TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Public Health Funding and Policy Committee

Annual Report

February 2013

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Acknowledgements
The Public Health Funding and Policy Committee (PHFPC) acknowledges and thanks the following individuals for their subject matter expertise, facilitation, and support of the PHFP Committee:

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Public Health Funding and Policy Committee

Department of State Health Services
P.O. Box 149347. Austin, Texas 78714-9347

Attention: Governor Rick Perry
Lieutenant Governor David Dewhurst
House Speaker Joe Straus
Senator Jane Nelson
Representative Lois Kolkhorst
Commissioner David Lakey

In 2011, the 82nd Texas Legislature passed Senate Bill 969, which established the Public Health Funding and Policy Committee (Committee). The Committee's general duties as outlined in Section 117.101 of the Texas Health and Safety Code, in part, are as follows:

(1) Define the core public health services a local health entity should provide in a county or municipality;
(2) Evaluate public health in this state and identify initiatives for areas that need improvement;
(3) Identify all funding sources available for use by local health entities to perform core public health functions;
(4) Establish public health policy priorities for this state; and
(5) Make formal recommendations, minimum of once annually, to the department [DSHS] regarding:

(A) The use and allocation of funds available exclusively to local health entities to perform core public health functions;
(B) Ways to improve the overall public health of citizens in this state;
(C) Methods for transitioning from a contractual relationship between the department and the local health entities to a cooperative-agreement relationship; and
(D) Methods for fostering a continuous collaborative relationship between the department and the local health entities.

***

The Committee was established, in part, as a result of the Texas Association of Local Health Officials (TALHO) White Paper, *The Future of Public Health in Texas*. TALHO is a non-profit organization consisting of 64 directors of local health departments and public health districts. The TALHO membership provided feedback and suggested revisions prior to final approval of the White Paper. The White Paper recommended strategies to improve public health in Texas. With the support of Senator Jane Nelson, Senate Bill 969 passed.

This report outlines the public health complexities and challenges the Committee identified in its first year, the approaches the Committee took to identify the issues, and the recommendations to improve public health.

The Committee examined multiple complex public health program areas and structures within the state. For example, the tuberculosis (TB) program has several intertwining factors that complicate TB diagnosis and treatment. The treatment of TB is a long, tedious process. As a result, individuals infected with TB may not complete treatment. Incomplete treatment leads to drug resistant TB, jeopardizing successful treatment of the disease.

Complexities also exist in the public health preparedness program. These programs educate the public and build capacity to plan for and respond to emergency events. The need for resources during a disaster, add to the complexity of public health preparedness necessitating constant training and cross-training of staff in preparation for when events do occur. Public health entities spend considerable time planning for disasters but cannot anticipate the expense of the disaster. For example, during the recent West Nile Virus outbreak in Texas funding for aerial spraying was not readily available.

The structural complexities in the public health system exacerbate the complexities in the public health programs. One such complexity pertains to the contracts between the state and local health entities. The Texas Department of State Health Services (DSHS) issues a total of 458 contracts to local health departments, public health districts and local health units. The 458 contracts are divided into 74 types of public health services, such as HIV/STD, TB, immunizations, public health emergency preparedness, and family planning. The sheer number and diversity of the contracts demonstrates the intricacy of the contract process.

Further complicating the system is the variety of jurisdictional structures within the state. Public health entities include the state, local health departments and public health districts. Each entity is established either by a county, a municipality, or a combination of both. If the entity is in a county its governing body is the Commissioners Court; the governing body of a municipality is the City Council; and district may have an administrative, policy-making board of health. Although this is the usual framework of local government in general, the development of a public health system that delivers consistent services throughout the state must take these complexities into consideration.

The committee sought to obtain information from a variety of sources while exploring these complexities. One source of information was direct contact with public health providers. The Committee went to different geographical areas throughout the state each month and sought input from the local health officials regarding the particular challenges in their regions. The committee also hosted two stakeholder meetings and sought input from attendees.

Another source of information for the Committee was an examination of House Bill 1444, which led to the codification of Section 121.002 of the Texas Health and Safety Code, and defines the ten essential public health services. Section 121.002 provides the philosophical foundation for the committee's actions.

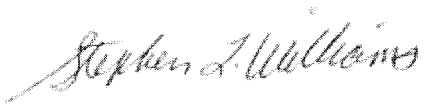
The Committee received vital information through three public health surveys. The surveys evaluated (1) the services and funding sources of local health entities, (2) characteristics and educational needs of local health authorities, and (3) accreditation. Findings stimulated a number of the committee's recommendations to the DSHS Commissioner.

Additionally, several DSHS programs and sections such as the Immunization Branch, Tuberculosis Prevention and Control Unit, Community Preparedness Section, the Contract Management Unit, and the Environmental Section made presentations to apprise the Committee on current conditions and challenges in their respective areas.

The Committee's actions during the last year resulted in recommendations pertaining to maximizing resources, accreditation, the 1115A Medicaid Waiver, workforce issues, and programming. Some of the recommendations were implemented and others are pending approval.

The Public Health Funding and Policy Committee appreciate the opportunity to effect change in the public health system and values continued support in its efforts.

Sincerely,



Stephen L. Williams, M.Ed., M.P.A.
Chair, Public Health Funding and Policy Committee
Director, Houston Department of Health and Human Service

Executive Summary

Not every Texan has the same level of local public health protection. The Texas public health system is fragmented, complex, and in some instances, non-existent. Texas delivers public health services in a system of state and local health entities with mixed accountabilities and often unmatched and/or competing priorities.

Surveys of local public health entities confirm that the presence, scope, and quality of public health services vary greatly among Texas counties and cities. Among the 254 counties in Texas, 59 operate under a Local Public Health Contract with the Department of State Health Services (DSHS). These 59 entities are commonly referred to as "participating" local health departments, and they deliver a diverse array of local public health services to 82 percent of the state population. Many other entities, referred to as "non-participating," provide a small subset of environmental permitting and/or clinical services. DSHS health service regions provide local public health services to counties without a local public health entity. In addition, regions also play a gap-filling role, delivering a critical piece of essential public health services when a local public health entity is inadequately funded to deliver a specific service. This typically occurs in less populated counties.

State funding of local public health services is equally complex and poorly understood. Local public health entities may receive city, county, state, federal, or other sources of funding. Historically, local public health entities' funding does not align with known public health risks, vulnerabilities, threats, and disease statistics. Local public health entities, 11 DSHS Health Service Regions, and DSHS central office compete for state funding of local public health services.

In its first year of work, the Public Health Funding and Policy Committee (Committee) obtained stakeholder input by hosting monthly meetings across the state. To accomplish its charge, the Committee: a) reviewed prior efforts to define and improve local public health in Texas, b) evaluated the nature of DSHS contracts with local public health entities, c) surveyed local public health entities' services and funding, d) surveyed the characteristics and needs of local health authorities, e) evaluated the readiness of local public health entities for accreditation, and f) assessed issues affecting existing public health programs.

During the first year, the Committee made several recommendations to DSHS. Listed here is a summary of the recommendations for review. The Committee's initial recommendations address local public health issues in the following areas:

- **Maximizing the efficiency of resources**
- **Pursuing public health accreditation**
- **Establishing opportunities for local public health under the 1115A Medicaid waiver**
- **Addressing critical workforce needs**
- **Addressing critical issues impacting public health programs, such as:**
    - **environmental and consumer health**
    - **tuberculosis prevention and control**
    - **immunizations for both adults and children**
- **Preparing for healthcare reform and the impact on public health**

Recommendations Completed:

Completed 9/1/2012

- *Recommendation A (1):* Bundle non-competitive grant contracts.
- *Recommendation A (2):* Allow five percent of non-competitive grant funds to go toward staff training.
- *Recommendation A (3):* Increase allowable budget category changes in non-competitive contracts.
- *Recommendation A (4):* Increase allowable equipment purchases in non-competitive contracts.

Completed 5/31/2012

- *Recommendation C:* Cooperation with the HHSC Executive Commissioner to grant special consideration to the area of public health under the 1115A Medicaid Waiver.

HHSC (Texas Health and Human Services Commission)

Recommendations Pending or Ongoing:

- *Recommendation B:* Cooperation with PHAB to pursue public health accreditation and serve as the model for all other public health entities in the state.
- *Recommendation D(1):* Charge the Public Health Collaboration to develop a plan to identify and address workforce needs.
- *Recommendation D(2):* Prioritize adequate resources and commitment to meet the statutory requirement to convene an annual CME training for physicians who serve as local health authorities (LHAs) in Texas.
- *Recommendation E(1):* Seek adequate funding for the DSHS Division of Regulatory Services, Environmental and Consumer Safety Section, to ensure environmental programs function at full capacity throughout the state.
- *Recommendation E(2):* Enhance resources supporting the Infectious Disease Prevention program's capacity to identify and treat persons with active Tuberculosis (TB) and latent TB infection.
- *Recommendation E(3):* Encourage 1115A Medicaid Waiver funds be utilized to implement a TB strategy focusing on regional population-based activities.
- *Recommendation E(4):* Seek resources to restore adult safety-net and Texas Vaccine for Children (TVFC) vaccines.
- *Recommendation E(5):* Support and promote simplified credentialing for local health departments with CHIP/Medicaid and private insurance companies.
- *Recommendation F:* If the state should enter into a waiver negotiation with Medicaid and the Affordable Care Act expansion, the state should receive the five percent public health set-a-side established by the existing 1115A waiver program.

