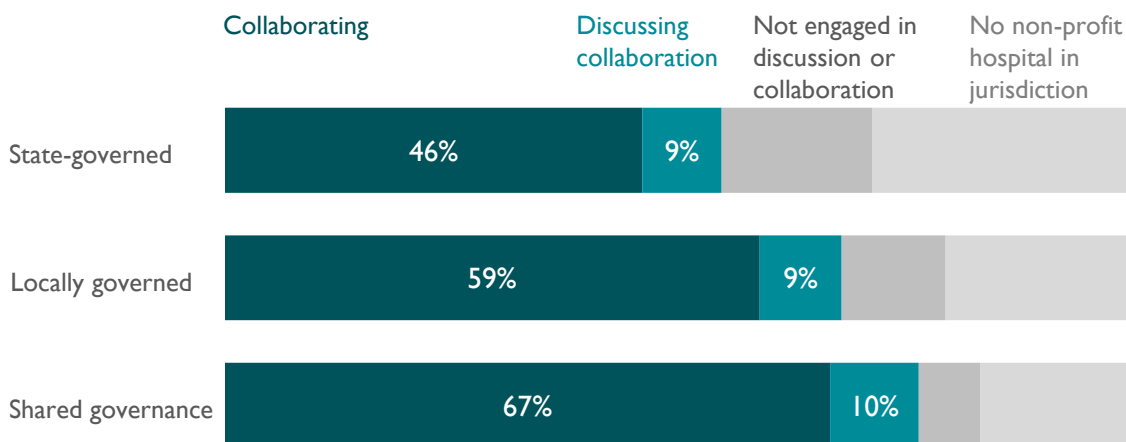
However, among only those LHDs that reported having a non-profit hospital serving their jurisdiction, small and large LHDs were equally likely to report collaborating on a CHNA.

A smaller proportion of state-governed LHDs were collaborating with non-profit hospitals on a CHNA

Fewer state-governed LHDs reported collaborating or discussing collaboration with a non-profit hospital on a CHNA than LHDs governed by local authorities or those with shared governance.

Several factors could account for this difference. For instance, state-governed LHDs are less involved in conducting community health assessments in general and therefore may be less involved in a hospital's assessment, as well. In addition, some state-governed LHDs may be less connected to their communities than LHDs with local governance, making it more challenging for LHDs to develop relationships with community partners.

Fewer state-governed LHDs are collaborating or discussing collaboration with non-profit hospitals on a CHNA



n=621

Percent of LHDs

As indicated in previous chapters, LHDs with shared governance were the most likely to reduce services and were more likely to report serving fewer patients in their clinics; this finding shows that these LHDs are also more likely to collaborate with a non-profit hospital on a CHNA. These LHDs might be more strategic about the care they provide because of their relationships with hospitals and other providers in their area.

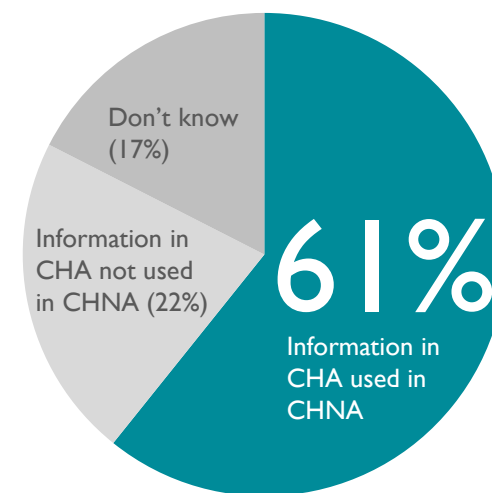
Information from LHDs' CHAs were used in hospitals' CHNAs

Not only are most LHDs collaborating or discussing collaboration with non-profit hospitals on a CHNA, 60% also indicated that information from their CHA was used in a CHNA. As CHAs and CHNAs are based on some of the same kind of data, this type of data sharing minimizes the duplication of efforts and reduces unnecessary community burden.

Twenty-two percent indicated information from their CHA was not used and 17% did not know.

Almost one-third of respondents from state-governed LHDs did not know whether information from their CHA was being used in a hospital's CHNA. Many state-governed LHDs answer the Forces of Change survey at the district level, and therefore might not be aware of the collaborations that exist at the county level.

Three in five LHDs reported information from their **CHAs was used in hospitals' CHNAs**



n=515

Among LHDs with a non-profit hospital serving their jurisdiction

CHNA: Community Health Needs Assessment

Required for non-profit hospitals every three years to maintain tax-exempt status

CHA: Community Health Assessment

Process that helps LHDs assess their community's health and well-being and identify the unique health needs of their communities

More than half of LHDs were involved in some way in a non-profit hospital's implementation plan

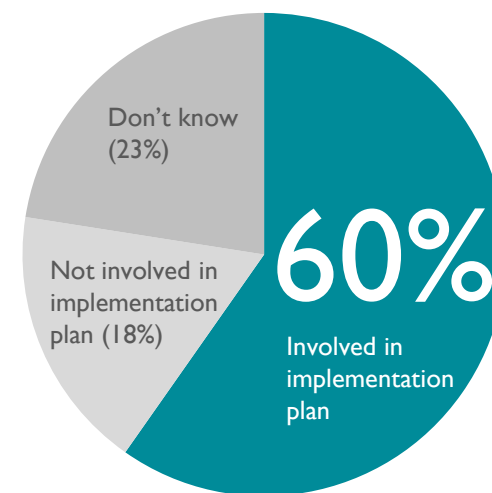
In addition to conducting a CHNA, non-profit hospitals are required to develop an implementation plan to meet the community health needs identified through the CHNA. However, hospitals are not required to involve community partners in the implementation plan.

