


# ARIZONA **HEALTH** FUTURES

DECEMBER 2011



## PUTTING THE PIECES (BACK) TOGETHER

*Public Health and Prevention*

Part II: Arizona's Emerging Healthcare Landscape



# Putting the Pieces (Back) Together:

## An Overview

Budget cuts and other changes occurring at a state and national level are reshaping our public health system.

State funding for public health is disappearing. Local funding for core services is being squeezed. Federal funding is up, down, possible or uncertain – depending on the issue area (or the day). Grant money is filling some gaps, but such funding is becoming increasingly competitive to seek. National funders are also demanding new approaches to achieving public health goals.

Some changes are weakening the public health infrastructure. In other instances, changes are causing public health leaders to innovate, collaborate or rethink their roles. What is clear: public health is transforming, though the shape of its future is still being defined.

### Second of Three Reports

This publication, *Putting the Pieces (Back) Together*, is the second in a series of three reports on Arizona’s changing healthcare landscape.

In these reports, we consider how budget cuts and other changes are affecting Arizona’s health system and the people it serves. In all three reports, we also consider the implications of the changes and the challenges – and the opportunities – ahead.

Our working premise for all three reports is that change – even bad change – presents new opportunities. When change occurs and challenges mount, it is time to rethink business-as-usual. You don’t run away from change or ignore that it is occurring. You figure out a plan for managing the change – or even taking advantage of it. It’s what we teach our kids, and it’s how we try to handle problems in our day-to-day lives. It is the responsible thing to do.

This report focuses on changes and trends occurring in the area of public health. Our scope includes state and local health programs; prevention; planning, preparedness and emergency response; and surveillance, assurance and disease control. An earlier report addressed changes that are occurring that affect our state’s most vulnerable citizens, including people with behavioral health needs, and adults and children with other special health needs. The last report will focus on our state’s healthcare safety net.

Our hope is that these reports will provide an overview of the many forces that are changing our healthcare landscape – and opportunities to reshape or rethink systems moving ahead. Our goal is to spark some new ideas and inspire a conversation about what is possible for our state moving forward.

*“I would just like a crystal ball so I could know where to position myself for 2015.”*

*Local health officer*





# Arizona's Public Health System

## The Behind-the-Scenes Player with a Major Role

Public health plays a critical role in helping communities and individuals thrive. However, rather than being in the spotlight, it more often than not works behind the scenes, assessing and monitoring the health of communities and populations, preventing the spread of disease, and influencing and formulating policies and partnerships to identify and solve health problems.

In the 1988 report, *The Future of Public Health*, the Institute of Medicine defined public health as “an organized community effort aimed at the prevention of disease and the promotion of health.” From this definition flows its central mission: to “fulfill society’s interest in assuring conditions in which people can be healthy.”

In Arizona, the Arizona Department of Health Services (ADHS) serves as the state’s public health leader. By statute, the Department is responsible for a wide array of public health-related activities, including (but not limited to):

- Public health nursing
- Emergency response
- Laboratory services
- Vital statistics
- Epidemiology
- Communicable disease prevention and control
- Dental caries prevention
- Nutrition services
- Immunizations
- Health education and training
- Chronic disease prevention
- Community health services
- Comprehensive health planning
- Licensure<sup>1</sup>

The Department has historically funded these activities through federal funds, state general fund appropriations and other funds (including collected fees and other grant monies).

The Department works in tandem with county health departments, often delegating duties when they are more appropriately performed at the local level. (For example, some local health departments are responsible for inspecting restaurants.) The Department also contracts with county health departments (except for Maricopa County and Pima County, which are excluded by statute) to provide core public health functions at the local level, providing them with limited financial support (until recently). In addition, the Department enters into contracts with all counties to perform a wide variety of services for the counties, ranging from immunizations and communicable disease surveillance to administering child nutrition programs.



*“When public health works, nothing happens.”*

*Local health administrator*

The counties, in turn, also play an important public health role. By statute, local county health departments are responsible for providing “essential public health services.” State law requires that county boards of supervisors establish a county health department or a public health services district to develop these services with the use of any combination of state, federal or local funds.<sup>2</sup> The latter may include special assessments specifically dedicated to local public health services. Local health departments’ services are also funded by private grants and assessed fees. Many county health departments also provide limited direct health services such as immunizations, allowing them to draw dollars from sources such as Medicaid and Medicare. Nationally, local health departments rely more heavily on Medicaid and Medicare for funding than in Arizona.<sup>3</sup>

## Ten Essential Public Health Functions

1. **Monitor** health status to identify and solve community health problems.
2. **Diagnose and investigate** health problems and health hazards in the community.
3. **Inform, educate,** and empower people about health issues.
4. **Mobilize** community partnerships and action to identify and solve health problems.
5. **Develop policies and plans** that support individual and community health efforts.
6. **Enforce** laws and regulations that protect health and ensure safety.
7. **Link** people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. **Assure** a competent public and personal healthcare workforce.
9. **Evaluate** effectiveness, accessibility and quality of personal and population-based health services.
10. **Research** for new insights and innovative solutions to health problems.

Source: American Public Health Association, <http://www.apha.org/programs/standards/performancestandardsprogram/resexentialservices.htm>.

# Arizona's Need for a Strong Public Health System

The more we learn about health, the more we recognize that very little of what affects our health occurs within the walls of a doctor's office or a hospital. For example, evidence now suggests that medical care accounts for only 10 to 15 percent of preventable early deaths.<sup>4</sup> In contrast, social, environmental, behavioral and genetic factors play a profound role in affecting our health.<sup>5</sup>

Public health can play an important role in influencing such factors. While others have noted that "medical thinking has been largely concerned with the needs of sick individuals,"<sup>6</sup> public health's focus is population health. Its aim is to create the conditions for the entire population's health to thrive.

Public health has numerous "tools" that it can and does use to address population health. It supports individual and community health efforts. It enforces laws and regulations that protect health and ensure safety. It diagnoses and investigates health problems and health hazards in the community. It also can affect public policy that influences many of the social, environmental and behavioral determinants of health.

In many ways, the need for a strong public health system has never been greater – although the challenges that it faces today are far different than those experienced in the past. Years ago, issues such as vaccinations, clean water and disease outbreak were of paramount concern. Today, while these are still important issues, we largely take for granted that children will be immunized, diseases will be controlled, and the water we consume will be safe. We make such assumptions largely because the public health system has worked so effectively over the years. As one public health professional we interviewed admitted, "We are victims of our own success."

Today, the leading causes of death are no longer related to infectious diseases but instead to chronic conditions such as heart disease and diabetes.<sup>7</sup> Accordingly, dramatic increases in obesity and chronic disease require attention. The rate of childhood obesity grew faster in Arizona than in all other states over the past few years, from 12 percent to 17 percent – a 45 percent rate of change from 2003 to 2007.<sup>8</sup> Experts project that if obesity rates continue to climb, today's young people may be the first generation in American history to live sicker and die younger than their parents' generation.<sup>9</sup> By 2018, if national childhood obesity rates continue to increase at their current levels, the U.S. will spend an expected \$344 billion on healthcare costs attributable to obesity – 21 percent of the nation's direct healthcare expenditures.<sup>10</sup>

Public health also faces other daunting challenges. For example, our aging population places new demands on our public health system. As the population grows older, there is a greater need for community-based efforts to prevent and manage chronic disease. More emphasis will be needed on evidence-based, fall-prevention efforts. And more focus will be needed on ensuring that older adults receive flu vaccines.<sup>11</sup>

Of course, there are many other public health issues needing attention in our state. Unfortunately, the reality is that Arizona's commitment to public health has been historically weak. We trail other states in public health (state and federal) spending per capita, \$48 versus the national average of \$94.

Local health spending in our state varies substantially, due to a variety of factors, including the tax base of different counties, whether or not they have the taxing authority of a local health district, local commitment to public health and the scope of services provided. But most local health funding falls far below the national norm. In 2008, the average national per-capita spending for a county health department was \$65.



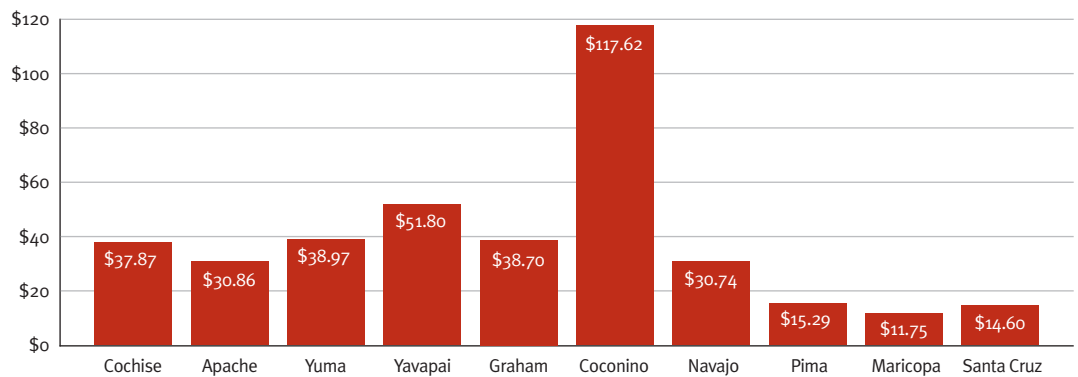
*“Measures to improve public health, relating as they do to such obvious and mundane matters as housing, smoking, and food, may lack the glamour of high-technology medicine, but what they lack in excitement they gain in their potential impact on health, precisely because they deal with the major causes of common disease and disabilities.”*

Geoffrey Rose, *The Strategy of Preventive Medicine* (1992)

In 2010, Arizona ranked 47th in the country for public health spending per capita (state and federal spending).