PHAB (Public Health Accreditation Board), CME (Continuing Medical Education), DSHS (Texas Department of State Health Services), CHIP (Children's Health Insurance Program, Local Health Authorities (LHA)

In Summary, the Committee made significant progress in its first year by initiating an aggressive process to evaluate and define local public health, and by making recommendations to improve local public health in Texas.

SECTION I: HISTORY AND DUTIES OF THE COMMITTEE

Historical Context: The Texas Legislature

In 1997, the 75th Legislature's House Concurrent Resolution (HCR) 44 established an interim study to evaluate the role of local governments in providing public health services. As a result, a steering committee and working group submitted recommendations to the 76th Legislature. With the passage of House Bill (HB) 1444, in 1999, Texas established itself as one of the first states to codify the essential services of public health into statute. However, the effort to fund these essential services remains "subject to the availability of funds." In addition, local service delivery remains problematic because the majority of funds are tied to categorical streams. What is needed is transformative change in state and federal funding of services.

Although HB 1444 provided a foundation, it did not define what constitutes a health department in Texas, establish standards, scope of services, or establish a mechanism for funding. Persistent programmatic funding cuts resulted in decreased public health capacity since HB 1444's passage. This includes a decrease in the number of staff in state and local health departments. Many local governments voiced concerns about their inability to absorb state funding cuts without additional county or city dollars. The Committee emphasized the need for a stable source of state funding to ensure equitable distribution of local public health services across the state.

In March 2010, discussions began on how the Department of State Health Services (DSHS) may benefit from the creation of an advisory committee aimed at reviewing policy development and funding allocations to local health departments. During the 82nd Legislative Session, Senator Jane Nelson developed and filed Senate Bill 969 to create the Public Health Policy and Funding Committee (Committee). On June 17th, 2011, Governor Rick Perry signed the bill, effective September 1, 2011, requiring the Commissioner of DSHS to appoint nine members to the Committee SB 969 is subject to the Texas Sunset Act in 2023. The bill requires DSHS to provide staff and material support to the Committee and meetings. The committee meetings are subject to Chapter 331 of the Government Code, Open Meetings Act.

The general duties of the Committee, outlined in SB 969, consist of the following:

> Define core public health services a local health entity should provide; Evaluate public health in the state of Texas and identify initiatives for areas that need improvement; Identify all funding sources available for use by local health entities to perform core public health functions; Establish public health policy priorities for the state of Texas; and at least annually, make formal recommendations to the Department of State Health Services.

Committee recommendations must be in accordance with prevailing epidemiological evidence, variations in geographic and population needs, and best practices or evidence-based interventions related to the populations served. Committee recommendations must also conform to state and federal law, and federal funding mechanisms.

Finally, the bill requires the committee to provide opportunities for public testimony at least twice a year. SB 969 requires DSHS to submit a plan to transition from a contractual type relationship with local health entities to one of a cooperative agreement type relationship. Based on the duties outlined above, SB 969 requires DSHS to file an annual report with the Governor, Lieutenant Governor, and Speaker of the House of Representatives on the agency's implementation of the committee's recommendations and provide explanations for recommendations not implemented by the agency.

To increase the committee's exposure to local and regional health issues and to gather input from stakeholders across the state, the committee meetings are open to the public, and held monthly in communities ranging from Harlingen along the border to Tyler on the Northeast section of the state (see Appendix A, pp. 32). The committee established two sub-committees (policy sub-committee and a local health entity survey sub-committee) to research and address committee duties.

Historical Context: National Discussions

In 1988, the Institute of Medicine (IOM) published *The Future of Public Health*. The report asserted public health is "what we as a society do collectively to assure the conditions in which people can be healthy" and went on to describe the system as working in "disarray." The Institute identified the need to describe the special and complementary role of governmental public health, and established the three core functions of public health (assessment, assurance, and policy development) as the foundation for future public health practice.

In 1994, as the country began to discuss health care reform, the need to further define what public health is and does resulted in the formation of a Core Function of Public Health Steering Committee, which produced a statement called "Public Health in America." (See Figure 1, pp. 12) This statement was the first to list the Six Public Health Goals and to institutionalize the Ten Essential Services of Public Health relating them to the core functions. (See Figure 2, pp. 13)

Following the release of *The Future of Public Health* in 1996, the IOM established the Committee on Public Health to review progress toward achieving the recommendations. The resulting report *Healthy Communities: New Partnerships for the Future of Public Health* described how to provide the essential services. Recommendations pointed in the direction of creating partnerships to form an efficient and effective public health delivery system.

In 1999, the IOM released a statement portraying how future Public Health Systems should organize their work to achieve improvements in health outcomes. The resulting document *Improving Health in the Community* established community health assessment as core to the community health improvement process. In 2002, the IOM released *The Future of the Public's Health in the 21st Century*, which revisited the subject of public health infrastructure in the context of the Post 9/11 terrorist attacks and Healthy People 2010 goals and objectives. The report called for strengthening of governmental public health agencies as the backbone of the Public Health System, and focused on the roles and actions of other entities that could and should be potential partners within the system.

Figure 1:

PUBLIC HEALTH IN AMERICA

Vision: Healthy People in Healthy Communities

Mission: Promote Physical and Mental Health and Prevent Disease, Injury, and Disability

6 Public Health Goals

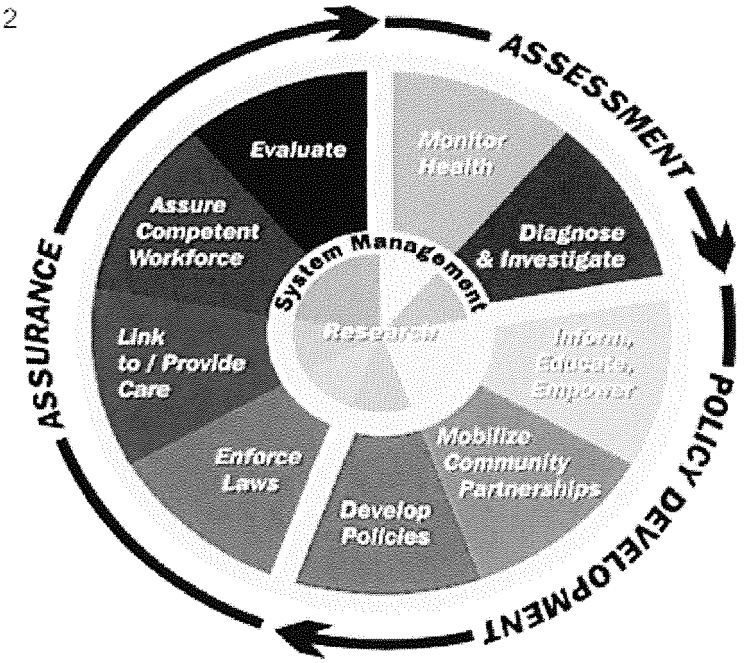
- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

10 Essential Public Health Services

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the p ovision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems

Adopted: Fall 1994, Source: Public Health Functions Steering Committee, Members (July 1995) American Public Health Association-Association of Schools of Public Health-Association of State and Territorial Health Officials-Environmental Council of the States-National Association of County and City Health Officials-National Association of State Alcohol and Drug Abuse Directors-National Association of State Mental Health Program Directors-Public Health Foundation-U.S. Public Health Service --Agency for Health Care Policy and Research-Centers for Disease Control and Prevention-Food and Drug Administration-Health Resources and Services Administration-Indian Health Service-National Institutes of Health-Office of the Assistant Secretary for Health-Substance Abuse and Mental Health Services Administration

Figure 2



With the passage of SB 969 by the 82nd Legislature and the establishment of the Public Health Funding and Policy Committee, Texas officially recognized the need to improve governmental relationships between local, regional and state public health entities.

SECTION II: PUBLIC HEALTH AROUND THE STATE

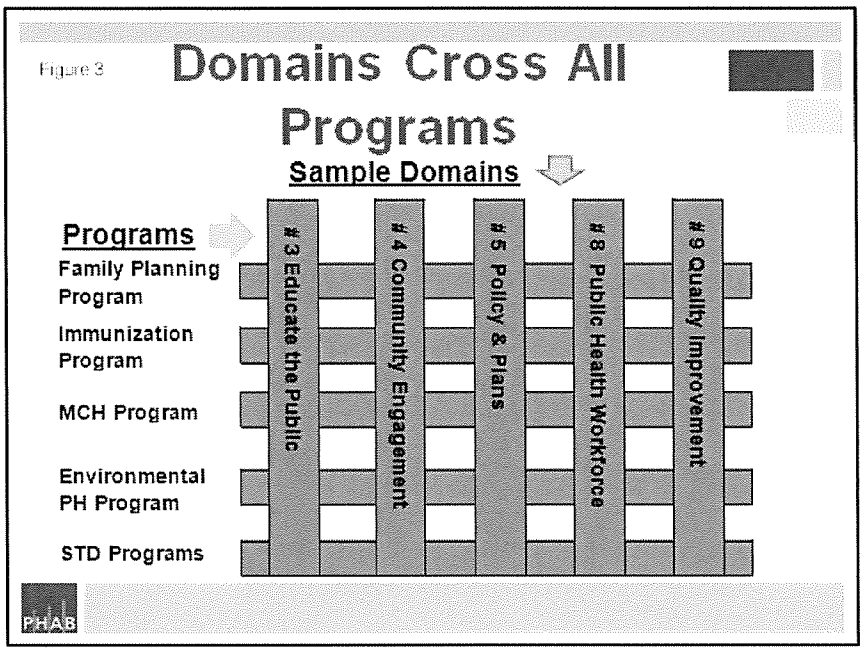
SB 969 calls for the committee to define appropriate core public health services, examine funding sources, and recommend policy priorities and initiatives in areas needing improvement. In particular, the committee is to target the nature of existing contractual relationships between local health departments and the state and move toward a more collaborative arrangement.