Nevertheless, 60% of LHDs indicated their LHD was included in some way in a hospital's implementation plan, suggesting that LHDs and hospitals are working together to plan and implement local strategies to improve the health of their communities.

Eighteen percent were not involved and 23% did not know whether their LHD was involved.

Nearly half of state-governed LHDs did not know if their LHD was included in any hospital's implementation plan, compared to 18% of locally governed LHDs and 18% of LHDs governed by both state and local authorities. Similar to above, many state-governed LHDs answer the Forces of Change survey at the district level, and therefore might not be aware of the collaborations that exist at the county level.

Three in five LHDs reported their LHD was **included in a hospital's implementation plan for the CHNA**



n=515

Among LHDs with a non-profit hospital serving their jurisdiction

Almost half of LHDs were listed as a partner in a non-profit hospital's implementation plan

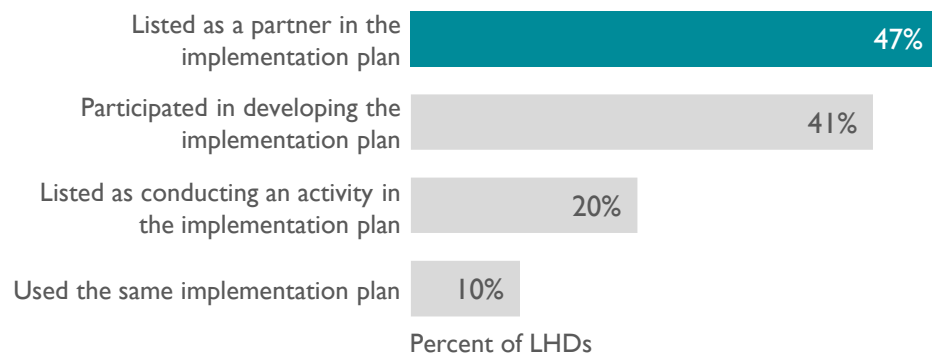
When asked how LHDs were involved in a non-profit hospital's implementation plan, almost half indicated they were listed as a partner. Two in five developed implementation plans with hospitals and one in five was listed as conducting an activity in the implementation plan.

Few LHDs, only 10%, used the same implementation plan as a non-profit hospital in their jurisdiction.

Involvement in a non-profit hospital's implementation plan varied across LHDs. Excluding LHDs that indicated they did not know their level of involvement, almost half were not included in a hospital's implementation plan or were only minimally involved (only listed as a partner in the implementation plan).

Almost half of LHDs were listed as a partner in a non-profit hospital's implementation plan

Few used the same implementation plan



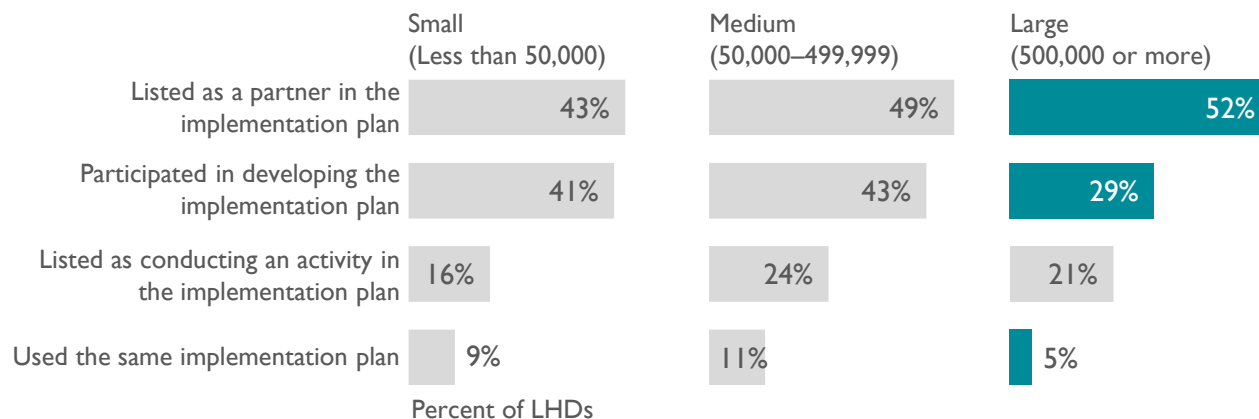
n=402

Among LHDs with a non-profit hospital serving their jurisdiction and who knew how their LHD was involved in a non-profit hospital's implementation plan.

Large LHDs were less likely to use the same implementation plan as a non-profit hospital

Large LHDs, those serving populations of 500,000 or more people, were slightly more likely to be listed as a partner in an implementation plan but less likely to participate in developing the implementation plan or use the same implementation plan as a non-profit hospital in their jurisdiction.