America's Health Rankings

**Figure 1: Total Per Capita Local Health Department Funding by County**

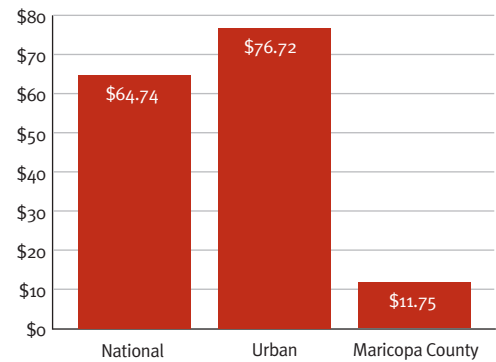


Source: National Association of County and City Health Officials (NACCHO) The 2008 National Profile of Local Health Departments.

In quite a few instances, the funding discrepancies are dramatic. For example, for the Maricopa County Health Department – the third largest local health department in the country – funding was \$11.75 per capita, or less than one fifth the national average.

Arizona lags behind the rest of the country on many health indicators. These national health rankings aren't surprising given the context of per capita public health funding in the state, although we are ahead of other states in areas such as physical activity (5th highest in the country) and smoking (11th lowest in the country).

**Figure 2: Local Health Department Funding Per Capita, 2008**



Source: National Association of County and City Health Officials (NACCHO) The 2008 National Profile of Local Health Departments.

### Arizona's State Health Ranking\* According to Select Public Health Indicators

Physical Activity	5th
Cardiac Heart Disease	10th
Prevalence of Smoking	11th
Daily Fruits and Vegetables	20th
Motor Vehicle Deaths	23rd
Percent of Children Ages 10-18 Who are Overweight	24th
Infectious Disease	31st
Percent of Adults Age 50 and Older Receiving Recommended Screening and Preventive Care	31st
Immunization Coverage	33rd
Percent of Adult Diabetics Receiving Recommended Preventive Care	33rd
Prenatal Care	43rd
Suicide Deaths per 100,000 Population	44th
Teen Birth Rate	45th

\* The lower the number the better the ranking. For example, Arizona was 5th in the nation in physical activity, making it one of the healthiest states in this area.

Sources: America's Health Rankings, 2010 and The Commonwealth Fund State Health Scorecard, 2009.

# Budget Cuts and Their Impact

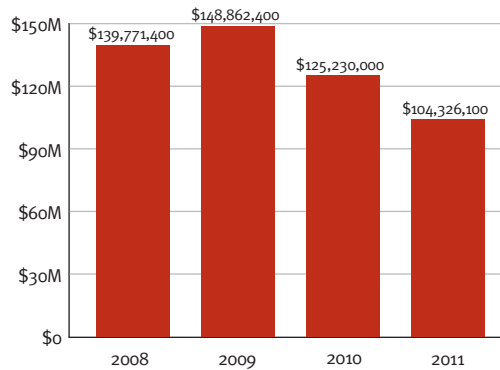
## State Budget Cuts

While Arizona has never dedicated itself to adequately funding public health, its commitment has fallen precipitously over the past several years during our state’s budget crisis.

State funding for all non-Medicaid health services has fallen 47 percent over the past four years. Federal grants and American Recovery and Reinvestment Act (otherwise known as ARRA or “stimulus”) funding have been able to reduce the overall impact of the state general fund reductions; however, even with federal and other non-appropriated funds included, ADHS public health funding has fallen by 25 percent from \$139 million in FY 2008 to \$104 million in FY 2011.

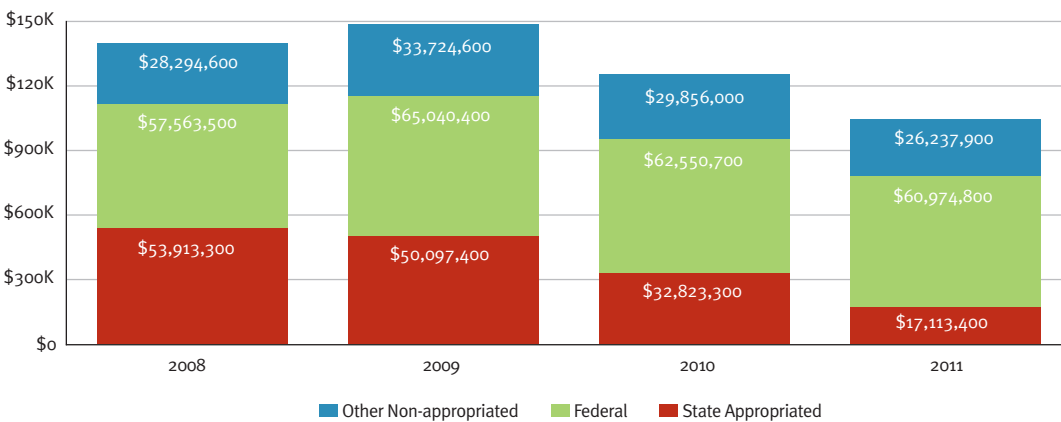
During the same time period, state general funds<sup>12</sup> specifically for public health have dropped from \$54 million in FY 2008 to \$17,113,400 in FY 2011, a 68 percent decrease. The last time Arizona’s general fund budget was of a similar level was in 1998 (\$16.7 million), when Arizona’s population was approximately 5 million compared to its 2010 population of 6.4 million. While state funding for ADHS has never been significant (comprising less than 20 percent of its budget), the state cuts have – by any measure – been substantial.

**Figure 3: Total Public Health Budget, Arizona Department of Health Services**



Source: JLBC Appropriations Reports FY 2008, FY 2009, FY 2010 and FY 2011.

**Figure 4: Public Health Funding by Fund Source, Arizona Department of Health Services, FY 2008-2011**



Source: JLBC Appropriations Reports FY 2008, FY 2009, FY 2010 and FY 2011

Among the reductions were funding cuts in many of the Health Department’s primary areas of responsibility, including prevention and planning (\$33,638,860), preparedness and emergency response and surveillance (\$10,264,300), and assurance and disease control (\$9,286,400).

*“It’s not the cuts. It’s the pitiful place where we started to begin with.”*

Local health department administrator



State funding for public health has decreased 68 percent over three years.

## Prevention Funding

Many prevention programs funded with state general funds have been eliminated during the past three years. Other programs such as laboratory services and high-risk perinatal services have been dramatically reduced. Overall state funding for prevention programs was reduced by nearly \$34 million. The cuts include:

- Over \$1 million in cuts for prenatal services provided by counties, affecting 19,000 women.
- \$400,000 in cuts for diabetes prevention and awareness.
- Over \$600,000 in cuts to laboratory services, resulting in the closure of the Tucson and Flagstaff health labs and the freezing of existing positions.
- Nearly \$700,000 in reductions to rural counties for prevention-related services.
- Over \$10 million in cuts to community health centers for primary care services.
- A \$2.8 million reduction in services for women with high-risk pregnancies and their at-risk infants.
- A \$1.5 million funding reduction for abstinence education.
- A reduction of \$500,000 for youth methamphetamine prevention efforts.

## Planning, Preparedness and Emergency Response

Reductions of over \$10 million have been made to licensing and emergency preparedness training<sup>13</sup> programs since FY 2008.

In response to cuts to funding related to the Department's licensure and oversight of medical and child care facilities, fees have been newly implemented or increased. Even with these fees, ADHS anticipates delays in surveys and complaint investigations, potentially leaving vulnerable Arizonans at increased risk. Twenty-nine surveyor positions are currently unfilled.

ADHS has also curtailed some of its emergency preparedness funding. For example, it suspended training grants (\$250,000) for first responders in the state. While the dollar amount of the cut is not large, the difficulty – once again – is that Arizona faced challenges related to emergency preparedness *before* the cuts occurred. For example, a 2009 assessment of Arizona's public health preparedness conducted by the Trust for America demonstrated Arizona's lack of emergency preparedness in 10 key areas. Arizona met only five of the 10 indicators assessed for pandemic preparedness.<sup>14</sup>

## Surveillance, Assurance and Disease Control

Surveillance, assurance and disease control play a vital role in ensuring the health of Arizonans. These services allow state and local agencies to monitor and track infectious and other diseases in Arizona, conduct investigations when disease outbreaks occur, and coordinate disease prevention and control activities.