Given this charge, the committee examined past legislation and existing public health documents to form a foundation for meeting the SB 969 legislative expectations. First, the committee reviewed the landmark House Concurrent Resolution 44 and House Bill 1444. These two documents set the stage for public health activities in Texas. Second, the committee reviewed the White Paper drafted by the Texas Association of Local Health Officials (TALHO). The committee members determined its work should occur within the context of these directives.

Subsequently, the committee sought to gather new information from three sources: (1) central DSHS program staff; (2) surveys of local health authorities and local health department directors; and (3) the public. Throughout 2012, the Committee members traveled to various local health entities (counties, municipalities, health districts, and DSHS health service regions) and regions in Texas. Many public health professionals (local health department Directors, Local Health Authority/Medical Directors, Public Health Nurses, Environmental Health staff,) and local stakeholders (County and Municipal Government officials) reported challenges and pertinent information to the committee. This information was valuable in helping the Committee

with its required duties to define core public health; evaluate public health services and identify initiatives in areas that need improvement; identify funding sources available for local public health entities; and establish public health policy priorities for Texas.

The committee traversed the state in this first year, taking testimony, and discussing the challenges and opportunities facing local public health agencies. Testimony involved topics across the spectrum of chronic diseases, communicable diseases, and environmental health programs. Because the essential services of public health cut across program lines (see Figure 3) this report is organized by the Essential Services.



The Committee used the ten essential public health services codified by the 76th legislature in House Bill 1444 to illustrate issues and challenges facing public health entities in Texas. The examples demonstrate how testimony revealed the status of essential services across the state and provided material for several committee recommendations.

1. **Monitor health status to identify community health problems.** The committee heard testimony from local health entities regarding difficulties in funding capacity to do this most basic Essential Public Health Service. The lack of a state or federal funding stream dedicated to local epidemiology of chronic diseases, cancer, health behaviors, and demographics limits what local health entities in Texas can do. While local health departments shared a few success stories, the Accreditation Readiness survey showed most are in need of significant support in this area. (See Recommendation B; pp. 24)

2. **Diagnose and investigate health problems and health hazards in the community**. The committee heard multiple concerns about the limited resources local health entities have to carry out this inherently governmental function. Examples included recent TB outbreaks, West Nile Fever, Hepatitis, and Pandemic Influenza. Houston provided testimony regarding the over-dependence on dwindling Federal funding from the Centers

for Disease Control and Prevention (CDC) Public Health Preparedness to accomplish outbreak investigations. This year the committee acted on specific requests to explore and clarify the flexibility associated with using program staff in response activities. (See Recommendation A(2); pp. 23)

3. **Inform, educate and empower people about health issues**. While the committee saw several encouraging examples emerging from the CDC-funded Community Planning Grants/Transforming Texas Program, the extent of Health Departments' ability to carry out this essential service is program-dependent and often restricted to small percentages of staff time. Some DSHS staff indicated that inadequate funding of environmental health services limited their ability to inform, educate and empower the community.

4. **Mobilize community partnerships to identify and solve health problems**. Public health entities frequently testified to competing priorities and expectations that limit their ability to mobilize and sustain coalitions and collaborative efforts in their communities. Constraints in grant funding streams, coupled with staffing limitations, especially in rural areas often lead to sporadic and fragmented services. The committee received testimony about how Northeast Texas Public Health District rallied to support its Fit City Tyler initiative. This is an example of what Public Health should do but few public health entities are funded to do.

5. **Develop policies and plans that support individual and community health efforts.** The need for this essential service is evident in the current Texas Medicaid 1115A Waiver efforts. While Delivery System Reform and Integration Projects should be easily selectable from local lists of initiatives, this experience showed hospitals and local health entities struggled to mobilize and develop plans and policies in the Public Health area of the waiver. Of the more than 60 local health entities, only one-third had the capacity to actively participate in the Waiver process. For example, the Cherokee County Public Health administrator, excited about the opportunity to create transformative change between public health and health care providers, participated in multiple meetings with local hospital administrators. The processes focused on how to maximize the dollars for hospital systems. The hospitals hired staff or consulting firms to assist with the process. Their small health department could not compete. Consequently, they did not secure funds for public health activities in this small rural area with a County Health Ranking of 197 for health outcomes. Additionally, many local health departments compete with fire, police, roads, and bridges for local funding. (See Appendix B; pp. 36)

6. **Enforce laws and regulations that protect health and ensure safety**. The committee heard testimony involving Food-Borne Disease and Food Safety issues. Several locations shared difficulties associated with detecting clusters, outbreaks, threats, and enforcing existing regulations. The committee entertained stories of overlapping and missing services and initiated discussions on improving communication between local, state, and federal agencies who collectively share responsibility for environmental health, food, and water safety. The committee identified the need to explore disparities in the fees and policies that limit the ability of cities, counties, public health districts, and DSHS health service regions to carry out these services. (See Recommendation E(1); pp. 26)

7. **Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable.** Testimony regarding high uninsured rates and lack of access to care were common to all regions of the state. Local health entities confirm they face expectations of providing clinical safety-net services to their entire community. Expected services include: primary care to medically needy persons; clinical preventive services; immunizations; sexually transmitted infection services; and tuberculosis treatment and prevention. These expectations are difficult to meet with diminishing resources, and constrain the local health entities' ability to focus on essential services. While these demands for clinical services could easily consume the local budget, funding strategies to improve populations and prevent disease may decrease the need for personal health care.

8. **Assure a competent public health and personal healthcare workforce**. Beginning with the training needed to support Local Health Authorities (physicians) in Texas, and extending to all disciplines, the committee received testimony confirming that sustaining an adequately trained Public Health Workforce is a significant challenge to local health entities in Texas. Funding for training is lacking in many programs and some local health departments report having to abandon sponsored training. The committee explored barriers to cross-training public health staff and concepts related to establishing contingency pools to deal with workforce challenges. (See Recommendation D(2); pp. 26)

9. **Evaluate effectiveness, accessibility, and quality of personal and population-based health services**. Testimony to the committee suggests many local health entities fell short of the ideal vision of public health practice. As a reflection of continuous quality improvement capacity of an agency, the Accreditation Readiness Survey confirmed relative absence of resources to perform, monitor, document continuous quality improvement activities, and the lack of workforce capacity.

10. **Research for new insights and innovative solutions to health problems.** Another advanced but essential service is the capacity of local health entities to utilize and contribute to the public health literature and evidence-based science of public health program and services. Testimony revealed a relatively rich source of resources within Texas' Schools of Public Health, which historically was marginally accessed by the public health infrastructure. However, Commissioner Lakey established a collaborative between DSHS and the three schools of public health, to provide a platform for collaborative innovation in the future. (See Recommendation D(1), pp. 26)

Other testimony heard addressed the following topics:

Funding

There is no systematic approach to funding the various public health programs in the state. Funding typically occurs in response to public health events and/or based on historical practices. Examples include TB and West Nile.

Enhancing Communication
The committee heard testimony of increasingly strained resources at the state and local levels and limited communication among and between public health partners. Efforts to strengthen these communication channels are urgently needed.

Border Issues
Testimony pertaining to the unique challenges and environment that exists due to the U.S. Border with Mexico was a prominent feature of many meetings. Implications for funding formulas and public health system design and interrelationship with health care were components of testimony and discussions.

Geographic Challenges/Growing and Changing Populations.
Demographic changes within the state are evolving much faster than the existing public health programs and systems can address them. These findings are not limited to the Texas - Mexico border regions of the state. Testimony relating to increasing services needs versus capacity was common to each hearing.

TALHO White Paper, The Future of Public Health in Texas, was developed under the auspices of and supported by a majority of TALHO's membership. TALHO's membership consists of 64 local health department directors. In upcoming meetings the committee will begin to discuss the specific recommendations contained in the White Paper.

TALHO put forth the following recommendations for enhancing public health capacity. TALHO put forth the following recommendations for enhancing capacity to deliver the ten essentials of public health services in the state of Texas.

The recommendations included:

1. Define what constitutes a bona fide local health department and consider combining jurisdictions to provide comprehensive services.
2. Assess the role of the Texas Department of State Health Services (suggesting DSHS provide state-wide leadership for the core public health functions and leave service provision to local health departments when present in communities).
3. Provide surge capacity to local health departments when the need exists.
4. Change public health funding to local health departments.