Large LHDs were more likely to be listed as a partner in the implementation plan but less likely to participate in developing or use the same implementation plan



n=402

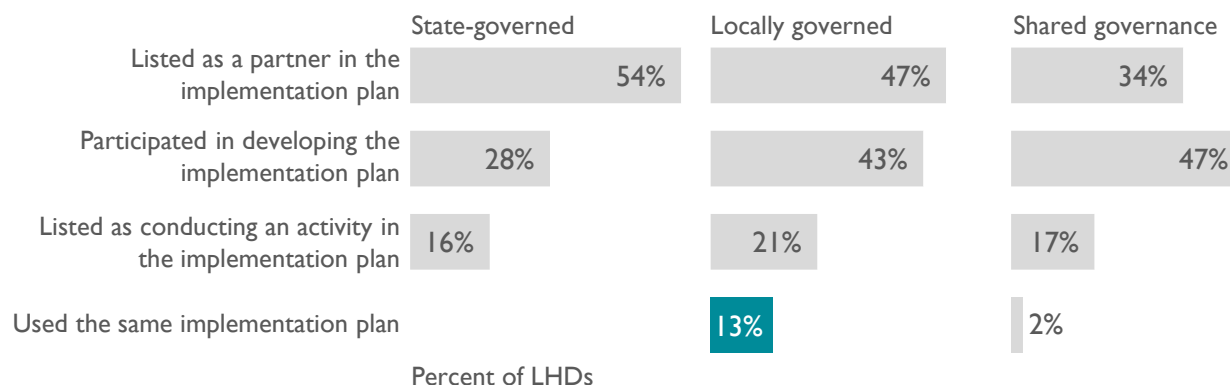
Among LHDs with a non-profit hospital serving their jurisdiction and who knew how their LHD was involved in a non-profit hospital's implementation plan.

Almost all LHDs that use the same implementation plan as a non-profit hospital are locally governed

While few LHDs use the same implementation plan as a non-profit hospital in their jurisdiction, among those that do, almost all are locally governed LHDs. This may reflect stronger community ties among locally governed LHDs.

State-governed LHDs were more likely to be listed as a partner in a non-profit hospital's implementation plan than locally governed LHDs or LHDs with shared governance. However, they were less likely to be included in the implementation plan in other, more collaborative ways.

Almost all LHDs that use the same implementation plan as a non-profit hospital are **locally governed**



n=402

Among LHDs with a non-profit hospital serving their jurisdiction and who knew how their LHD was involved in a non-profit hospital's implementation plan.

LHDs can be conveners who build, renew, and strengthen critical local relationships

The advent of the ACA and public health accreditation requirements provides an opportunity for hospitals and LHDs to collaborate on community health assessments and minimize duplication of efforts and unnecessary community burden.

Findings from the Forces of Change survey show that LHDs are taking advantage of this opportunity. More than half of LHDs reported collaborating with non-profit hospitals in their jurisdictions on a CHNA, and three in five reported that information from their CHA was used in a hospital's CHNA.

However, LHD capacity to dedicate resources to the CHNA process varies across LHDs, and some still report information from their CHA was not used in a hospital's CHNA and they are not involved or minimally involved in a hospital's implementation plan.

Nevertheless, the ACA's CHNA requirement provides additional incentive for communities with existing partnerships to build upon their collaborative work and incentive for communities without a history of collaborative community health assessment to begin working together.

LHDs, non-profit hospitals, and other community partners can pool resources to conduct comprehensive community health assessments that benefit multiple stakeholders and the community-at-large.

Collaboration with Primary Care Providers

05

Collaboration between public health and healthcare is critical

Both local health departments (LHDs) and primary care providers (PCPs) are committed to improving the health of their communities.

Primary care providers (PCPs) and local health departments (LHDs) share the goal of improving the health and well-being of the communities they serve. However, only recently have they explored how to integrate their work.¹

In the face of rising rates of chronic diseases such as obesity, heart disease, and diabetes, collaboration between LHDs and PCPs is critical to improving the health of communities.

Regardless of whether LHDs provide clinical care services themselves, LHDs play an important role in improving aspects of clinical care delivered to their communities.

This chapter provides an overview of how LHDs are working with PCPs across a variety of areas.

Areas of collaboration are grouped according to the triple aim framework: improving the experience of care, improving population health, and reducing costs of healthcare.²