Over \$9 million in state funding cuts to surveillance, assurance and disease control have occurred over the last four years. State funding for three specific programs have been eliminated: Sexually Transmitted Disease (STD) Control, Hepatitis C Surveillance and Valley Fever Surveillance. Additionally, ADHS has reduced the number of staff who work in this area, including epidemiologists responsible for surveillance and analysis.

Other cuts in this area include:

- Reducing county contracts for tuberculosis care by 58 percent (\$818,000).
- Trimming funding for database monitoring of AIDS cases (\$125,000).
- Cutting funding for poison control call centers (over \$1.2 million).
- Reducing Alzheimer's research (\$2.8 million).





## Federal Funding Changes

Overall, total public health funding for the Arizona Department of Health Services has declined less dramatically than public health funding from state-only dollars. In part, this has been attributed to federal stimulus dollars, which provided approximately \$9 million in time-limited monies for public health services in recent years.

### American Recovery and Reinvestment Act 2009 Arizona Department of Health Services

Purpose	Amount
Fund immunization-related activities including education campaign, improvements to data quality	\$3,741,938
Provide nutrition support and support physical activity, tobacco policy change initiatives in schools, hospitals and worksites	\$950,018
Integrate tobacco cessation into behavioral health provider communities, increase Arizona Smokers Helpline (ASH) utilization, increase client referrals	\$817,621
Improve oversight of ambulatory surgical centers to reduce the incidents of healthcare-associated infections	\$461,871
Investigate cases to determine if newly licensed meningococcal conjugate vaccine is effective in preventing disease	\$91,000
Support for WIC technology improvements	\$2,952,662
Improve the health of Arizonans by increasing workforce development for the National Health Service Corps to increase the number of safety net providers throughout the state	\$53,775

Source: ADHS, Public Information Office, May 2011.

However, federal stimulus dollars and funding for emergency preparedness (which surged after 9/11) are now disappearing. In addition, other significant federal funding cuts are beginning to occur.

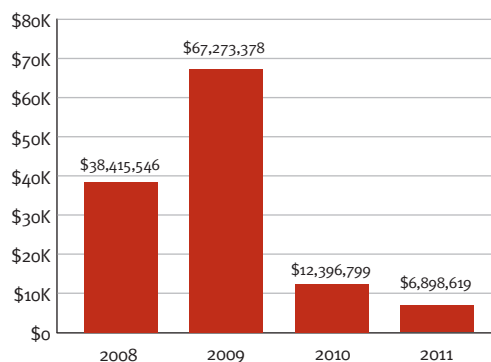
Between 2008 and 2011, ADHS received multiple federal grants for emergency preparedness, chronic disease control and prevention. At their peak, they provided over \$60 million in funding for state emergency preparedness, chronic disease control and prevention efforts.

Beginning in FY2009, \$54 million dollars in funding dedicated to responding to public health emergencies, cancer screening, injury surveillance and pandemic influenza capacity were eliminated or reduced.

By 2010, other federal funding cuts occurred. These included:

- Reductions in the Preventive Health and Health Block Grant, resulting in an additional \$911,000 in funding reductions to ADHS.
- Reductions in grants related to TB control, immunizations for various infectious diseases and sexually transmitted diseases. Much of the funding from these grants, while received by ADHS, was subsequently distributed to local health departments.
- Significant federal cuts affecting the epidemiological and laboratory capacity.
- Reduced funding for HIV prevention, treatment and surveillance. Funding was reduced from \$16.3 million in FFY 2010 to \$7.2 million in FFY 2011.

**Figure 5: Federal Grant Funding for Emergency Preparedness, Chronic Disease Control & Prevention 2008-2011**



Source: U.S. Department of Health and Human Services, Tracking Accountability in Government Grants System (TAGGS), Customized Reports through Advanced Search, April-May, 2010, May 2, 2011 <http://taggs.hhs.gov/AdvancedSearch.cfm>.



## Examples of Recent Federal Funding Changes

Grant Purpose	FFY 2008	FFY 2009	FFY 2010	FFY 2011
To assist state and local health agencies in carrying out tuberculosis (TB) control activities designed to prevent the transmission of infection and disease	\$1,172,939	\$1,171,614	\$1,274,518	\$1,092,814
To conduct sexual violence prevention and education	\$698,527	\$746,900	\$642,494	\$624,027
To assist states and communities in establishing and maintaining preventive health service programs to immunize individuals against vaccine-preventable diseases	\$6,252,332	\$5,896,379	\$6,361,054	\$2,290,704
To support epidemiology and laboratory capacity for infectious diseases	\$983,121	\$847,832	\$318,551	\$378,991
To improve healthy communities, tobacco control, diabetes prevention and control	\$0	\$1,848,162	\$1,877,646	\$1,541,730
To reduce morbidity and mortality by preventing cases and complications of sexually transmitted diseases (STDs)	\$1,364,486	\$1,461,598	\$1,010,706	\$970,353
<b>Total</b>	<b>\$10,471,405</b>	<b>\$11,972,485</b>	<b>\$11,484,969</b>	<b>\$6,898,619</b>

Source: U.S. Department of Health and Human Services, Tracking Accountability in Government Grants System (TAGGS), Customized Reports through Advanced Search, April-May, 2010, May 2, 2011 <http://taggs.hhs.gov/AdvancedSearch.cfm>.

## Local Funding Changes

State budget reductions trickle down to county health departments in two ways. First, cuts made to the Arizona Department of Health Services' budget affect counties. Such cuts include reductions in targeted state-only funding appropriated to the Arizona Department of Health Services designated specifically for county health departments. It also includes reductions in federal grant funding received by ADHS that is distributed to county health departments.

In addition, county health departments are affected by cuts in state support that goes directly to counties. In recent years, state general funds to counties have decreased by \$5,582,700. The state general fund appropriation for designated county funding was reduced by 67.5 percent from FY 2008 to FY 2011.

Local health departments are also affected by declines in county government revenue. For example, county property tax collections, sales tax collections and special districts represent possible sources of revenue for public health that have all been impacted by the current economic recession, resulting in locally imposed funding cuts. In

Coconino County, for example, state shared sales tax collections dropped by \$3.6 million, 20 percent below the FY 07 actual figure. Additionally, since 2008, county sales taxes have fallen 14 percent (\$1.7 million).<sup>15</sup>

While all of these factors have affected local health department funding, the county health departments that we reviewed all show actual *increases* in overall funding in recent years.

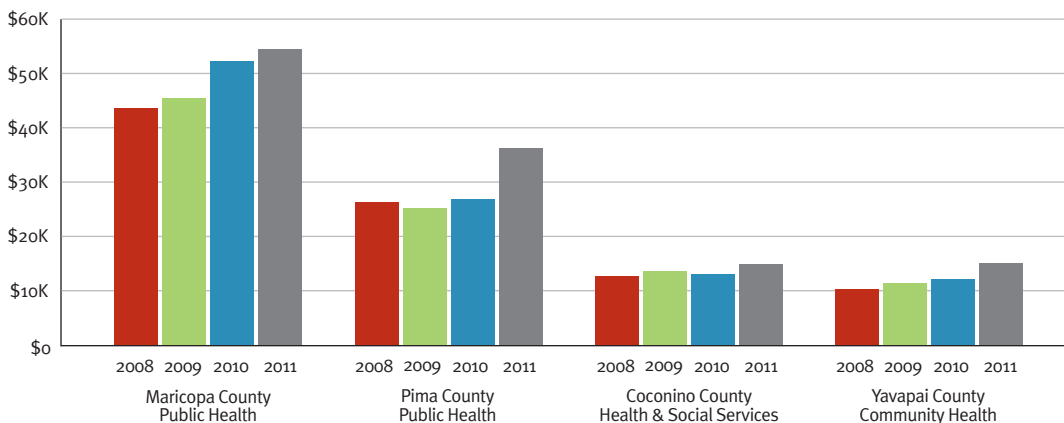


## Selected State General Fund Reductions for County Health Programs

	FY 2008	FY 2011	Impact
County TB Provider Care & Control	\$1,410,500	\$591,700	Reduced reimbursement to hospitals and physicians for the care of hospitalized TB patients and for assistance to all county health departments for local TB control programs
Direct Grants	460,300	0	Eliminated state funding for a portion of the cost of employing one public health nurse and one sanitarian in counties with populations of fewer than 500,000 persons
Reimbursement to Counties	67,900	0	Eliminated state matching monies to counties with populations of fewer than 500,000 persons for local health work
County Public Health	200,000	0	Eliminated reimbursement to local health departments pursuant to §36-189 in Coconino, Gila, Mohave, Yavapai and Yuma counties in 2009
County Prenatal Grants	1,148,500	0	Discontinued grants to counties for prenatal services for 19,000 individuals
High Risk Perinatal Program	4,980,600	2,093,400	Eliminated approximately 8,800 home visits to babies discharged from neonatal intensive care and reduced hospital and transport services to high risk women and infants
<b>Total</b>	<b>\$8,267,800</b>	<b>\$2,685,100</b>	