The white paper suggests solutions such as:

1. Set and provide local health departments with a minimum level of funding to provide the 10 core (essential for consistency) public health services.
2. Give local health departments the latitude to redirect funds to meet their needs and cross-train staff.
3. LHD's serve as catalysts, not implement the community prevention strategies.

TALHO (Texas Association of Local Health Officials),

SECTION III: PRESENTATIONS BY DSHS PROGRAMS

The committee also received input on pertinent public health issues from Texas Department of State Health Service's (DSHS) program staff. Subsequent committee discussions centered on the seven topics summarized below.

Tuberculosis (TB)
TB funding, management, and prevention issues were discussed frequently. DSHS stated FY 13 TB funding would be level. In addition, with the assistance of the Litaker Group, DSHS initiated the TB Strategic Planning Process. DSHS obtained input for the plan from both internal stakeholders and local health departments. An expert panel convened to provide best practices guidance to the agency. The complete strategic plan along with recommendations will be presented to DSHS and the committee in early 2013.

Concurrent with the strategic plan DSHS updated the group on the development of a new TB funding formula. DSHS revised the TB funding formula every three to five years to establish equity in the distribution of funds. A Funding Formula Workgroup was established and the group's activities are ongoing.

The committee considered strategies to access the 1115A Medicaid Transformation Waiver resources to provide tuberculosis services. The committee suggested one or more regions propose tuberculosis pilot projects.

Immunizations
The DSHS Immunization program reported a reduction in the FY 13 federal immunization funding. These reductions resulted in policy changes restricting vaccine utilization. Texas adopted the CDC's definition of underinsured, further restricting vaccine access for children. "Underinsured" means an individual possesses private health insurance but their policy does not cover vaccines. In response, the CDC and Health Resources and Services Administration (HRSA) agreed to a mechanism allowing rural health centers and Federally Qualified Health Centers (FQHCs) to "delegate" authority to public health departments to provide these services. Therefore, local health departments became eligible for free federal vaccine to increase vaccine administration to children in the underinsured group. DSHS is seeking one FQHC in each Health Service Region that is willing to delegate authority.

Questions also arose regarding local health department credentialing process for the Children's Health Insurance Program. DSHS initiated discussions with Texas Health and Human Services Commission (HHSC) to simplify this process.

Lastly, DSHS currently does not anticipate purchasing meningococcal vaccine for adults.

Emergency Preparedness
DSHS funding for preparedness enhances the local entities ability to effectively respond to public health threats, from natural to manmade disasters. The proportion of preparedness funding for direct local public health services increased regularly since FY08. In FY13, the base funding

increased by eight percent as a result of a change in the federal allocation formula. DSHS incorporated this increase into funding allocations for local health departments.

Fiscal/Contracting Issues
For years, local health departments reported issues associated with entering into multiple DSHS contracts. Effective September 1, 2012 DSHS began bundling local contracts to decrease the time spent seeking signature authority. Local health departments still have separate contract attachments to allow for federal grant requirements. DSHS added language to categorical contracts (example immunizations) allowing agencies to use five percent of awarded funds for non-categorical activities including preparedness response, exercising and training. These changes permit greater flexibility.

DSHS awarded local health departments the authority to transfer 25% of funds between budget categories in non-competitive contracts. Previously the limit was 10%. In addition, new regulations allow equipment purchases up to $5,000 without prior approval. Previously this amount was set at $500.

Preventive Health and Health Services Block Grant
The Preventive Health and Health Services Block Grant provide funding for several DSHS activities, including grants to local health departments. During FY12, DSHS assumed a 19% reduction in funding. However, Congress reauthorized the grant and DSHS reinstated the 19% reductions to local health departments.

Laboratory Services
Currently, 19 city and county health departments provide lab services that range from testing drinking water to higher complexity testing. Compliance with lab regulations is burdensome. Therefore, lab directors are considering offsetting costs by charging a fee or seeking additional resources from the city or county.

HIV
The agency shared a presentation on the National HIV Surveillance System (NHSS) Cooperative Agreement (previously known as the HIV/AIDS Surveillance Grant). This is a cooperative agreement between DSHS and CDC to conduct certain HIV related activities. The NHSS is funded by the CDC and the new five-year competitive grant cycle will start in 2013. NHSS funds support several local health departments.

Environmental Health
DSHS also described its environmental health program. The Department has capacity challenges with regard to fulfilling inspection obligations. The committee is exploring options for local health departments to assist with the workload.

Government Affairs and General Counsel
The DSHS Center for Consumer and External Affairs liaised with the committee providing advice and linkages to elected officials. In addition, the Office of General Counsel provided guidance regarding concepts set forth in Senate Bill 969, open meetings requirements, and rules emanating from the bill.

SECTION IV: SURVEYS

Survey of Local Public Health Entities

Public health services in Texas are delivered locally in several ways (Texas Health and Safety Code Chapter 121). Local government may establish a health department, district or unit. Or the DSHS health service region may provide essential public health services for the local jurisdiction. Local public health entities in Texas customarily sort into two types: "participating" and "non-participating." "Participating" refers to health departments receiving state contracts funded through federal preventive health block grant; "non-participating" typically do not. The entities providing public health services in the state are diverse in funding, services, local versus state accountability, structure/formation, challenges and complexities. As a foundation for making policy and funding recommendations, the committee needed up-to-date public health entities' size services, and funding information.

In September 2012, the committee established a sub-committee to work with DSHS staff to develop and disseminate a survey to 129 known local health departments, districts, units, and DSHS health service regions. A survey tool was presented to the committee for comment and feedback and beta-tested with representatives from local health departments, health service regions, and DSHS central office staff. The sub-committee incorporated the feedback into the final survey instrument. The web-based tool was disseminated on September 5th, 2012 with official announcements and follow-up to increase survey response rate.

Data collection ended on September 28th, and produced an overall response rate of 45%. Among the 61 local health departments who receive DSHS Local Health Services Contracts funding the response rate was 75%. The data provides a snapshot of the total funding each respondent (participating and non-participating) received from local, state and federal sources for public health services. Not surprisingly, "participating" local health departments receive the bulk of state funding and larger urban health departments are more likely to receive federal funds directly than other health departments.

The survey results should assist the committee with defining a public health entity and determining funding needs. Given the permissive nature of state law related to public health services, local jurisdictions can opt to support local health department operations to the extent they wish. However, outside large metropolitan areas locally-supported public health services typically include general sanitation and environmental services. Some provide individual health care services and vital statistics, but few provide additional essential services. Prior to this survey there was little recent information on local public health funding.

Survey analyses provided basic distributions on key public health services (immunization, tuberculosis {TB}, HIV/STD, disease surveillance and Epidemiology, community preparedness, lab, PH regulatory, direct clinical care, WIC, oral/dental), and the specific functions within each service type, that local or multiple source funding supports. For example, 69% of respondents indicated they provide TB services. About 43% reported local funding for TB services and 18% indicated DSHS is their sole source of funding for TB services. Most local health departments (82%) provide immunization services funded by state (35%), local (37%) and other (27%)

revenue streams. Similar patterns exist for STD/HIV services, disease surveillance and epidemiological services, community preparedness, and regulatory services. Local health departments are less likely to provide clinical services (46%), WIC (46%), Lab Services (37%) and oral/dental care (17%).

In summary, services vary considerably across the state. There is no set of basic services universally available at the local level.

Texas Local Health Authority Assessment

Local Health Authorities (LHAs) are physicians, appointed by local governments, who take an oath to execute the duties of the office of Health Authority in the State of Texas. The statute mandates the local health authority to promote and protect the health of the appointing jurisdiction. This is done within the confines of state and federal laws, and in coordination with DSHS Commissioner of Health and staff. There is no training requirement or certification to act as a LHA. Statute calls on DSHS to provide an annual meeting of LHAs, efforts to identify, train, and coordinate with LHA have been incomplete.

In March 2012, DSHS Division for Regional and Local Health Services, through the LHA Education and Steering Committee, partnered with the Texas A&M Health Science Center School of Rural Public Health (SRPH) and the Texas Public Health Training Center, to conduct a survey of LHAs. The survey's purpose was to identify LHA needs for educational programs and support.

The survey showed the majority of LHAs were over the age of 50 (60%) and served in rural settings (60%). LHA position type is fairly equal between contract (34%), employee (33%), and volunteer (31%). The most common responsibilities cited by LHAs included: advising local government and elected officials on health matters (90.8%), responding to public health emergencies (90.8%), advising staff on actions to take regarding disease outbreak in their community (89.5%), and advising staff on actions to take regarding infectious diseases (86.8%).

Almost 50% of respondents had never attended an LHA educational program. Most of the LHAs who attended an educational program in the past five years lived in urban jurisdictions. The reported reasons LHAs participated in training included: education provided Continuing Medical Education (CMEs; 70%); and available online (46%), free-of-charge (45%), or held within 100 miles from practice or home (41%).