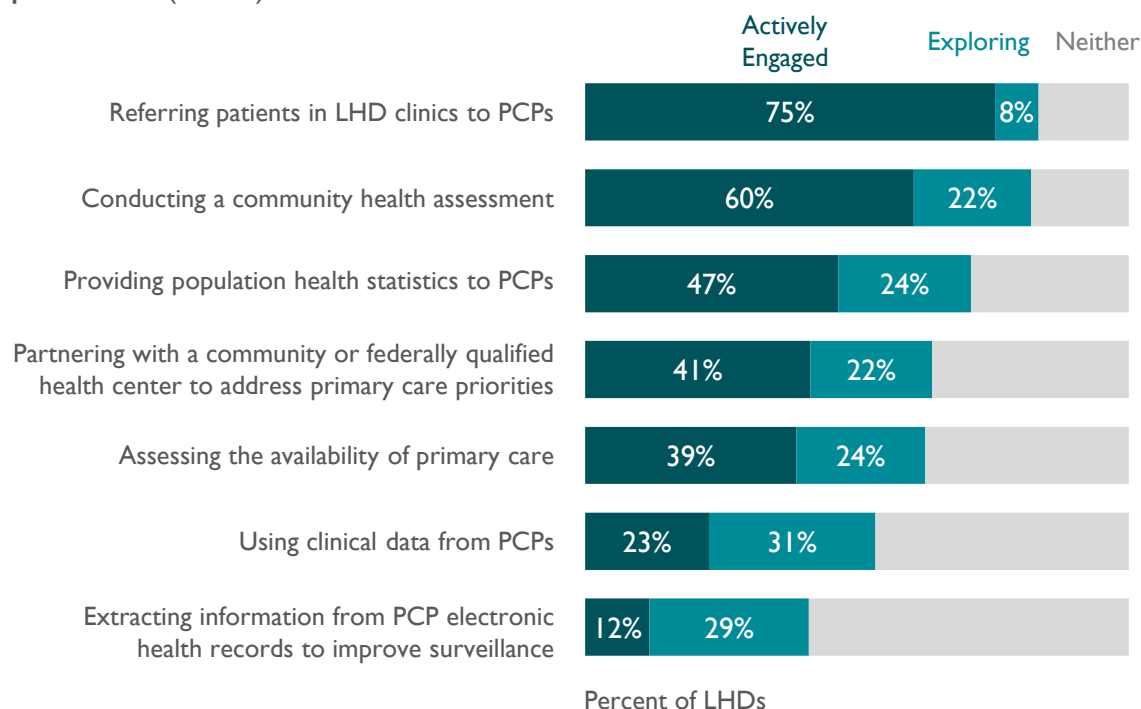
While the Forces of Change survey did not ask directly about reducing costs of care, LHDs were asked about their involvement in new systems of care, including State Innovation Models (SIM), Patient-Centered Medical Homes (PCMHs), and Accountable Care Organizations (ACOs), which are designed to address all three aims, including healthcare costs.

References

1. Institute of Medicine. Primary Care and Public Health: Exploring Integration to Improve Population Health. Institute of Medicine of the National Academies
<http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx>
 2. Institute for Healthcare Improvement. The IHI Triple Aim.
<http://www.ihl.org/Engage/Initiatives/TripleAim/pages/default.aspx>
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Most LHDs refer patients in LHD clinics to PCPs

Three-quarters of LHDs refer patients in LHD clinics to primary care providers (PCPs)



n=643-666

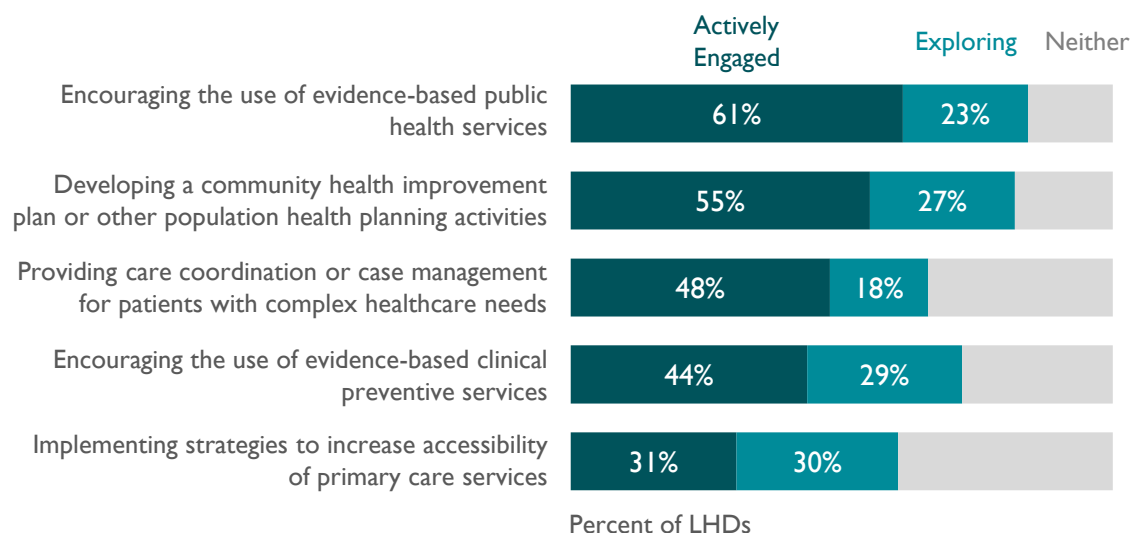
LHDs are collaborating in a variety of ways with PCPs to improve population health.

Most LHDs refer patients in LHD clinics to PCPs and more than half conduct a community health assessment with PCPs.

LHDs are more likely to provide data to PCPs than receive data. Almost half of LHDs are actively engaged in providing health statistics to PCPs, but less than a quarter use clinical data from PCPs and few extract information from PCP electronic health records.