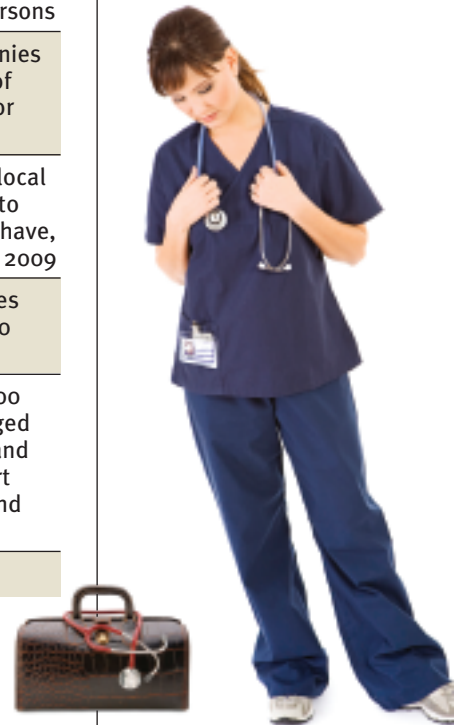
Source: ADHS; General Fund Budget Reductions, FY 2008-FY 2011, March 26, 2010.

**Figure 7: Public Health Budgets 2008-2011**



Source: Maricopa, Pima, Coconino and Yavapai County Public Health Budgets, 2008, 2009, 2010 and 2011.

In each of the counties reviewed – Maricopa, Pima, Yavapai, and Coconino – public health budgets have increased from 2008 to 2011. However, as we heard through our interviews, budget increases have come as the result of grant funding for specific programs and services. For example, the Pima county health budget for 2011 includes \$9.8 million in federal stimulus funding for Communities Putting Prevention to Work and Emergency Management/Homeland Security grants.



*“Some of our best work will be dead within a year.”*

*Local health administrator*

*“We are creating a bill for ourselves somewhere down the road.”*

*Local health administrator*



Since 2009, Maricopa County has been awarded \$54,741,345 in funding (for all programs, not just public health) through the American Recovery and Reinvestment Act of 2009 (ARRA).<sup>16</sup> Many of the projects funded with ARRA grants began in FY 2009-10 and will continue in FY 2010-11. Highlights of the public health projects funded with ARRA grants include the following:

- Homeless programs, Public Health – \$238,718
- Electronic medical records, Public Health – \$456,185
- Lead-Based paint hazard reduction program, Public Health – \$312,347
- Miscellaneous ARRA, Public Health – \$930,840

In addition, First Things First, the state’s early childhood agency, has provided more than \$29 million in grants to local health departments and nonprofit organizations to implement health-related prevention and direct care services. An additional \$32 million in health-related funding is planned for FY 2012. These services include evidence-based, child-focused prevention programs such as the Nurse Family Partnership Program, prenatal outreach, oral health efforts, injury prevention and developmental screening.

While state and federal grants have provided county health departments with critical funding at a time when state funding was being eliminated, it is important to note that such grants often do not replace dollars that were lost. Many of those interviewed noted that these grants are often intended for specific purposes and do not fund many of the “core” public health functions, such as disease control and surveillance, expected of local health departments. In addition, as noted above, these grants are time-limited, suggesting that local health departments may soon begin feeling an even greater effect of state budget cuts as federal stimulus dollars expire and the federal budget cuts occur.

## **Combined Impact on Public Health Services**

The combined state, local and federal cuts have had a variety of effects on the public health infrastructure in Arizona.

In some instances, the state and local health departments have found ways to seek alternative funding and innovate in response to budget cuts. For example:

- When state funding cuts for vaccinations occurred, the Arizona Department of Health Services identified a creative way to draw down federal dollars for immunizations by partnering with federally qualified community health centers. The federal dollars replaced state dollars, allowing publicly funded immunizations to continue at the offices of rural health providers and at local health departments.
- In another case, the Department used money from a federal grant (Title V) and tobacco tax dollars to reward child care providers who adopted healthy practices at child care centers, such as limiting TV viewing. The rewards not only encouraged healthy behaviors, but also ameliorated some of the financial impact of increased licensing fees for some child care providers.
- In the past, a local health department hired nurses to case manage people with tuberculosis to ensure they followed through with treatment. Budget cuts forced the department to eliminate some of those nursing positions. In their place (at a lower cost), they hired an epidemiologist and only one nurse. This less expensive approach is actually yielding better outcomes.



- Local health departments shifted money back to the Department that had formerly been used for tobacco education in school settings. Instead, the Department is now using the money to conduct social media efforts, which many of those interviewed considered a more cost-effective approach.
- To address funding cuts for epidemiology, three local health departments – Graham, Greenlee and Gila – are working together to hire and share one epidemiologist.

State and local health officials interviewed also discussed creating program efficiencies, prioritizing services by risk, and having staff perform multiple jobs as ways in which they were addressing funding reductions.

While these practices are yielding cost savings and other benefits at times, other trends or effects of budget cuts were less positive. They include:

- **REDUCTIONS IN COMMUNICABLE DISEASE CONTROL CAPACITY** Several state and local health department officials interviewed noted that they are now following up on only the most serious communicable disease cases. For example, one local health official said that while her department would contact all of the sexual partners of someone who contracted chlamydia in the past to encourage them to be tested and seek treatment, they no longer do so. She also noted that it is hard to know what the impact of such changes will be, since they have never developed sufficient capacity to track disease outbreaks in their area. An official in another county stated that they occasionally turn away people needing treatment for sexually transmitted diseases due to lack of capacity.
- **LOSS OF STAFF AND EXPERTISE** State and local health departments have been reducing the number of staff due to budget cuts. The Arizona Department of Health Services has seen a 10 percent reduction in the number of authorized full-time (FTE) positions since 2008. In the Public Health Division, there was a 15 percent reduction in the number of authorized FTEs in this same time period.<sup>17</sup> Local health departments are also feeling the impact. For example, Coconino County has reduced the number of FTEs from 142 to 119 over the past two years. Additional cuts were avoided only due to not filling the positions vacated by the turnover of existing staff.

Another local health administrator interviewed said that she is increasingly hiring people with minimal qualifications as a means of saving money. She said that while this creates efficiencies in the short term, she is worried that in the long term, local health departments may be comprised of people who are capable of delivering only a specific service, rather than public health professionals who understand the many facets of public health.

A licensure administrator noted that even though their budget has not been cut, the state salary freezes and the elimination of performance-based pay has made it very difficult for them to hire nurses to perform inspections of long-term care facilities. State salaries are now approximately \$20,000 a year less than those of the private sector. As a result, she is relying more on social workers or other non-medical professionals to perform such work. While these professionals are often capable of performing many of the necessary tasks, she is worried about the impact of having some functions, such as assessing medication administration at nursing homes, being performed by non-medical professionals.



*“It’s really hard to keep digesting bad news.”*

*Local health department administrator*

- **SHIFTING SERVICES TO THE COUNTIES** As state funding is cut, counties are in some instances being left to devise their own means of performing some public health functions. For example, the state is performing limited West Nile Virus, STD and rabies testing. As a result, counties are investing in infrastructure to perform their own testing – despite the fact that the state invested more than \$30 million<sup>18</sup> to develop a state-of-the-art laboratory fewer than 10 years ago.
- **ADHS’ SHRINKING ROLE** Several of our interviewees noted that as state funding shrinks and ADHS has fewer and fewer staff, the Department is playing a diminishing role in overseeing what is occurring at a local level. One local health official interviewed thought that this actually provided more opportunities for him to innovate and address local health needs. However, the official also worried that the technical assistance needs of some local health departments might go unanswered.
- **INCREASED DEPENDENCE ON GRANTS** As federal, state and local dollars decrease, local health departments are in many instances relying more and more on grants. For example, federal, state and local grant funding comprised 78 percent of public health revenue for Pima County in 2011, compared to 67 percent in 2009. While these grant monies can fund important public health efforts, many of the public health officers expressed concern regarding this trend. They noted that these monies often do not replace core funding that has been lost, and the danger is that you end up going where the money is – rather than addressing local needs. Nonetheless, several local health officers noted that they are adding grant writers to their staff to be able to compete for such money.



“Live by the grant,  
die by the grant.”

*Local health officer*

# The Changing Public Health Picture

While budget cuts that have occurred to date are having an impact on public health, recent and impending changes occurring at the national level are also reshaping the field. Some of these changes relate to the flow of dollars to states. However, national shifts in philosophy, priorities, expectations and opportunities are also likely to change the face of public health in Arizona.