Eighty-eight percent indicated annual LHA-specific CME programs specific would benefit them and 70% indicated resources that outline all state law references to responsibilities of LHAs would be helpful. Respondents indicated interest in the following training topics:

- LHA Roles and Responsibilities (81%);
- Coordination between Public Health and Governmental Authorities (70%);
- Disease Surveillance and Reporting (73%); and
- Infectious Disease Prevention and Control (67%)

Those serving rural jurisdictions were much more likely to request training in disease surveillance and reporting than other jurisdiction types.

In Summary, the survey information will assist with developing and disseminating LHA CME in Texas. (See Recommendations D and E; pp. 25-27)

Accreditation Survey Summary

An important factor in quality enhancement of public health services in Texas is the accreditation of local health departments. Accreditation of public service (police and fire departments) and educational institutions (Kindergarten through 12th grade and higher education) is a standard approach for assuring these organizations comply with nationally expected criteria. The Public Health Accreditation Board (PHAB), a national, not-for-profit entity supported by the CDC and the Robert Wood Johnson Foundation extended this approach to local health departments. In Texas, local health departments in conjunction with the Texas Association of Local Health Officials (TALHO), responded to the challenge by establishing the Public Health Accreditation Council of Texas (PHACT).

To understand better and advance the accreditation process in Texas, DSHS contracted with the University of North Texas Health, Science Center School of Public Health to produce a readiness report based on a survey of participating health departments, a master plan for advancing accreditation, and an online toolkit to assist local departments by simplifying initial steps of the process. The readiness report identified several barriers to participating in the accreditation process. The barriers focused on the cost of the process and included the need for staff resources, time lost to other responsibilities, and accreditation fees, which depend on the size of the department. Additional barriers were the lack of technical support and the lack of commitment from governing authorities. (See Recommendation B, pp. 24)

SECTION V: COMMITTEE RECOMMENDATIONS

The charge to the PHFP Committee is broad. During the first year of deliberations the committee was strategically proactive and reactive. For example, the committee proactively took on items explicitly articulated in the enabling legislation; and reacted to situations arising as a result of testimony or events occurring in the state and national health arena. Some of the committee's recommendations led to DSHS altering procedures or implementing new approaches, other more complex recommendations will require additional time to develop and implement. The committee decided to present the recommendations in six conceptual clusters: (1) service and contract efficiencies; (2) accreditation of public health entities; (3) role of public health and the Texas 1115A Medicaid Waiver; (4) public health workforce; (5) public health program areas; and (6) healthcare reform and public health. Each recommendation is followed by a status summary and additional discussion if needed.

Maximizing Efficiencies of Resources

In response to TALHO White Paper recommendations and feedback from local public health and DSHS, the committee determined modifying the DSHS' contract process to mimic the federal contract process would result in more efficient use of resources. While these efficiencies are

primarily in staff time, it is anticipated that they will also result in other tangible efficiencies as well.

Recommendation A (1): The committee recommended to the DSHS Commissioner that the agency bundle noncompetitive contracts.

Progress to Date: Completed September 1, 2012

Discussion:
DSHS bundled multiple non-competitive grants into on core contract for a local health department. This process reduces the local health departments' administrative time and expense.

Recommendation A(2): The committee recommended to the DSHS Commissioner that the agency allow local health departments to utilize up to five percent of a grant funded staff's time for non-categorical activities.

Progress to Date: Completed September 1, 2012

Discussion:
DSHS confirmed that a local health department can use up to five percent of an individual's time on non-categorical activities, including preparedness training, participation drills, and exercises. (See Appendix C, pp. 38)

Recommendation A (3): The committee recommended to the DSHS Commissioner that the agency increase allowable budget category changes in noncompetitive contracts from 10% to 25%.

Progress to Date: Completed September 1, 2012

Discussion:
DSHS awarded local health departments the authority to transfer 25% of funds between budget categories in grant contracts. Previously the limit was 10%. The change provides: a) local health departments with flexibility to spend funds where needed, b) reduces the instances of having to seek approval from DSHS for transferring funds from one category to another and also reduces the amount of unexpended funds. (See Appendix D, pp.39)

Recommendation A (4): The committee recommended to the DSHS Commissioner that the agency increase allowable equipment purchases in non-competitive contracts from $500 to $5,000. (See Appendix D, pp.40)

Progress to Date: Completed September 1, 2012

Discussion:
DSHS increased the prior approval limit from $500 to $5000 for "equipment." This allows local health departments to purchase essential assets (minor laboratory equipment

and computers) without prior approval from DSHS. It saves DSHS and local health departments time and money by providing more efficiency in purchasing and eliminating the need to amend contracts to account for equipment purchases for less than $5000.

Accreditation

Accreditation of local and state health departments is a national initiative sponsored by the CDC and the Robert Wood Johnson Foundation to improve the quality of public health services. Accreditation emphasizes widespread accomplishment of the ten essential public health services by departments. The Public Health Accreditation Board (PHAB) was created to implement this voluntary accreditation process.

Recommendation B: The committee recommends to the DSHS Commissioner that the agency work with the Public Health Accreditation Board (PHAB) to pursue public health accreditation and serve as the model for all other public health entitles in the state. Furthermore, the committee recommends that DSHS explore ways to support local health department initiatives to seek public health accreditation.

Progress to Date: Pending

Discussion:
Several local health departments in the state initiated the accreditation process. DSHS began internal discussions regarding the accreditation process.

1115A Medicaid Waiver for Public Health

On December 12, 2011 the Centers for Medicare and Medicaid Services (CMS) approved the Texas request for a new Medicaid demonstration waiver entitled "Texas Healthcare Transformation and Quality Improvement Program" (Project #11-W-00278/6) in accordance with section 1115A of the Social Security Act. The 1115A Medicaid Waiver was approved through September 30, 2016. The 1115A Medicaid Waiver allows the state to expand Medicaid managed care while preserving hospital funding, provides incentive payments for health care improvements and directs more funding to hospitals that serve large numbers of uninsured patients.

The public health professionals in the regions of the state the committee visited reached a consensus that public health should play an integral role in the 1115A Medicaid Waiver process. Several public health programs, such as Immunization and Tuberculosis, are underfunded and the 1115A Medicaid Waiver could provide opportunities to expand and enhance these programs significantly.

Recommendation C: The committee recommends to the DSHS Commissioner that the agency work with the HHSC Executive Commissioner to grant special consideration to the area of public health under the 1115A Medicaid Waiver.

Progress to Date: Completed on 5/31/2012.
Correspondence sent to Commissioner David Lakey, MD, requested support for furthering local public health agencies' role in the 1115A Medicaid Waiver. In addition, correspondence sent to the Texas Comptroller of Public Accounts requested authorization to use state funds for the 42% match required for local health department 1115A Waiver projects. The committee encouraged regional and local health authorities to participate in their respective 1115A Waiver regional healthcare planning initiatives. (See Appendices B and E, pp. 36-40) The 1115A Medicaid Waiver provided funding for health care providers with a set-aside for public health.

Discussion:
The assurance of the five percent public health set-aside allowed local health departments to partner and participate in the 1115A Waiver process. This created the opportunity to show true delivery system reform and increased emphasis on prevention. However, the timeliness of the public health set-aside presented challenges to accessing resources.

Workforce

The public health workforce consists of an extensive array of professionals, performing technical and administrative roles. These roles vary in their complexity and their occurrence depending on local health department's size, organizational structure and relationship to DSHS regional and statewide public health services. Public health is undergoing substantial change with regard to degree training, financial pressures, and national governmental programming.

Recommendation D (1): The committee recommends to the DSHS Commissioner that the agency charge the Public Health Collaborative, consisting of the Schools of Public Health and Central DSHS administration, to develop a plan to identify and address workforce needs.

Progress to Date: Pending

Discussion:
The Committee recommends the existing Public Health Collaborative work with local health departments to develop a plan and make recommendations regarding public health workforce needs. This initiative would consider workforce needs for technical and administrative personnel.

Recommendation D (2): The committee recommends to the DSHS Commissioner that DSHS provide adequate resources and commit to meeting its statutory requirement for annual Local Health Authority (LHA) Continuing Medical Education (CME), and work with the committee to study, draft and vet language to clarify the LHA's role.

Progress to Date: Pending

Discussion:
Nearly 50% of LHA's received no formal training. The committee recommended annual training and a future study of their statutory roles and qualifications.

Programs

Public health testimony identified multiple statewide program needs and issues. In response the committee determined that implementing a few interim steps would improve services from the state to the local level. Those steps are reflected in the recommendations below.

Recommendation E (1): The committee recommends to the DSHS Commissioner that the agency seek adequate funding for the DSHS Division of Regulatory Services, Environmental and Consumer Safety Section, to ensure environmental programs function at full capacity throughout the State, or consider options for local health departments to perform regulatory duties on behalf of DSHS and retain adequate revenue collected from these activities.

Progress to Date: Ongoing.
DSHS has convened several meetings with local health departments to explore options.

Discussion:
The Division generates sufficient revenue to sustain its operations; however it does not have the authority to retain the revenue it generates. The ability to retain this revenue would provide sufficient funding for the Division to carry out its duties. Legislative changes may be required to ensure local health departments have the authority to carry out the regulatory functions of the Division and retain the funds.

Recommendation E (2): The committee recommends to the DSHS Commissioner that the agency enhance resources supporting the Infectious Disease Prevention program's capacity to identify and treat persons with active and latent Tuberculosis (TB) infection.