LHDs encourage the use of evidence-based public health services

More than half of LHDs encourage the use of evidence-based public health services



n=660-664

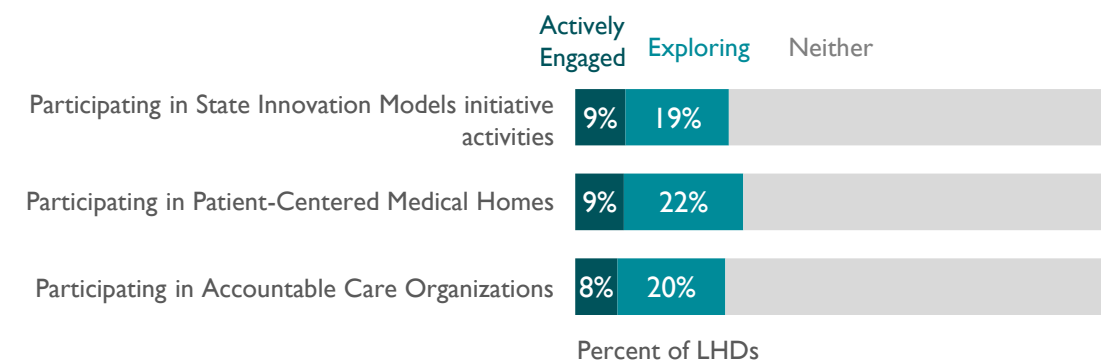
LHDs are also involved in a variety of collaborative activities with PCPs to improve the patient experience of care, including quality of care.

LHDs are more likely to encourage the use of evidence-based public health services than evidence-based clinical preventive services.

Approximately one-third are implementing strategies to increase the accessibility of primary care and another third are exploring this area.

Few LHDs are engaged in new systems of care

Few LHDs are engaged or exploring new systems of care



n=657-659

Few LHDs are engaged or exploring new systems of care. A similar proportion of LHDs are actively engaged in SIM activities, PCMHs, or ACOs.

While these new systems of care are designed to address all three aims in the triple aim framework, including reducing the cost of care, they are more resource intensive, often require existing relationships, and are likely more challenging for LHDs to implement. Additional support and technical assistance in these areas, including helping LHDs develop relationships with primary care partners, could help address some of these challenges and encourage LHDs to pursue collaborative activities.

State Innovation Model (SIM) Initiative: Funded by the Centers for Medicare & Medicaid Services, supports the development and testing of state-based models for multi-payer payment and healthcare delivery system transformation with the aim of improving health system performance for residents of participating states

Patient-Centered Medical Homes (PCMHs): A model of the delivery of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety

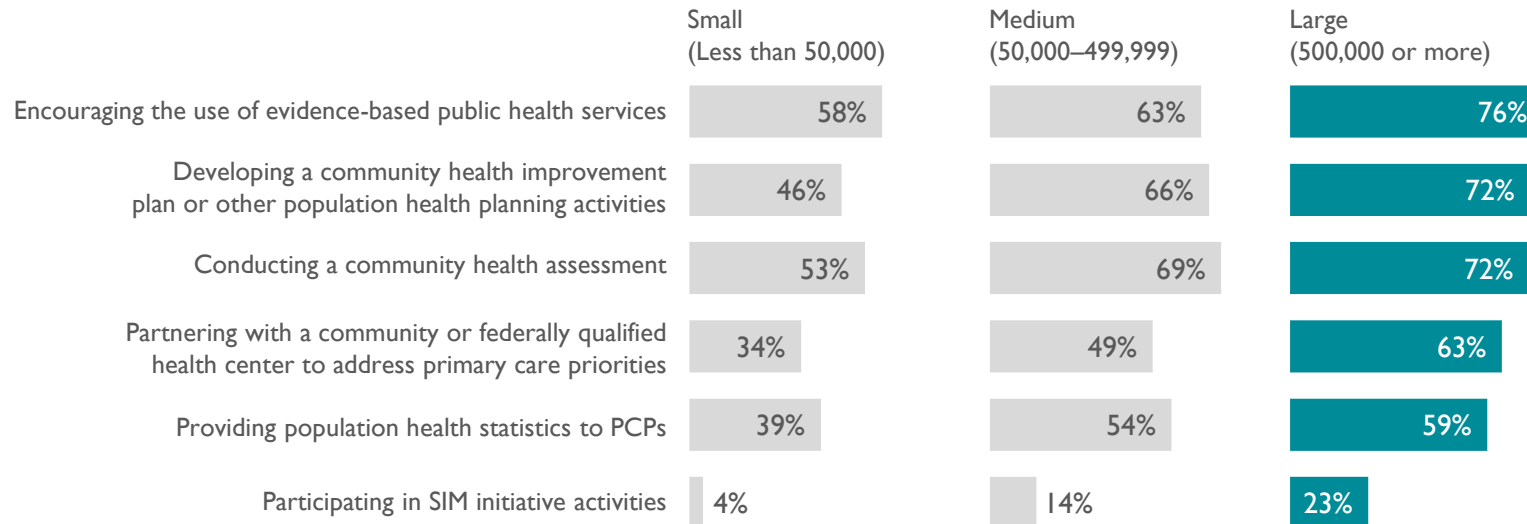
Accountable Care Organizations (ACOs): A network of healthcare providers and entities that share financial and medical responsibility for providing coordinated care to patients. These networks are sometimes called Totally Accountable Care Organizations, Accountable Care Communities, or Community Care Organizations.