**FEDERAL FUNDING SHIFTS** As stated earlier, during the Great Recession, the federal government provided stimulus money aimed at improving public health. That money ended as of September 2011.

With the advent of health reform, there was a great deal of optimism that the new law would dramatically change public health. Indeed, the law included the creation of a \$15 billion Prevention and Public Health Fund dedicated to funding public health services over the next decade. Some of that funding has already been awarded, including \$103 million in community transformation grants. However, the fund has also taken several financial hits since its creation. In addition, recent budget cuts to the Centers for Disease Control and Prevention (CDC) make it possible that some of the funding will be diverted to cover current CDC initiatives, rather than offer new opportunities for funding prevention efforts at the state and local level.

In general, it appears that federal funding for public health may be trending downward. As Congress attempts to cut federal spending, public health is likely to be on the chopping block. Cuts have already occurred in areas such as prevention, emergency preparedness and home health programs. The President's FY2012 budget proposal includes a \$580 million cut to the CDC from 2010 levels.<sup>19</sup>

**INCREASINGLY COMPETITIVE ENVIRONMENT** Federal funding is also becoming increasingly competitive. In several of our interviews, public health officials noted that rivalry for federal grant monies is increasing. Monies that were formerly awarded to state health departments (often on a formula basis) are now open to local health departments, community health centers, community-based organizations or other non-traditional entities.

While competition has benefits, it also poses risks for states such as Arizona. Arizona already ranks 31st nationally in the dollars it receives from the CDC.<sup>20</sup> Recent history in applying for and winning health reform grants also suggests that Arizona may lag behind in the competition for these federal dollars. According to the federal government's health reform website (healthcare.gov), Arizona has been awarded approximately \$1.77 million in grants to organizations through the Prevention and Public Health Fund to help improve wellness and prevention efforts as of February, lagging amounts awarded to other states. States that are comparable in size to Arizona and neighboring states have been awarded significantly higher amounts.



*“The state has done everything they can do to us. Now it’s the feds’ turn.”*

*Local health administrator*

*“You can’t write sexy grant applications when you say we are so poor we suck at everything.”*

*Local health administrator*

### Prevention and Public Health Fund Awards Arizona Versus States with Populations of Similar Size (as of February, 2011)

State	Population	Funds Awarded
Washington	6,664,195	\$8.45 million
Tennessee	6,296,254	\$10.37 million
Missouri	5,987,580	\$6.54 million
Indiana	6,423,113	\$2.46 million
Massachusetts	6,593,587	\$24.3 million
Arizona	6,595,778	\$1.77 million

Sources: <http://www.healthcare.gov/news/factsheets/prevention02092011a.html> and [http://factfinder.census.gov/servlet/GCT-Table?\\_bm=y&-geo\\_id=01000US&-\\_box\\_head\\_nbr=GCT-T1-R&-ds\\_name=PEP\\_2009\\_EST&-\\_lang=en&-format=US-4oS&-\\_sse=on](http://factfinder.census.gov/servlet/GCT-Table?_bm=y&-geo_id=01000US&-_box_head_nbr=GCT-T1-R&-ds_name=PEP_2009_EST&-_lang=en&-format=US-4oS&-_sse=on).

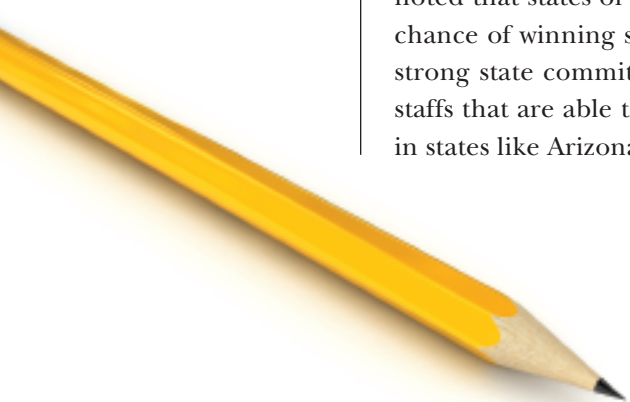
### Prevention and Public Health Fund Awards Arizona Versus Neighboring States (as of February, 2011)

State	Population	Funds Awarded
Colorado	5,024,748	\$8.45 million
Utah	2,784,572	\$3.35 million
New Mexico	2,009,671	\$1.2 million
Texas	24,782,302	\$17.63 million
Arizona	6,595,778	\$1.77 million

Sources: <http://www.healthcare.gov/news/factsheets/prevention02092011a.html> and [http://factfinder.census.gov/servlet/GCT-Table?\\_bm=y&-geo\\_id=01000US&-\\_box\\_head\\_nbr=GCT-T1-R&-ds\\_name=PEP\\_2009\\_EST&-\\_lang=en&-format=US-4oS&-\\_sse=on](http://factfinder.census.gov/servlet/GCT-Table?_bm=y&-geo_id=01000US&-_box_head_nbr=GCT-T1-R&-ds_name=PEP_2009_EST&-_lang=en&-format=US-4oS&-_sse=on).

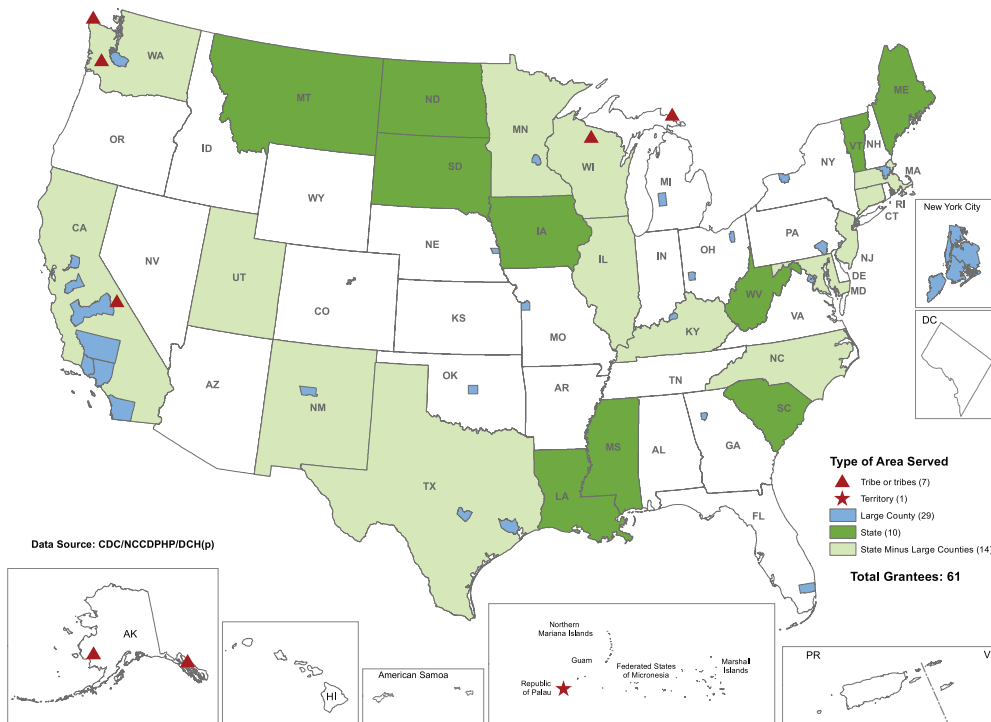
As recently as September 27, 2011, Arizona was passed over completely when the U.S. Department of Health and Human Services announced more than \$103 million in Community Transformation Grant funding that went to 61 state and community recipients across the country.<sup>21</sup> These grant monies were aimed at tackling the root causes of poor health so that chronic diseases such as stroke, heart disease and diabetes can be reduced. Thirty-six states were among the grantees. Twenty percent of the grant funds were authorized to be awarded for rural areas.

While our state has competed successfully for some of these new grant opportunities (such as a \$9.4 million grant for home visitation), many of the public health officials that we interviewed worried about this new frontier of competition for federal dollars. One person noted that while Congress likely intended many of the new federal prevention monies for states that lack public health capacity, the opposite appears to be occurring. Instead, he noted that states or localities with strong public health infrastructures often have the best chance of winning such awards. They can boast how they are already effective. They have strong state commitment to funding public health. They also have paid grant writers on staffs that are able to pull together strong proposals. He worried that the trend will result in states like Arizona falling farther and farther behind.





## CDC Community Transformation Grant Awards



Source: Centers for Disease Control and Prevention. Retrieved from <http://www.cdc.gov/communitytransformation/funds/map.htm>.