Progress to Date: Ongoing
DSHS submitted a TB exceptional item with their budget. Additionally, DSHS developed a TB work group to evaluate the TB program, including the TB Strategic Plan and the funding formula. The work group drafted the initial recommendations and will forward these to the committee for review.

Discussion:
DSHS must invest resources in the TB program to increase the use of new technology and community health workers in local health departments. Community health workers provide education, facilitate treatment, conduct patient referrals, and improve TB data for planning and evaluation interventions.

Recommendation E (3): The committee recommends to the DSHS Commissioner that the agency propose the use of 1115A funds to implement a TB strategy focusing on regional population-based activities.

Progress to Date: Request made of Commissioner and he is reviewing.

Discussion:
There is a clear distinction between role of public health and the delivery of individual clinical health care services. This distinction is critical in terms of addressing communicable diseases such as TB. Further, infectious disease prevention measures lead to less incidences of the disease.

Recommendation E (4): The committee recommends to the DSHS Commissioner that the agency seek resources to restore adult safety-net and Texas Vaccine for Children (TVFC) vaccines.

Progress to Date: Pending

Discussion:
Texas children's ability to receive immunizations from local health departments declined in January 2012 because of new DSHS guidelines and restrictions in the Texas Vaccine for Children (TVFC) and Adult Safety Net (ASN) programs. Local health departments throughout Texas must turn away children and adults in need of vaccinations. For example, many turn away college students requesting the mandated meningococcal vaccine because they can no longer order the vaccine through the adult safety net program. Local health departments now refer privately insured students to their Primary Care Practitioner (PCP). However, parents often report that the PCPs didn't stock the required meningococcal vaccine and referred the student back to the local health department for vaccines.

Recommendation E (5): The committee recommends to the DSHS Commissioner that the agency support and promote simplified credentialing for local health departments with Children's Health Insurance Program (CHIP), Medicaid and private insurance companies.

Progress to Date: Pending
DSHS received a CDC grant to evaluate health department immunization billing processes. DSHS hired the Public Consulting Group to survey local health departments and health service regions to assess their capacity to implement third party billing for immunization services.

Discussion:
Administering TVFC vaccine to Children's Health Insurance Program (CHIP) recipients obligates local health departments to bill the insurance company for the vaccine. Texas has numerous Medicaid and CHIP managed care organizations (MCO) and the local health department must credential with all the MCOs in their jurisdiction. The local health departments have difficulty becoming credentialed with the insurance companies. The committee requests that DSHS work with Health and Human Services Commission (HHSC) to develop a methodology and negotiate with MCSs to simplify the credentialing process to enable continued provision of vaccinations in Texas.

Healthcare Reform and Public Health

Recommendation F: The committee recommends to the DSHS Commissioner that Texas' response to Health Care Reform and state Medicaid planning continue to include deliberate provisions for public health agencies to provide preventive and population-based public health services.

Progress to Date: Pending

Discussion:
If Texas elects to implement the Affordable Care Act, the state should replicate the public health 5% set aside established with the Texas Health and Human Service Commission (HHSC) and Center for Medicare and Medicaid Services (CMS) under the 1115A waiver program. Such an investment would ensure increased public health system capacity for prevention and control of outbreaks, emerging threats, and community health improvement efforts. The committee feels that true transformation in health care funding must include consideration for the roles and solvency of the public health system as the two are interdependent.

SECTION VI: FUTURE DIRECTION OF THE COMMITTEE

During the Public Health Funding and Policy Committee's inaugural year, members have traveled throughout the state, receiving input from elected officials, academia, public health officials, and other citizens. We have heard many success stories. The innovative approach to tuberculosis management at the Hidalgo County Health Department, and the partnerships forged by the City of Garland Health Department and private health insurers regarding the delivery of immunizations are among them. In contrast, we also heard about many challenges. Shrinking public health budgets, workforce reductions, and about general lack of understanding of public health activities have been common themes. The committee will continue to analyze year-one qualitative input as we move forward.

The committee appreciates the opportunity to submit the recommendations previously listed in this document. We also look forward in our second year, to fulfilling more of the charges set forward in SB 969. This includes the following:

- To define core public health services a local health entity should provide in a country or municipality
- To evaluate public health in this state and identify initiatives for areas that need improvement
- To identify all funding sources available for use by local health entities to perform core public health functions
- To establish public health policy priorities for the state
- To continue to make formal recommendations to the Department of State Health Services

Finally, the committee will continue examining the impact of the Medicaid 1115A Transformation Waiver and the Affordable Care Act on Texas public health. In addition, the

Affordable Care Act could present Texas with unique opportunities for enhanced preventive and public health activities

SECTION VII: CASE STUDIES

TB in a High School – 2011

In the recent past, an active case of Tuberculosis (TB) in a school caused inconsequential community interest and minimal stress to the public health system. However, in September of 2011, this was not the case for one suburban Texas community. Due to a lack of local resources for proactive management of the circumstances, DSHS health service region provides this community's TB control and prevention services. Limited resources and negative media coverage of frustrated and concerned parents plagued the public health response. An after action report revealed the following contributing factors: shortage of public health nurses, limited agency media support, and cumbersome financial rules.

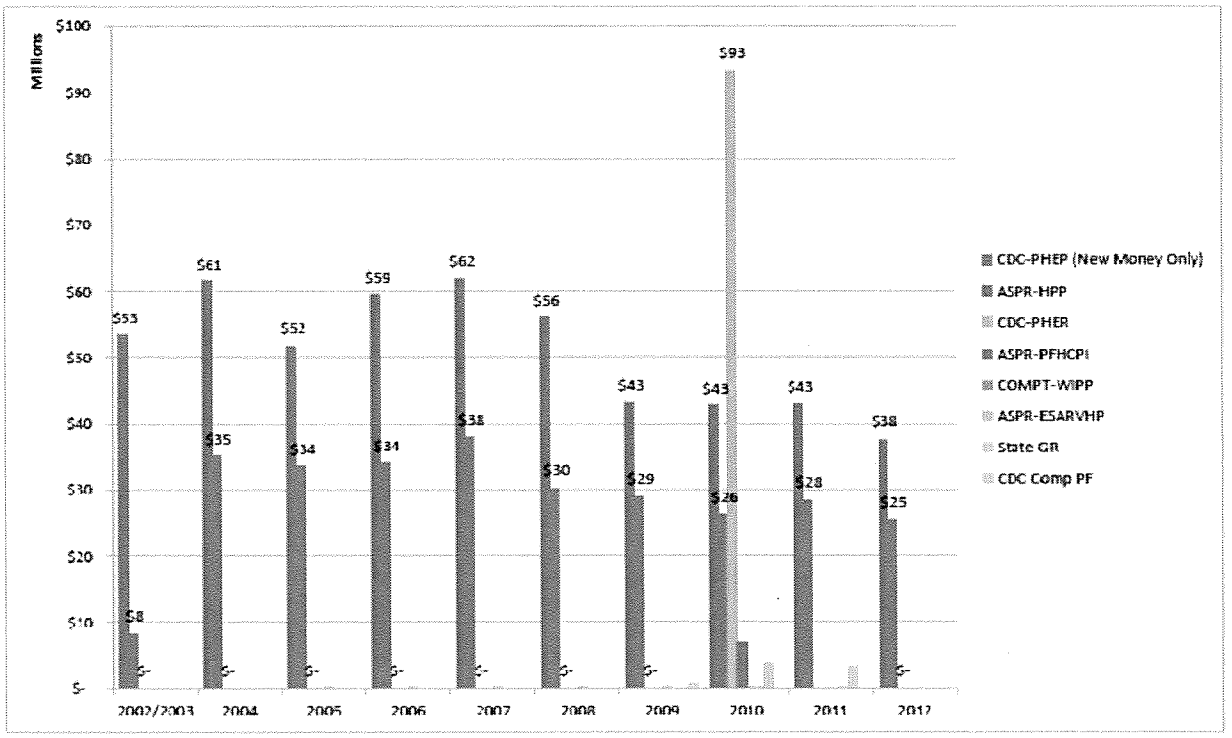
This example demonstrates the importance of providing essential public health services (monitor health status, diagnose and investigate, and inform, educate and empower) to the community. The investigation consisted of: conducting approximately 2000 TB skin tests with reading; identifying 12 additional active TB cases; investigating 508 "close contacts"; performing 300 chest x-rays, and initiating preventive treatment for 318 persons. Twelve persons diagnosed with active TB disease completed treatment and over 100 individuals completed treatment for latent TB infection. Overall, without treatment, about five to ten percent of infected persons develop active TB disease at some time in their lives. Therefore, these preventive health interventions averted approximately 32 future active TB cases in the community and Texas.

West Nile Virus – Case Study 2012

West Nile Virus re-emerged in 2012 to levels not seen in a decade and challenged our communities. Texas led the nation with 86 West Nile related human fatalities. Approximately half (134) of Texas Counties reported human West Nile Fever (WNF) cases. Of the 1,834 West Nile cases, 836 had the severe form of neuroinvasive disease.