Large LHDs are more likely to collaborate with PCPs

A larger proportion of large LHDs, those serving populations of 500,000 or more people, reported being actively engaged in collaborative activities with PCPs.

This higher level of collaboration is likely due to large LHDs' additional resources to collaborate and the larger primary care workforce in the more urban areas served by large LHDs.

Large LHDs are more likely to be collaborate with PCPs



n=643-666

Percent of LHDs that are actively engaged in activities

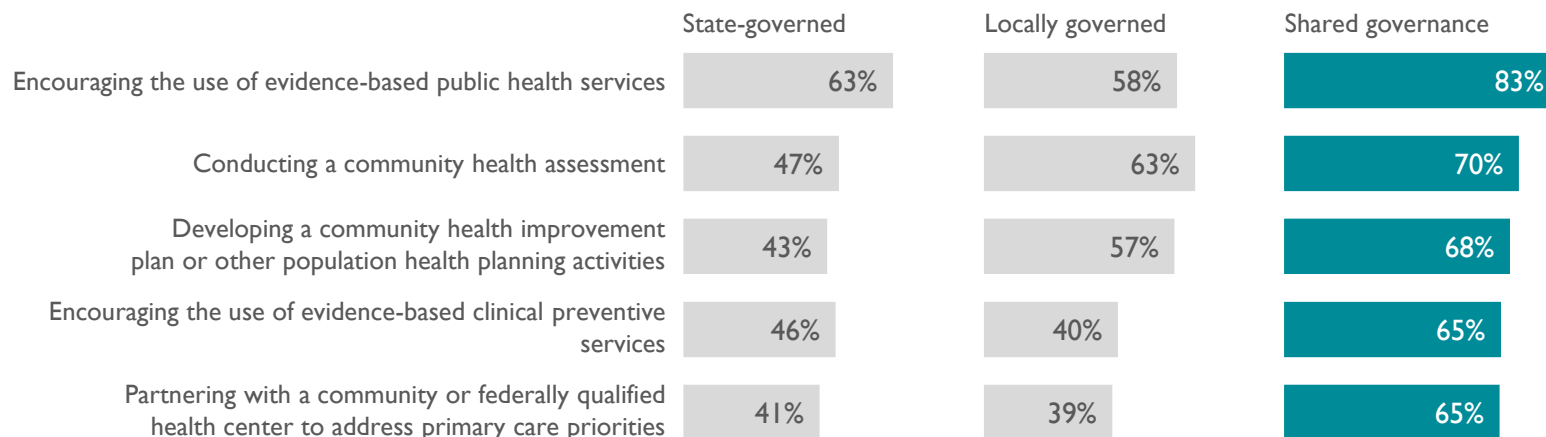
LHDs with shared governance are more likely to collaborate with PCPs

A larger proportion of LHDs with shared governance reported collaborating with PCPs, compared to locally and state-governed LHDs. LHDs in Florida, Maryland, and Kentucky reported high levels of engagement with PCPs.

As shown in previous chapters, LHDs with shared governance were more likely to reduce their services, but as shown here, more likely to collaborate with non-profit hospitals and PCPs.

This finding could suggest that these LHDs might be evaluating the public health services available in their communities when deciding what services to provide.

LHDs with shared governance were more likely to collaborate with PCPs



n=643-666

Percent of LHDs actively engaged in activities

LHDs are exploring collaboration with PCPs but need continued resources and support

Increased healthcare costs, rising rates of chronic diseases, and health reform have drawn attention to integrating public health and primary care

LHDs are actively engaged in or exploring collaborative activities with PCPs in improving the patient experience of care and improving population health. Fewer LHDs are involved in new systems of care, including SIMs, PCMHs, and ACOs.

While LHDs and PCPs share the same goal of improving the health of communities, they have traditionally worked independently. Increased healthcare costs, rising rates of chronic diseases, and health reform have drawn attention to integrating public health and primary care.

It is important for LHDs to pursue collaboration with healthcare partners, but LHDs may need additional support to do so. Mechanisms to share best practices, developing relationships among partners, and opportunities to connect staff, funding, and data at the regional, state, and local levels need to be explored.¹

Reference

1. Institute of Medicine. Primary Care and Public Health: Exploring Integration to Improve Population Health. Institute of Medicine of the National Academies
<http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx>
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Workforce Skills

06

Local health department staff require a broad skill set

An effective public health workforce relies heavily on the workforce capacity of national, state, and local health departments.

At the local level, local health department (LHD) staff carry out a wide array of responsibilities to promote and preserve the health of the communities they serve. The increasing complexity of disease patterns, interventions, partnerships, and technologies requires a broad skill set among public health professionals.

With the growing recognition of the importance of core competency development, public health agencies, including LHDs, have set workforce development as a priority.

Efforts are needed to gain a comprehensive understanding of the development and training needs of the public health workforce. This chapter provides a brief overview of the skills LHD leaders believe to be most important for their professional public health staff.