### Six Winnable Battles

- Obesity, nutrition, physical activity and food safety
- Motor vehicle injuries
- Healthcare-associated infections
- HIV
- Teen pregnancy
- Tobacco

<http://www2a.cdc.gov/phlp/winnable/>

**FEDERAL FOCUS CHANGING** The federal government also appears to be shifting the focus of the money it awards to states. Nearly a quarter of CDC dollars awarded to states are now targeted toward what CDC director Dr. Thomas Frieden has deemed the “six winnable battles.” This focus may very well shift priorities at the state and local level. A recent news article quoted Arizona Department of Health Services Director Will Humble stating that he was aware of these priorities, potentially affecting Arizona’s public health priorities. Said Humble, “We’re in the position of focusing pretty much on what we can get federal funds for.”<sup>22</sup>

**FOCUS ON MULTI-SECTOR APPROACHES** Another trend – seen in both federal grants and grants offered by national foundations – appears to be enhanced focus on multi-sector, coordinated approaches to improving health, often at a local level. For example, the CDC’s Healthy People 2020 objectives depart from the past by emphasizing the underlying environmental and social determinants of health, providing a stimulus for addressing population health using multi-sector approaches.<sup>23</sup> In addition, the newly released National Prevention Strategy takes a multi-sector approach to addressing the nation’s health and wellness challenges.<sup>24</sup>

Recent federal grants also suggest a shift. For example, \$372 million in federal grants were awarded in 2010 for Communities Putting Prevention to Work.<sup>25</sup> These grants were generally awarded to broad, multi-sector efforts aimed at preventing chronic disease. Community-based coalitions that were able to demonstrate sustained partnerships were favored.



## HEALTH REFORM AND PUBLIC HEALTH

The 2010 health reform laws contain many provisions related to public health. For example, the laws create:

- A Prevention and Wellness Trust Fund to provide \$34 billion in mandatory funding over the next 10 years to community-based prevention programs, a child obesity program, and related programs.
- Competitive grant opportunities for state and local governments and community-based organizations to implement and evaluate proven community preventive health activities to reduce chronic disease rates.
- Improved health insurance coverage for preventive services.
- Grants and incentives for employers to implement wellness programs.
- Opportunities for Medicaid programs to implement chronic disease prevention efforts.
- Expanded health insurance coverage beginning in 2014.

In FY2011, a number of programs that have historically been targeted as separate funding programs for states are being merged into the new Consolidated Chronic Disease Grant Program, including both base funding and prevention funds. This merger will require increased coordination to focus resources more strategically on addressing related issues such as increasing physical activity and improving nutrition with obesity, diabetes and heart disease.<sup>26</sup>

**INFRASTRUCTURE EXPECTED** For the past decade, significant federal investments in emergency preparedness have allowed public health officials to augment their public health surveillance and response systems. Moving forward, the federal government is reducing the flow of such monies – leaving states to pick up the expenses or curb emergency preparedness efforts.<sup>27</sup>

There is also a growing movement to ensure that states and localities can demonstrate performance against specific standards. A voluntary national accreditation program was recently announced by a national public health organization (the Public Health Accreditation Board) with the support of the Robert Wood Johnson Foundation, the Centers for Disease Control and Prevention, and a variety of public health associations.<sup>28</sup> The first applications are being accepted this year, and Coconino County already participated in a pilot. This may be an initial step in a plan aimed at developing a national accreditation requirement.<sup>29</sup> One of the national experts we interviewed questioned whether the federal government would ever go as far as making it a requirement, but she did say she thought accreditation may be tied to funding – or enhanced funding. In either case, accreditation may drive the need for state and local funding to support core infrastructure and services in the future.

**SERVICE DEMANDS IN FLUX** Many of those interviewed noted that it is hard to predict future demand for services at county health departments – in part due to the uncertain fate and impact of federal health reform efforts.

An increase in coverage due to health reform – expected to begin in 2014 – could result in many more people having public and private health coverage, potentially reducing the need for primary preventive services such as immunizations from county health departments. Expanded coverage could also reduce the need for secondary prevention services such as STD screenings. However, it is important to remember that not everyone will have coverage even after expanded health coverage begins in 2014. Some will still choose to remain uncovered, and others, such as unqualified immigrants, will not be eligible for benefits.<sup>30</sup>

Conversely, losses in health coverage due to state budget cuts may drive more people to need services from county health departments. For example, recent “freezes” in eligibility for AHCCCS and KidsCare are likely to result in hundreds of thousands of additional Arizonans becoming uninsured.

In many ways, such fluctuations in service demand are not new. For example, county health departments are now playing a declining role in offering vaccinations – in part because it has been profitable for many other providers to get in the business. However, if reimbursement rates for vaccines decline or a pandemic occurs, county health departments may once again need to play an expanded role.

The challenge is how to be prepared when the future is so uncertain.



# Putting the Pieces (Back) Together

Arizona’s public health system is shifting. Significant decreases in funding and a changing healthcare landscape are causing Arizona’s public health leaders to rethink how they work.

Change – even bad change – presents new opportunities. When change occurs and challenges mount, it is time to rethink business as usual. You don’t run away from change or ignore that it is occurring. You figure out a plan for managing the change – or even taking advantage of it.

Arizona’s public health leaders are imagining new possibilities. They are looking at what pieces are left from a battered public health system and envisioning how a public health system might look moving forward. Below we present some of their thoughts on key ways to address the changes that are occurring. We include thoughts (theirs and ours) on how to strengthen the public health infrastructure in the future.

**SETTING THE STANDARD, MAKING THE CASE** Given the significant changes that are occurring in the sector, now may be an appropriate time for state policy makers and public health leaders to define what they want from our state’s public health system.

As noted earlier, much of public health’s current activities have been defined by available funding rather than need. Little has been done to define what array of services or defined outcomes should be expected from public health. In turn, lack of defined standards and expected outcomes has contributed to the public’s “fuzziness” about what public health does or why it is needed.

Moving forward, policy makers and public health leaders could define core services and outcomes for the sector at a community or state level. Such a conversation could center on core public health services in areas such as assessment, assurance and policy.

State and local health leaders could also use the new national public health accreditation standards as a means to define a core set of public health activities. National accreditation – even though it is voluntary – provides a new mechanism for Arizona to measure itself against national benchmarks to determine if and where we are falling short.

Several of the people we interviewed also noted that – moving forward – it will be necessary for public health to rely more heavily on evidence-based practice as a means of instilling public confidence – and willingness – to fund public health activities. One public health expert stated:

*“Many of the programs that public health departments have conducted probably did little to nothing to improve the public’s health. There is a tendency in public health to implement programs because they seem to make sense, but actually they often have little to no evidence to support their effectiveness.”*

*“There is a tendency in public health to implement programs because they seem to make sense, but actually they often have little to no evidence to support their effectiveness.”*

*Public health researcher*



*“We need to work a little smarter – because we can’t possibly work any harder.”*

*Local health administrator*

By moving toward evidence-based practice, a stronger case can be made for public health investments. Nationally, the Task Force on Community Preventive Services – an independent, nonfederal, volunteer body of public health and prevention experts appointed by the Director of the Centers for Disease Control and Prevention – is identifying such practices. State and local leaders could begin to align existing efforts to reflect these evidence-based activities.

**ORGANIZATION AND FUNDING MATTER** Some national experts have suggested that the movement toward using objective performance standards may raise questions about the ability of some local health departments, particularly those in rural areas and those that lack sufficient resources to achieve standards on their own. They suggest that these deficits may spur further interest in cross-jurisdictional sharing and regionalization.<sup>31</sup> Two of the public health experts we interviewed thought it could (and in their opinion, should) lead to the consolidation of various local health departments.

Such standards could also lead to rethinking the way in which local health departments are organized, governed and funded. Nationally, at least one county health department has begun to use the accreditation standards to prioritize and redefine the services they provide and address budget shortfalls (see Tough Choices, Tough Times).

Standards could also prompt discussion about the adequacy of public health funding in this state.

As noted earlier in this report, evidence suggests that state and local funding for public health in Arizona lags behind that of other states. Established standards would provide public health officials with the ability to talk about the need for additional funding in a more compelling way.



## Tough Choices, Tough Times

In November 2010, the Kane County Health Department – a county health department 40 miles west of Chicago serving half a million residents – faced looming budget cuts. After years of revenue decline, the Executive Director responded to the latest round of funding cuts by proposing a dramatic shift in the department’s mission, structure and staffing.

Using the national accreditation standards as a model, the Kane County Health Department restructured itself so that it could address core public health functions adequately. They shifted their focus from addressing personal health issues to focusing on population health. Personal health services were transferred to three federally qualified health centers. The department’s workforce was cut in half and positions were redefined. Some new positions, such as a health planner position, were added.

The department also strengthened its community partnerships. They created a unified approach toward measuring health outcomes for the area, working with two local United Ways and five area hospitals to conduct a survey for identifying local health needs. They partnered with local transportation agencies to strengthen the built environment and conduct health impact assessments.