In the past 10 years declining morbidity and mortality associated with mosquito-borne diseases resulted in a loss of infrastructure for vector control. In some areas of the state, the existing capacity shifted from health department disease prevention programs to non-health related departments that managed vector control as a nuisance program. The disease reemergence reinforced the need for: a) sustained public health funding; b) established and functional essential public health services (monitor health status; diagnose and investigate; inform, educate and empower; mobilize community partnerships; and develop policies and plans); and c) integrated environmental and vector control programs at the state and local levels. (See Figure 4, pp. 30)

Figure 4: Texas Preparedness Funding Trends



Accreditation - Case Study

The national movement to accredit local and state health departments has engaged many of the major public health organizations in the state, including the TALHO, the DSHS, the Texas Public Health Association (TPHA), and the accredited schools of public health. In 2007, TALHO created an Accreditation Committee to investigate the interest in and feasibility of local accreditation in Texas. Based on this work, TALHO established the Public Health Accreditation Council of Texas (PHACT). The purpose of PHACT is to assure and enhance the quality of public health in Texas and to prepare local health departments for voluntary national accreditation through the Public Health Accreditation Board (PHAB). The PHACT meets monthly to provide a forum for communication regarding (1) the needs of local departments and (2) the local, state, and the national resources available to assist local agencies. In addition, PHACT in conjunction with TALHO, TPHA, DSHS, and the schools of public health developed two statewide conferences.

The conferences focused on assisting health departments with: a) implementing the accreditation process, and b) completing the prerequisites (community health assessment, community health improvement plan, and department strategic plan). TALHO recorded and posted the sessions to a website for subsequent use. The PHACT remains a vigorous advocate for local public health accreditation throughout the state.

DSHS is actively involved in advancing accreditation by assessing local health department interest, needs and support in the accreditation process. DSHS contracted with UNTHSC School of Public Health to evaluate local health department accreditation readiness. Seventy-seven

percent of the 48 responding departments indicated they were considering submitting an application and 31% indicated they would do so by 2014. DSHS supported the development of a master plan to accomplish local health department accreditation statewide, and a toolkit to assist departments with the process. DSHS, in conjunction with the UNTHSC School of Public Health, created an approach to advance local health departments' preparation with prerequisite development, improved documentation of criteria accomplishment, and fulfillment of other aspects of the accreditation process.

Many local health departments are developing the infrastructure needed to accomplish accreditation and educating local authorities and citizens on the importance of setting a standard of excellence for public health in the state. To educate their leadership and staff members regarding the process, local health departments used the substantial resources available through PHAB and the National Association of City and County Health Organizations (NACCHO). Although state and local financial support will be needed to fund the process, the ground work is being laid to accredit local health departments in Texas.

Reducing Adult Potentially Preventable Hospitalizations Initiative – Case Study

The 82nd Texas Legislature appropriated $2 million to DSHS to reduce potentially preventable hospitalizations in FY 2012/13 (09/01/11 - 08/31/13). With the appropriation, DSHS contracted with the following 16 countries: Angelina; Brooks; Ector; Grayson; Hunt; Liberty; Limestone; Nacogdoches; Orange; Polk; Red River; San Augustine; Tom Green; Trinity; Victoria; and Walker County. The 16 counties are targeting one or more of the following adult potentially preventable hospitalizations: Bacterial Pneumonia, Dehydration, Urinary Tract Infection, Congestive Heart Failure, Hypertension, Asthma, Chronic Obstructive Pulmonary Disease and Diabetes Complications.

The 16 county's projects are coordinating a public health approach to implementing one or more evidence-based interventions. These interventions include: immunizations, patient educations, community education, smoking cessation, healthcare provider education, diabetes self-management education, patient case management, nutrition and physical activity, weight management, glycemic control and blood pressure control. Early results reveal these community based public health interventions are successful in improving individual health, preventing hospitalizations, and saving money. This activity could be adopted by local health departments and other entities to assist in improving community health.

APPENDICES

Appendix A:
Monthly Committee Meetings

Austin, TX – October 24, 2011

Austin, TX – December 5, 2011

Austin, TX – January 9, 2012

Austin, TX – February 6, 2012

Arlington, TX – March 22, 2012

(1) PHFPC meeting held at the Texas Public Health Association's 88th Annual Education Conference

- Medicaid 1115 Waiver
- Defining of Public Health Core Services

Austin, TX – April 19, 2012 (TALHO)

(1) Ector County Health Department

- Public health training; stated they had received funding but had no trained staff able to use the funds
- Identify a contingency pool for leftover funds from DSHS

(2) City of Amarillo

- TB funding; need to revisit the formula funding
- All hazards funding for preparedness to train health department staff to respond to public health events

(3) Hidalgo County

- Need to incorporate regional health planning related to Medicaid 1115 Waiver

Edinburg, TX – May 31, 2012

(1) Hidalgo County Health Department

- Local health departments and public health partners must be part of the regional health teams
- Medicaid 1115 Waiver and the role of DSHS to help with public health needs
- Enhancing communication between local health departments and Regional/Central DSHS
- Limited Resource

(2) City of Laredo Health Department

- Increased need for resources for lab capacity at the local health department level
- Funding allocations in South Texas; needs to equitable
- TB in South Texas; border issues; TB continues to be a threat to U. S. and Mexico
- TB funding continues to be cut and downsized yet the threat continues to increase
- Food-borne illness prevalent at the border
- Detecting and enforcing regulations

(3) Cameron County Health Department

- Funding from DSHS - current formulas are not working
- Infrastructure
- Resources
- Responding to public health events; could be accomplished by pooling funds and cross-training public health staff (currently get "dinged" by DSHS)

San Antonio, TX – June 26, 2012

(1) DSHS Region 8

- Comprised of 28 counties
- Access to health care
- Correctional facilities disease burden
- TB disease
- Communicable disease/outbreaks

Andrews, TX – July 19, 2012

(1) DSHS Region 9/10

- Large in scope (size of Michigan) and small in population; considered frontier
- TB program understaffed
- Public health staff recruitment and retention
- Lack of access for immunizations because of new Vaccine for Children eligibility requirements
- Need for clearly defining the role of the local health department

(2) DSHS Region 1

- Larger geographic area and scattered population
- 41 counties with 4 local health departments
- Lack of health care access
- "Frontier County"
- Staffing - positions are vacant due to lack of applicants

(3) Ector County

- Midland/Odessa
- Lack of public health education and public health nurses
- Midland local health department concerned with lack of core public health services for prevention; workforce issues; not able to compete with salaries for public health staff
- Lubbock local health department concerned with budget constraints and keeping the health department open as the City of Lubbock considered cessation of their funding; resulting in restructuring public health by moving environmental, vital records, public health emergency preparedness (PHEP), and vector control out of public health; other concerns centered on staffing issues, immunization services, and public health infrastructure

El Paso, TX August 16, 2012

(1) DSHS Region 9-10

- Region is widespread; consists of > 61,000 square miles and includes 36 counties
- Challenges: Rapid population growth, Recruitment of public health personnel offering competitive salaries, Funding cuts to public health
- TB funding

(2) City of El Paso Health Department

- Communicable diseases - pertussis cases increasing; epidemiology staffing
- Providing immunizations to control disease spread
- Ability to provide safety net in the community
- Lab capacity
- Lack of access to health care
- High uninsured rate

Texas City, TX September 21, 2012

(1) DSHS Region 6/5S

- Texas fastest growing population with the highest uninsured rate
- Significant shortage of trained public health professionals; difficult to recruit
- Distribution of physicians is a problem; only 1 in 3 providers accept Medicaid/CHIP patients
- Need to expand safety net of hospitals
- More funds need to be put into prevention; cannot sustain current healthcare system

(2) DSHS Region 7

- Has 16 counties with population more than 6 million
- Challenges include recruiting and retaining qualified public health staff with limited state resources in a competitive job market

(3) City of Houston

- Support for training to recruit public health professionals
- Need to provide an annual training to educate local health authorities and provide ongoing support
- Barrier-time and money for regulatory enforcement
- Challenges-loss of positions in epidemiology and lab due to funding cuts
- Increasing expectations with level funding
- Recruitment and retention of qualified public health personnel
- Lab equipment replacement is not funded
- HIV prevention activities
- Syndromic surveillance system
- Flexibility in programs and grant activities
- Prevention activities to decrease health care costs

(4) Galveston County Health District

- DSHS needs to provide timely clarity on Medicaid 1115 Waiver to local health departments
- Training to local health departments on billing Medicaid/CHIP and private insurance for immunizations
- Need more efficient delivery model for public health in Texas
- Need for state leadership and guidance
- Need for a TB funding formula that establishes equity in the distribution of funds

Tyler, TX October 25, 2012

(1) City of Tyler

- Challenges: Focus on prevention

(2) Angelina County Health and Human Services

- Public Health Infrastructure to core public health functions

(3) NET Health - Northeast Texas Public Health District

- Core public health functions: TB funding, PH Infrastructure
- Food Safety with revision of Food Establishment Rules
- Revenue and funding strategies

(4) Cherokee County Health Department

- Challenges: "Silos" that exist in public health
- Public Health needs to focus on prevention
- Challenges: Primary Health Care, Women's Health and Family Planning

(5) Paris-Lamar County Health

- Challenges: High number of uninsured population
- Funding streams
- Has no full time epidemiologist

