Texas Department of State Health Services

Public Health Funding and Policy Committee

Annual Report

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Acknowledgements

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Public Health Funding and Policy Committee

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

Attention: The Honorable Rick Perry, Governor
The Honorable David Dewhurst, Lieutenant Governor
The Honorable Joe Straus, Speaker, Texas House of Representatives
The Honorable Jane Nelson, Chair, Senate Committee on Health and Human Services
The Honorable Lois Kolkhorst, Chair, House Committee on Public Health
Dr. David Lakey, Commissioner, Department of State Health Services

The following is the second annual report of the Public Health Funding and Policy Committee (Committee). The Committee continues to carry out its duties under Section 117.101 of the Health and Safety Code. This report outlines the status of the Committee's initial recommendations, current areas of focus, new recommendations, and future considerations.

In its initial report, the Committee made 14 recommendations to the Commissioner of the Texas Department of State Health Services (DSHS). Of the recommendations, six are completed, two are in progress, five require legislative action, and one is pending further consideration. The Committee continues to monitor the progress toward completion or resolution of the outstanding recommendations.

The Committee has identified and addressed new areas of focus. These included evaluating the results of the local public health survey the Committee disseminated in 2013, determining the components of a public health system, exploring potential structures of a public health system, and initiating a statewide syndromic surveillance network. The

Committee analyzed the local public health survey results and identified a need to develop consistency in the services offered to the public by local public health departments.

With the participation of public health stakeholders, the Committee developed an outline for a public health system in Texas. The outline combines the National Association of County and City Health Officials' foundational public health capabilities as described in the Statement of Policy, "Minimum Package of Public Health Services," [1] with the Public Health Accreditation Board's 12 domains, standards, and measures.[2] The outline transformed into the document, "Prevent, Promote, Protect Building a Public Health Infrastructure in Texas."[3] The Committee continues to develop the document's concepts, and to design a public health system supported and maintained by local health entities statewide.

The Committee took steps toward implementing a statewide syndromic surveillance system, whereby centralized hubs collect and maintain syndromic surveillance data statewide. Although the project is in its early stages, the Committee recommended DSHS establish a Syndromic Surveillance Governing Council (SSGC) to provide guidance regarding the structure of the syndromic surveillance network.

The Committee's future activities include working with DSHS to develop funding formulas for federal and state appropriated funds, working with the Sunset Commission on relevant items, and completing the current Committee projects.

The Committee is continuing its efforts to effect change in the public health system and greatly appreciates your continued support in our endeavors to improve the system.

Regards,

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

[1] Appendix A.
[2] http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf.
[3] Appendix B.

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 through a system of state and local health entities. As detailed in the 2013 annual report, 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 Texas Department of State Health Services (DSHS). 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, DSHS Health Service Regions play a gap-filling role, delivering critical 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/or disease statistics. Local public health entities, 11 DSHS Health Service Regions, and DSHS central office compete for state funding of local public health services.

During its second year, the Public Health Funding and Policy Committee (Committee) obtained stakeholder input by hosting monthly meetings and worked toward accomplishing its legislative charges. The Committee was successful in achieving the following: a) contributed to the current, improved statewide TB funding formula; b) adopted the framework for 'core' public health services for local health departments; and c) proposed several recommendations to improve public health in Texas.

Section I of this report lists the Committee's initial recommendations and current status. In the second year the committee created recommendations to:

- Address critical issues impacting public health programs;
- Prepare for healthcare reform and the impact on public health; and
- Enhance statewide syndromic surveillance efforts.

In summary, during its second year the Committee made significant progress toward evaluating and defining local public health in Texas. In addition, the Committee presented recommendations to the Texas DSHS Commissioner to improve local public health in Texas. In 2014, the committee will continue working toward defining core public health services, evaluating public health, and making recommendations for public health improvements in Texas.

SECTION I: Status of Previous Committee Recommendations

In its initial report, the Committee made 14 recommendations that covered six categories: Maximizing Efficiencies of Resources; Accreditation; 1115A Medicaid Waiver for Public Health; Workforce; Programs; and Healthcare Reform and Public Health.

Six of the 14 recommendations were completed. As of September 1, 2014, the Texas Department of State Health Services (DSHS) Commissioner approved and implemented four recommendations associated with maximizing efficiencies of resources. This consisted of taking the following actions: 1. To bundle noncompetitive contracts into one core contract; 2. To permit local health departments (LHDs) to utilize up to five percent of the time for grant funded staff for non-categorical activities; 3. To increase allowable budget category changes in noncompetitive contracts from ten percent to 25 percent; and 4. To increase allowable equipment purchase in noncompetitive contracts from $500 to $5,000.

The fifth recommendation was completed on May 31, 2012, and requested DSHS to work with Health and Human Services Commission (HHSC) to grant special consideration for public health under the 1115A Medicaid Waiver. As a result, the Transformation Waiver planning process included a five percent public health set-aside, which provided LHDs additional opportunities to participate in the 1115A Medicaid Waiver.