While it is too early to gauge the success or failure of such efforts, the Kane County Health Department’s Executive Director offered the following sage observation:

*“If you keep making incremental cuts, when do you lose your ability to make an impact from the services you are providing?...We are in a difficult place in this country. We have to do things differently. We can’t continue to do business as usual if we are going to continue to protect the public’s health.”*



Discussions of public health funding could also include consideration of how public health is funded and organized in our state.

As we note earlier in this report, local funding for public health in Arizona varies widely. Some localities in our state sit in far better positions than others do. Interviews suggest that some local health departments have been able to weather the storm much better due to financial reserves, the ability to draw down Medicaid dollars for direct health services, or their access to a steady stream of funding through their local health district. Nationally, states and localities provide about 40 percent of revenues for public health programs on average.<sup>32</sup>

Currently, there appears to be a dearth of information nationally on best practices for the governance, organization and funding of local health departments and activities.<sup>33</sup> But it is clear from our interviews that local health departments in our state face a number of governing and funding challenges. Some county governments simply generate more tax revenue than others do, allowing public health to take a piece of a larger overall pie in some localities. Some counties have local health districts that provide funding for public health, while others do not. Some county boards of supervisors consider public health a priority, while in other areas public health competes for attention with other county priorities. And all county health departments have local health boards with advisory authority only, limiting their ability to influence county public health spending or priorities.

Ultimately, our state needs a public health system that ensures that core public health services are available no matter where you live in Arizona. The system should be fair – and efficient. Even though changes in funding or organization may require statutory or other significant changes, now may be an opportune time to address such issues.

**FLEXIBILITY AND LOCAL NEEDS ARE KEY** While a core level of funding and services need to be available in all parts of the state, funding also needs to be flexible enough for local communities to respond to local needs.

Local health needs vary. For example, Mohave County ranks low compared to other counties in the level of healthy behaviors (diet, unsafe sex, alcohol), while Apache and Maricopa counties do not do well in the area of physical environment, based on the Robert Wood Johnson Foundation’s county health rankings.<sup>34</sup>

These varying needs – in addition to the rapid and unpredictable shifts that are occurring in our health system – suggest a need for flexible funding. Unfortunately, recent trends suggest that funding streams are becoming more – rather than less – restrictive.

In our interviews, local health officers stressed the need for flexible funding. They noted that a lot of state, federal and grant funding is tied to particular programs addressing particular health goals established by some state or national entity. One local health officer said, “We have often found ourselves chasing the money.” Instead of addressing local needs, too often local health departments deliver services based on funding requirements.

If and when state funding for public health returns, there should be emphasis on funding for core public health functions, with the addition of flexible funding that allows localities to respond to local needs.

That said, it is important to note that flexibility is not a strategy in itself. As one person interviewed said, “One of the hardest things is to have the freedom to decide where money should be spent.” Local funding should be used to support strategies aimed at moving specific, locally identified public health metrics in communities. Nationally, poor performance in achieving population health goals is well noted – approximately 10 percent of public health measures tracked are met.<sup>35</sup> Limited public dollars need to be spent strategically in order to make progress in achieving public health goals.



#### EXAMPLES OF POTENTIAL POLICY ISSUES THAT STATE AND LOCAL HEALTH DEPARTMENTS COULD CHAMPION

- Changing state law to require school recess to be offered before (rather than after) lunch
- Changing the procurement code to encourage the purchase of healthy, locally grown foods for schools
- Working with city planners and school boards to implement environmental changes that encourage walkability to school
- Encouraging state or local lawmakers to implement a tax on soda
- Working with local lawmakers to change zoning codes to discourage the number of drive-thru restaurants in an area

## HEALTHY COMMUNITIES MOVEMENT

According to the CDC, some of the critical elements to creating a successful healthy communities movement include:

- Strong distributed leadership and governance
- The existence of a health status improvement focus that distributes the broad-focused community intervention among its various targeted parts
- Metrics to help guide the local efforts
- Accountable leadership
- Well-supported infrastructure
- Investment in data systems that integrate across efforts.

Focusing on Solid Partnerships Across Multiple Sectors for Population Health Improvement. Baile, SB. [http://www/cdc.gov/pcd/issues/2010/nov/10\\_0126.htm](http://www/cdc.gov/pcd/issues/2010/nov/10_0126.htm)

**CHANGING ROLES FOR THE STATE, COUNTIES** The significant changes occurring in our public health system also provide an opportunity for our state to rethink the roles that the state and county health departments play.

Currently, state funding cuts and fewer staff mean that ADHS is administering fewer public health programs. At first blush, this trend suggests a diminished role for the Department in the future. However, we see it a bit differently. We think that the Department's role could shift rather than simply diminish moving forward. A change in focus could even increase the importance of the Department by allowing it to play even more of a leadership (rather than administrative) role.

In the future, the Department could play a far greater role in addressing health policy issues. One ADHS administrator interviewed was genuinely excited about the prospect of an increased focus on policy work, noting that often policy change has a greater impact on changing health outcomes than program delivery does.

The prospect of increased focus on policy also mirrors much of the national thinking about where public health is moving. For example, one national expert commenting on the "new public health" noted the following:

*"There's been this transition in public health and the prevention world, from thinking less about programs and one-on-one interventions and really thinking about the communities in which people live, thinking about policies, thinking about systems, and also thinking about programs that address these behaviors."*

This shift toward an increased emphasis on policy is already occurring at the local level. For example, the Maricopa County Health Department recently cobbled together a small but active policy unit, focusing on issues related to healthy eating and active living in the region, as well as built environment issues.

Greater emphasis on policy does not come without challenges. Some policymakers object to policy changes aimed at influencing individual health behaviors.

They charge that society is becoming a "nanny state," where government intervenes in every aspect of our lives to do what some group of bureaucrats think is best for us.

Obviously, there should be limits to the number of ways in which government intervenes in our private lives. But it is also naïve to think that government doesn't play a role in influencing the individual choices we already make. For example, when a city builds a road and no sidewalk in our neighborhood, we may choose to drive rather than walk our kids to school. When the federal government subsidizes unhealthy foods, it makes such foods cheaper and more likely to be consumed than healthier alternatives.

In some instances, it makes sense for government to create restrictive laws or policies to prohibit or prevent some harmful activity or condition due to a sizable threat to public health. For example, a county health department closing a public swimming area due to health hazards comes to mind. Perhaps more often, it makes sense for government to play a role in creating the *conditions* for us to make it easier for us to choose to live healthy lives.

Evidence suggests that the public supports such measures. For example, the 2006 ballot initiative on controlling smoking in public places garnered widespread support. Nonetheless, many in the public health community shy away from policy, given our state's anti-government political climate.



In spite of the politics, public health leaders (both those in and out of government) may find it easier to engage in public policy by:

- **WORKING LOCALLY** School boards and local governments are sometimes less politicized than government at the state level – and policy change is often easier to achieve.
- **ENGAGING IN ADMINISTRATIVE ADVOCACY** A lot of public policy decisions are made within the authority of public administrators. At times, changing practice requires no need to change statute, city ordinances or rules – it is simply a matter of an administrator deciding to do things differently or implement a program in a certain way. For example, making a community more walkable may occur by providing information on the walkability of local communities, engaging neighbors, and meeting with local planning, transportation or city administrators to ensure that existing resources are devoted to improving walkability where it is most needed.
- **PARTNERING WITH THE PRIVATE SECTOR** Increasingly, the private sector is interested in public health and prevention. Private employers want to improve community health as a means of controlling costs. Insurers want to advance the health of their customers as a means of improving their margins and building relationships with potential clients and the community. Partnering with them – or even letting them take the lead – may take off some of the political heat as policy solutions aimed at improving the public’s health are forwarded.
- **ACTING AS A CONVENER, NOT A CHAMPION** Another way to make it easier to engage in policy change and minimize the effect of politics is to act as a convener, facilitator and planner – and not a champion. For example, public health administrators could convene local farmers and school procurement officials to identify ways procurement could change to allow for the purchase of healthy, locally grown foods for schools. Members of the group – in this case the local farmers – could then become the advocates for change.
- **MESSAGING** A lot of work has been done by psychologists and linguists in recent years on exploring how the public responds to public policy differently based on the messaging. Of course, at its worst, messaging efforts can be used to deceive the public. But they can also be used to help add clarity to real social problems and help the public (and elected officials) think about problems in a new way. For example, it may be easier to build public support for disease prevention by focusing on the costs that may be averted by all of us than to talk about the prevalence of the disease.
- **CHANGING GOVERNANCE** Public policy engagement would ultimately be easier if public health officials did not report directly to elected officials. In states such as Utah, Idaho, North Carolina and Ohio, local health officers report to the local health board and not to elected officials. That allows a group of public health experts to evaluate the effectiveness and appropriateness of public health officials and their actions, creating some distance between local health administrators and politics.

**CONNECTING THE PIECES** In the future, both the Arizona Department of Health Services and local health departments could place more emphasis on convening and supporting coalitions aimed at addressing public health issues.