(6) DSHS Region 4/5N

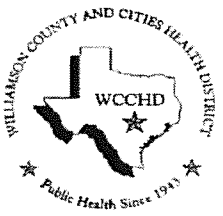
- Consists of large rural population with many negative health indicators
- Lack of access to health care
- Lack of infrastructure in public health
- Sickness-based system instead of focusing on preventive-based system

Appendix B

WCCHD Board of Health

Kerry Russell, Chair, Williamson County
Katherine M. Galloway, Cedar Park
Rob Hardy, Georgetown
Florence Winkler, Liberty Hill/Hutto
Andy Martinez, Round Rock
Pamela Sanford, Taylor
Mary Faith Sterk, Williamson County

W. S. Riggins Jr., MD, MPH, WCCHD Executive Director/Health Authority



April 23, 2012

Dr. David Lakey
Commissioner of Health
1100 W. 49th Street
Austin, TX 78756

Dear Dr. Lakey:

On behalf of the Public Health Funding and Policy Committee and its Policy Workgroup, I would like to request your support for furthering Local Public Health Agencies' (LPHA's) role in Texas' 1115 Transformation and Quality Improvement Waiver design. It is our hope that the aggressive timeline for implementation does not preclude a thoughtful and deliberate inclusion of Public Health agencies through process and projects along with Mental Health Authorities as together, we try to leverage this Waiver to improve outcomes as well as the effectiveness and efficiency of the public health system in Texas. As you know, this waiver comes at an opportune time for us. Local Health Departments across Texas are preparing for voluntary accreditation, are working to sustain local coalitions for Community Health Assessments (CHA's) and Community Health Improvement Processes (CHIP's). To seize this moment and achieve the vision of a truly systematic approach to transformational change, we offer the following recommendations.

First we would like the list of required Regional Healthcare Partnership (RHP) membership be amended to include representatives of any Local Public Health Agencies in that region in addition to the DSHS Regional Director as currently required. This will help leverage synergies with any current or future community-wide CHA/CHIP processes, and insure local epidemiologic data is brought to the RHP table along with state and institutional level data. The list of Community Data and Resources for RHP Assessment of Needs should likewise be updated to include the CHA as a Report for additional County Level Data available from the LPHA.

Secondly, we recommend each of the 4 categories of the DSRIP project list be organized to include a field "Expand/Improved/Enhance Public Health and Preventive Services" project area category to complement those for "Primary Care" and "Behavioral Health." The attached Spread sheet contains examples of the reworded project area that will serve to reflect the collaborative and supportive roles of Public Health Agencies in system re-design. Local Health Departments may likely use participation in RHPs as examples of community CHA/CHIP processes and conversely huge potential synergy will come to RHP's that follow nationally recognized processes such as Mobilizing for Action through Planning and Partnership (MAPP).

Administrative Services • 100 West Third Street, Georgetown, TX 78626 • 512-943-3600 • Fax: 512-943-1499
Visit *your public health department* online at www.wcchd.org

(Appendix B continued…)

Many local health departments serve as the primary care safety net in their community while others compliment primary care providers with clinical preventive services for specific acute and chronic disease prevention. They have expressed the desire for more projects that reflect the need to create a stronger patient centered neighborhood by adopting the electronic health record and linking for better coordinated care, less duplication and fewer missed opportunities for prevention.

I would like to thank you for your leadership and for helping insure the inclusion of Projects that reflect the interdependence of Hospitals and Health Departments on the Clinical Champions Workgroup. We were pleased that the Executive Waiver Committee includes representatives of TALHO and Schools of Public Health but even with them, your task is daunting. Local Public Health Agencies have never been systematically drawn to the table but as the value and potential cost savings from a data-driven prevention and collaborative process grows, we will be here…anxious to join with hospitals to insure optimal outcomes for our healthcare dollar. Thank you for your support and for doing everything possible to see that the 1115 Waiver brings Quality Improvement for Health Care and Public Health together.

Sincerely Yours,

W.S. Riggins Jr. MD, MPH
Executive Director/Health Authority, WCCHD
Member, Public Health Funding and Policy Committee

Cc: Mr. Billy Milwee

Appendix C

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Disease Control
and Prevention (CDC)
2920 Brandywine Road
Atlanta, GA 30341-3724

DATE: June 2, 2006

TO: All State and Local Government Public Health Partners who receive CDC Categorical Grants and Cooperative Agreement Funds:

FROM: Office of the Director, Procurement and Grants Office

SUBJECT: Supporting and Funding Emergency Preparedness and Response Activities

Due to ever increasing emphasis on public health emergency preparedness and response, questions have been raised concerning the participation of employees whose salaries are paid for by CDC categorical grants and cooperative agreements that are not tied to preparedness and response activities (i.e., Sexually Transmitted Disease, Tuberculosis Control and Prevention, Chronic Disease and Health Promotion, Cancer Prevention, and a number of others). The purpose of this letter is to clarify PGO's policy in this regard.

The scope limitations of CDC's categorical cooperative agreements do not preclude participation in activities related to maintaining safe and secure working environments by individuals employed with grant funds. The participation of such employees in first-aid and safety training, fire and disaster drills, and general in-service education during normal (non-emergency) times is covered routinely by categorical grant funds. In today's world, the obligation of public health agencies to prepare for the catastrophic consequences of terrorism and naturally-occurring events necessitates involvement of the entire public health workforce in preparedness, in the same way that all staff are expected to participate in safety and security drills. In general, approximately 5% of an individual's time is a reasonable amount for staff supported with grants funds to spend on non-categorical activities, including preparedness training and participation in drills and exercises in the pre-event time period. However, actual costs associated with developing and conducting preparedness training should still be covered by existing emergency preparedness and response resources.

Restrictions in the scope of CDC's categorical grants and cooperative agreements must never prevent individuals employed with CDC grant funds from reasonable participation in public health readiness activities sponsored by their agency. For accountability purposes, when staff paid with CDC non-preparedness grant/cooperative agreement dollars are tasked to support preparedness and response activities, records should be kept by the grant recipients to document time spent on these activities.

This policy should be disseminated to all local health departments and other recipients of funding from CDC grants and cooperative agreements. Please contact your Grants Management Specialist or Project Officer if further information is required.

William Nichols, Director
CDC Procurement and Grants Office

Appendix D

Local Health Department Consolidated Contract Announcement

The Department of State Health Services is pleased to announce we have an initiative currently underway for the FY13 contracts. Non-competitive sub-recipient contracts will be migrated to **one core contract** with attachments for each program by 9/1/2012. This will also include reduced onsite monitoring visit starting in State Fiscal Year 13.

As part of this effort, we are evaluating changing the restrictions we place on budget category changes from the current 10% to 25% within the boundaries of Federal requirements. This also includes evaluating increasing the equipment threshold from $500 to $5,000. More information will be available on this potential change in late spring 2012.

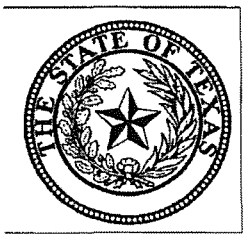
Here is a brief summary of what you can expect between now and 9/1/2012:

- **April 2012:** Amendment packages will be distributed for approximately 146 of the 277 contracts within the scope of this effort requiring extensions or reductions to align with the State Fiscal Year. While amounts for contract years may change, overall funding to local health departments is not being reduced or increased as part of this streamlining effort.
- **May 2012:** Amendments Executed, Renewals packets for contracts starting 9/1/2012 will begin.
- **July 2012:** Renewal contracts will be distributed under one contract for each local health department with all non-competitive programs as attachments to be effective 9/1/2012.
- **September 2012:** All Renewals will be complete

More information will be provided in mid-April of 2012 via a to-be-scheduled open forum/open mic call where you will learn more information in a free form question and answer format. All information from the calls will be distributed for those who are unable to attend.

If you would like additional information regarding the initiative, please contact Patty Melchior, Director, at (512) 776-2115, or e-mail to patty.melchior@dshs.state.tx.us.

Appendix E



Public Health Funding and Policy Committee
Department of State Health Services (DSHS)
P.O. Box 149347. Austin, Texas 78714-9347

June 15, 2012

To: All Regional and Local Health Authorities

Re: Medicaid 1115 Waiver

The DSHS Public Health Funding and Policy Committee would like to encourage all regional and local health authorities to contact the anchor agency in their regions to ensure public health agencies are included in the their respective 1115 Waiver regional healthcare planning initiatives. Each region has established deadlines to meet the Texas Health and Human Services Commission requirements and any delay may impact your agency's ability to participate in strategic planning for your region and in some cases receive funding.

The attached document provides information regarding how to get involved in your region's healthcare plan and includes a list of Delivery System Reform Incentive Payment (DSRIP) projects. The projects in the first two categories appear to be good for local public health engagement.

Additionally, below is a link to the Texas Health and Human Services page that provides the regional map of Texas and the Anchor Contact List.

http://content.govdelivery.com/bulletins/gd/TXHHSC-43e81f?reqfrom=share.

Please contact your Regional Anchor for additional information regarding this matter.

Sincerely,

Stephen L. Williams, M.Ed., M.P.A.
Chair, Public Health Funding and Policy Committee