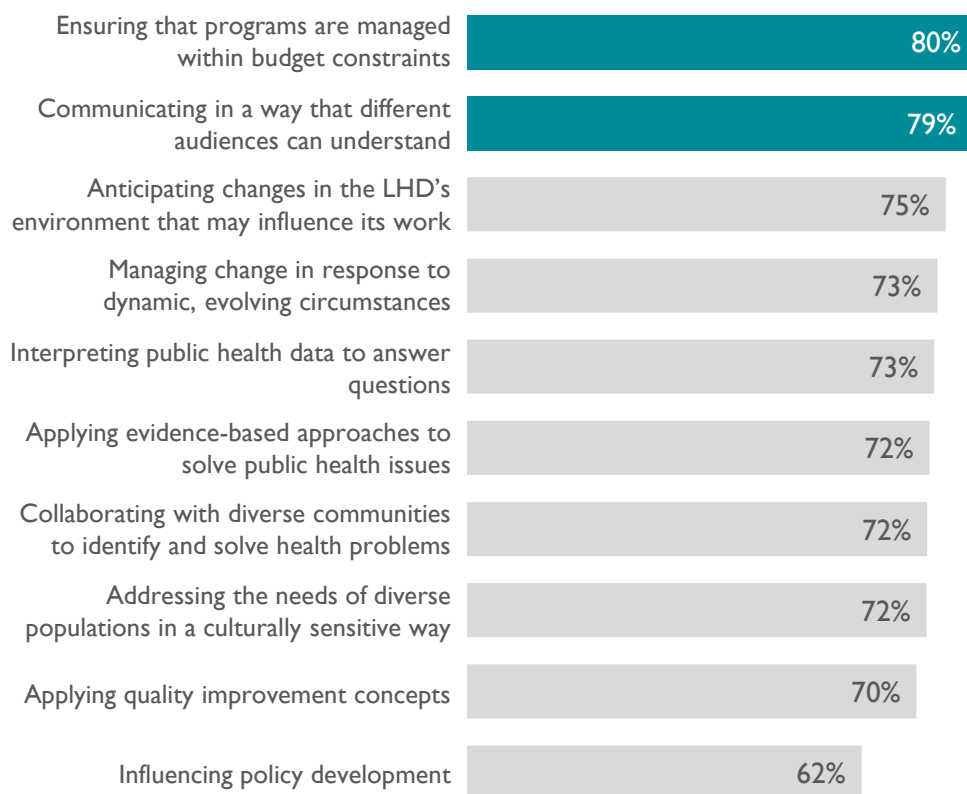
Notes on Methods

The skills listed in the 2015 Forces of Change survey are a subset of a list of competencies developed by Association of State and Territorial Health Officers for the Public Health Workforce Interests and Needs survey to assess workforce knowledge, skills, and attitudes. These skills are based on the Core Competencies for public health professionals.

Additional findings from this survey will be published in the special supplement of the *Journal of Public Health Management and Practice* in October 2015 (Leider J, Bharthapudi K, Pineau V, Liu L, Harper E. The Methods Behind PH WINS. *Journal of Public Health Management and Practice*, 2015)

LHD leaders rate a wide variety of competencies as important for their professional public health staff

Approximately 80% of LHD leaders rated budget management and communication as important skills for their professional public health staff



Percent of LHDs that rated skill as a 6 or 7 on a 7-point scale (7 is most important)

Overall, LHD leaders believe that skills embodied in the core competencies are important for their professional public health staff. High percentages of LHDs rated all skills on the positive end of the scale.

LHDs leaders rated ensuring that programs are managed within budget constraints and communicating ideas and information in a way that different audiences can understand most highly.

However, influencing policy development was rated as less important by LHD top executives. This may suggest that limited policy-oriented work takes place at some LHDs or that the policymaking activities that do take place are limited to the leadership team, rather than the rest of the professional public health staff.

n=658-666

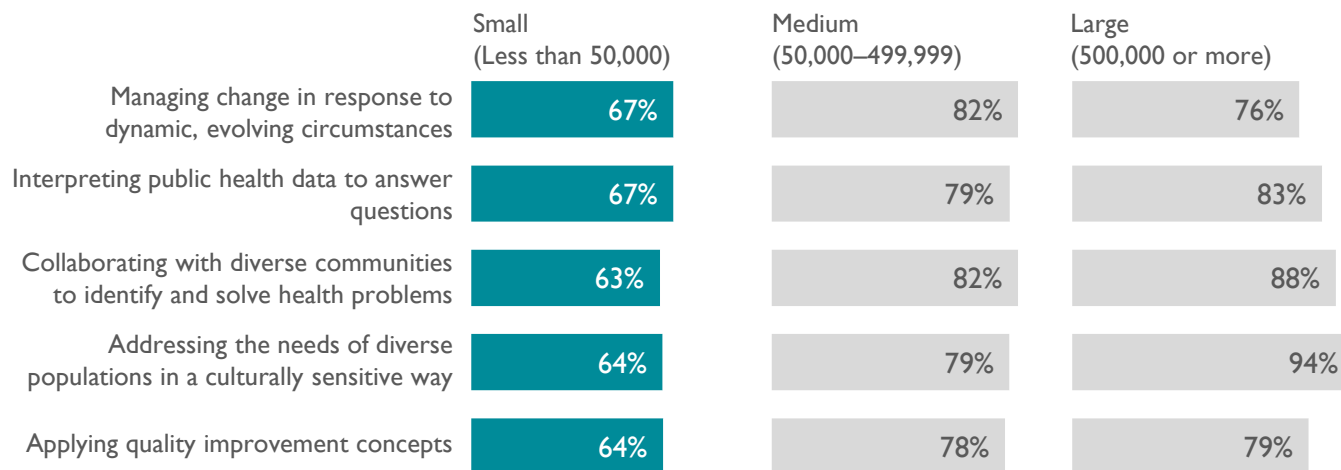
Leaders of small LHDs rated all skills as less important

The number of staff and types of occupations employed by LHDs varied by the size of the LHD. These variations may affect employees' perception of skills required for their work.