As noted earlier, changing federal funding priorities may result in more dollars flowing to the local level. Non-governmental entities, such as community health centers, may play a greater role in public health as federal funding increasingly flows in their direction. At the same time, local health departments may face more limited resources – and a greater need to collaborate.



#### CALIFORNIA'S “HEALTH IN ALL POLICIES”

In 2010, Governor Schwarzenegger established a task force (staffed by the California Department of Public Health) comprised of representatives from 19 state agencies to recommend programs, policies and strategies aimed at improving the health and well-being of Californians. The recommendations are focused on how health can be advanced in the policy areas of transportation; housing and indoor spaces; parks, urban greening, and places to be active; violence prevention; and healthy food. The taskforce is currently in the process of selecting a small number of recommendations for near-term implementation.

These changes may require the Arizona Department of Health Services and local health departments to build local coalitions to address local health needs. ADHS could support such efforts by:

- Supporting health assessment and planning efforts at the community level.
- Helping local communities identify, synthesize and track a myriad of metrics at the local level to help drive community-based change.
- Playing a larger role in public health workforce planning and training efforts to ensure that public leaders are prepared for their changing roles. For example, several state and national experts interviewed noted the increasing need to prepare future public health workforce leaders in the area of public policy.

While many examples of such coalitions already exist at the state and local levels, many of those interviewed noted that they are often convened and loosely organized to respond to the latest and greatest funding opportunity. They lack breadth, depth and longevity.

## The Coverage, Quality and Cost Connections

It wasn't too long ago that the roles public agencies played in our state's health system were very straightforward.

The Arizona Department of Health Services and local health departments were focused on surveillance, assurance and prevention. AHCCCS was focused on coverage. No public agencies really focused on quality, except as it related to contract compliance or licensure. Improvements in the quality of healthcare delivery were something for the private sector to figure out.

Today, all of that is changing. The more we understand about the changes needed to improve our health system, the more we know that coverage, quality and cost are all related. It is important for our public agencies to focus on all three.

When Medicaid expands in 2014 as a result of health reform, there will be new incentives for AHCCCS (our state's Medicaid agency) to focus on prevention. More people are likely to stay on AHCCCS for longer periods of time – providing increased incentive for AHCCCS to think more about prevention and reducing expensive chronic care conditions. New partnerships with public health may be possible.

Incentives and penalties included as part of healthcare reform mean that those delivering health services will be increasingly focused on keeping people healthy and out of costly inpatient settings. There will be increased emphasis on quality – making sure people get the right treatment at the right time in the right place. Collaboration opportunities between the medical and public health sectors will abound.

And public health will need to pay a lot more attention to coverage moving forward. More people with coverage will mean that a lot more people may be able to access preventive services – something that public health has been championing for a long time. Public health could play a role in coverage expansion by helping people enroll in coverage through the health insurance exchange. The public health community could also play a role in advocating for preventive services to be included in the exchange plans offered. The public health community could also lead efforts to educate the public about the need to take advantage of the expanded preventive benefits included as part of their health insurance.

Perhaps the most important change moving forward will be that everyone will likely be focusing on cost. After all, it's concerns about cost that are resulting in cuts to public coverage, provider rates, and public health funding in this state – as well as nationally. And the more we understand about how best to control rising healthcare costs, the more we know that one of the most effective ways to bend the cost curve is to focus on quality.

It's all connected.





The problem with this approach is that it simply does not lead to meaningful change – or even allow our state to be competitive in attracting big federal or national foundation grants. For example, Arizona was recently denied one large federal grant that had a health component due to the fact that the reviewers found that the relationships among the proposed collaborators appeared “superficial.”

In our interviews, local health officials noted the need for them to play an increased role as community conveners. However, they noted that they needed financial or other support to build sustainable coalitions with diverse community partners.

**FORGING NEW PARTNERSHIPS TO BECOME MORE EFFECTIVE** To implement prevention, preparedness and surveillance efforts successfully, state and local health departments may also need to build new relationships and partnerships. As one local health department officer noted, 9/11 required public health to build relationships across sectors to address emergency preparedness better. The same now needs to be done to address chronic disease prevention.

State and local health departments are already headed down this path. For example, they have begun to forge relationships with local school districts. However, Arizona’s efforts pale in comparison to those of other states, where large, multi-sector planning efforts aimed at improving health in the state are occurring (see “California’s Health in All Policies”). The Arizona Department of Health Services and county health departments could collaborate in a similar manner with other state and local health agencies to implement broad policy changes affecting health in our state.

New relationships also could be forged between public health and medicine to address issues related to chronic disease prevention and management and quality improvement. Nearly a decade ago, the Institute of Medicine’s review of the nation’s public health system called for “a new generation of intersectoral partnerships” that span and coordinate many different sectors affecting population health.” It noted that “partnerships that integrate medical care and public health to achieve comprehensive health improvement are particularly important.”<sup>37</sup>

The CDC has also noted that:

*“Partnership between public health agencies and health care organizations are likely to have the largest and most direct effects on population health – and are the most difficult – and therefore the least prevalent – form of collaboration.”<sup>38</sup>*

While Arizona’s health department is implementing some efforts in this area (such as the Living Well Program aimed at community-based chronic disease management efforts), some states are far ahead of Arizona in achieving these partnerships.

For example, beginning in 2003, Vermont began an effort aimed at addressing the increasing costs of people with chronic illnesses. By 2007, the state began implementing “integrated” pilot projects to test best methods for delivering chronic care to patients based on a medical home model and multi-disciplinary, community-based coordination teams that help connect patients with a full range of health and human services. These efforts have evolved into an advanced primary care practice model that provides seamless coordination across a broad range of health and human services (medical and non-medical) to optimize patient experience and improve the long-term health status of the population.<sup>39</sup>

Vermont’s effort represents how public health and medical care can be linked to improve health outcomes. The creation of the Vermont Blueprint represents a forging of community-based prevention efforts and medical care delivery. Early efforts in creating the Blueprint also showcase how partners who rarely work together – public health, a state Medicaid agency, the human services sector and insurers – can forge new partnerships to improve health.

## COLLABORATE TO COMPETE – AND SUCCEED

For this report, we interviewed the head of one large, out-of-state, local health department that has been successful in both implementing change and winning a lot of national support. We wanted to get his thoughts on some of the key ingredients for success in attracting large federal and national grants and tackling population health issues.

He attributed much of his department’s success to the relationships it had with different organizations and different sectors over time. He noted that this work takes years – not months. He also added that two other factors were critical to his department’s success: 1) data richness and 2) prior experience in policy, systems and environmental change. Finally, he noted the importance of local foundations in the work they do. For example, he noted how a local health foundation assisted them in preparing and applying for large federal grant opportunities.

Such efforts take years to develop and require committed, visionary political leadership. While Arizona may not be anywhere close to where Vermont is in building these partnerships, Vermont at least provides lessons that such sustained, effective relationships are possible.

Partnerships are also possible between public health organizations and nonprofit hospitals to implement community-based prevention and chronic disease management efforts. The 2010 federal health reform law includes provisions requiring nonprofit hospitals to perform community assessments and improvement plans – and direct resources to implement those improvements efforts. State and local health departments, community-based organizations, and even other funders such as foundations could partner in such efforts. Such partnerships could also help local health departments conserve limited resources. For example, hospitals and local health departments could partner in the performance of community needs assessments – a requirement for public health department accreditation and a long-recognized core function of local health departments.<sup>40</sup>

## The Big Picture

Public health is changing. Budget cuts, a weakening public health infrastructure, an increasingly competitive funding environment and looming health issues such as obesity suggest that business as usual will no longer do. At the same time, shifting federal priorities, the changing healthcare landscape and innovation at the state and local level are causing public health leaders to rethink their roles and innovate.

What is clear is that we have a unique opportunity right now to reshape public health and potentially make it stronger for the future. While this may eventually require renewed funding to support core public health functions, it also requires new partnerships and new ways of viewing the role of public health in our state.



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## ***Our Mission***

*To inform, connect and support efforts to improve the health of individuals and communities in Arizona. In all that we do, St. Luke's Health Initiatives seeks to be a catalyst for community health.*

The purpose of *Arizona Health Futures* is to unravel an important health policy topic of relevance to Arizonans, provide a general summary of the critical issues, background information and different perspectives on approaches to the topic, tap into the expertise of informed citizens, and suggest strategies for action.

*Arizona Health Futures* is available through our mailing list and also on our web site at **www.slhi.org**. If you would like to receive extra copies or be added to the list, please call 602.385.6500 or email us at info@slhi.org.

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Comments and suggestions for future issues, as always, are welcome.

St. Luke's Health Initiatives is a public foundation formed through the sale of the St. Luke's Health System in 1995. Our resources are directed toward service, public education and advocacy that improve access to health care and improve health outcomes for all Arizonans, especially those in need.

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