Forces of Change findings show that leaders of small LHDs, those serving populations of less than 50,000 people, rated all workforce skills as less important than medium and large LHDs.

Smaller LHDs tended to have less capacity to specialize in a variety of competencies, thus leaders of these LHDs may not consider all of these competencies important for their workforce. In addition, the characteristics of smaller communities (for instance less diversity in demographics), may influence leaders to view these competencies as less important for their staff.

Leaders of **small LHDs** rated all skills as less important for their professional public health staff



Percent of LHDs that rated skill as a 6 or 7 on a 7-point scale (7 is most important)

n=658-666

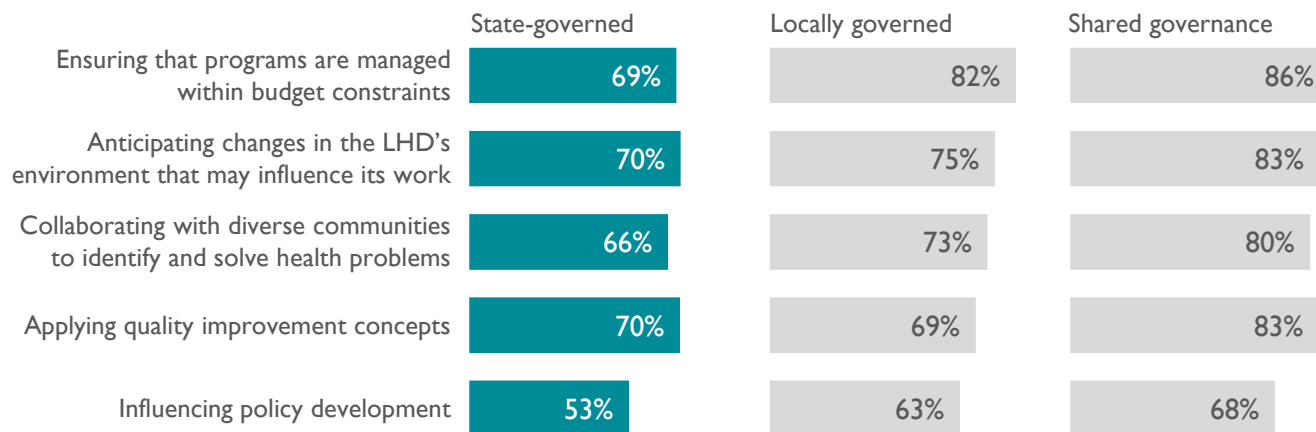
Leaders of state-governed LHDs were less likely to rate policy development as an important skill

Leaders of state-governed LHDs rated most workforce skills as less important than leaders at LHDs governed by local authorities or those with shared governance.

A notable finding was that only 53% of leaders at LHDs with state governance rated influencing policy development as important.

As units of the state agency, these LHD leaders might feel they have less influence on policy development (or might not be allowed to work in policy), and therefore believe these skills to be less important for their staff.

Leaders of **state-governed LHDs** rated most skills as less important for their professional public health staff



n=658-666

Percent of LHDs that rated skill as a 6 or 7 on a 7-point scale (7 is most important)

Core Competency based workforce skills are important for LHD staff and should be incorporated into LHD staff trainings

LHDs overwhelmingly rated most skills as important or very important. Fewer small LHDs and state-governed LHDs rated the skills as important.

LHDs were most likely to rate managing a program within budget constraints as a very important staff skill. As described in previous chapters, most LHDs experienced cuts in budgets, staff, and programs during the Great Recession and the years immediately following. LHDs struggle to deliver services with limited resources, which requires LHD leaders to give high priority to employing strategies to mitigate the impact of funding cuts.

Most LHDs, especially those serving small jurisdictions, do not have formal workforce-development plans. Forces of Change findings show that a wide variety of these skills are important for LHD staff and highlight the importance of incorporating them into trainings. However, resources may need to be tailored to LHDs of different sizes because small LHDs are less likely to view some specific skills as important to their work.

The Public Health Accreditation Board has included a competency-based training plan as one requirement for accreditation, which may encourage more LHDs (even those not applying for accreditation) to formalize their workforce-development plans.

Thank You

Acknowledgments

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Its contents are solely the responsibility of NACCHO and do not necessarily represent the official views of the sponsors.

For more information, please contact the Research & Evaluation Team at research@naccho.org.

Authors include Sarah Newman, Carolyn Leep, Jiali Ye, and Nathalie Robin.

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1100 17th St, NW, 7th Floor Washington, DC 20036

P 202-783-5550
F 202-783-1583

www.naccho.org

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