The last approved recommendation requested DSHS to enhance resources supporting the Infectious Disease Prevention Program's capacity to identify and treat people with active and latent tuberculosis (TB) infection. DSHS approved and implemented this recommendation in May 2013 after state budget approval. DSHS increased the budget for the program by over $two million.

Two of the Committee's previous recommendations are in progress. The Committee recommended that DSHS pursue national public health accreditation through the Public Health Accreditation Board (PHAB), serve as a model for other public health entities in the state, and provide support to LHDs seeking accreditation. DSHS is reviewing this recommendation, and contracting with an outside entity to support three LHDs prepare for components of accreditation. The Committee is looking forward to a positive response from DSHS regarding its accreditation intentions, and expects a progress update in fiscal year 2014.

The final Committee recommendation in progress is a request for DSHS to support and promote simplified credentialing for LHDs with Children's Health Insurance Program (CHIP), Medicaid, and private insurance companies. DSHS is in the process of exploring the streamlining the managed care credentialing processes for all Medicaid and CHIP providers, including LHDs. Private insurance matters fall under the purview of the Texas Department of Insurance and not DSHS. DSHS continues to support reducing the LHDs administrative burden associated with insurance credentialing.

The Committee will follow up with DSHS regarding the status of the five recommendations DSHS determined as requiring additional consideration and/or subject to legislative action. The following are the five recommendations subject to legislative action:

- Recommendation that DSHS charge the Public Health Consortium, consisting of the schools of public health and Central DSHS administration, to develop a plan to identify and address workforce needs.
- Recommendation that DSHS seek adequate funding for the 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 the revenue collected from these activities.
- Recommendation that DSHS propose the use of 1115A funds to implement a tuberculosis strategy focusing on regional population-based activities.
- Recommendation that DSHS seek resources to restore adult safety-net and Texas Vaccine for Children (TVFC) vaccines.
- Recommendation that Texas' response to Health Care Reform and state Medicaid planning continue to include deliberate provisions for public health agencies to provide preventative and population-based public health services.

The final recommendation requested DSHS to provide adequate resources and commit to meeting its statutory requirement for annual local health authority Continuing Medical Education (CME). DSHS agrees with this recommendation; however, it is pending further consideration.

The Committee will continue to follow the progress of the pending recommendations to encourage movement and, if necessary, legislative action for those that require it during the next session.

SECTION II: Committee Accomplishments

Tuberculosis (TB) Funding Formula

In 2013, the Texas Department of State Health Services (DSHS) developed a revised funding formula for the treatment and prevention of TB. As a result, 31 local health departments (LHDs) received TB funding from DSHS, up from 15 LHDs the previous year. Contractual dollars for TB also increased from $10.5 million to $12.7 million.

The TB Funding Formula Workgroup, a committee made up of DSHS representatives, LHD staff, and Committee members developed the new funding methodology. The committee's inclusion of multiple stakeholders in the process and cross-sectional membership serves as an excellent model to emulate for funding public health in Texas.

First, the workgroup reviewed the previous formula. In the funding calculations the formula considered TB case numbers, those suspected of illness, drug resistance, co-infection with HIV, population counts, geographic factors, and cases completing adequate therapy. After review, the workgroup added a parameter counting latent TB infection (LTBI). Individuals with LTBI are infected with the TB organism but have not developed TB disease. For these individuals, preventive medications can halt the progression from TB infection to TB disease. Since preventive therapy is a pivotal component in controlling the spread of TB infection, the workgroup opted to include it in the formula.

With the full support of the Committee, the workgroup's activities concluded with the funding formula's approval by DSHS Commissioner, David Lakey, M.D., on May 1, 2013.

Define Core Public Health Services

Another important facet of the Committee's activities was to refine the elements that constitute essential or 'core' public health services for Texans. When provided, these services enhance the health of individuals and communities; promote physical health; improve mental health status; and prevent disease, injury, and disability. The process entailed reviewing national documents and guidelines regarding best public health practices and then applying these concepts to the Texas public health system.

The 1988 Institute of Medicine's (IOM) *Future of Public Health* provides the national framework for government's role in public health.[4] This study identified the core functions of public health agencies as 1) assessment, 2) policy development, and 3) assurance. Regarding assessment, the IOM committee recommended that every public health agency regularly collect and analyze data on the health of a community. Regarding policy development, it recommended in the public's interest that every public health agency develop comprehensive public health policies. And lastly, regarding assurance, the IOM committee recommended that public health agencies assure their constituents receive the services necessary to achieve public health goals.

[4] http://iom.edu/Reports/1988/The-Future-of-Public-Health.aspx.

Six years later in 1994, the Public Health Functions Steering Committee (consisting of numerous national public health and governmental groups) crafted the landmark "Essential Public Health Services" document.[5] Closely aligned with the assessment, policy development, and assurance pieces of 1988, the ten services describe the public health activities that ideally all communities should provide. For two decades, the ten, listed below, have served as the linchpin for state and national public health policy development.[6]

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 competent public and personal health care 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: Centers for Disease Control and Prevention

In 2009, the Robert Wood Johnson Foundation petitioned the Institute of Medicine (IOM) to assemble a committee to examine three public health related topics: measurement, the law, and funding. The IOM responded, and the Committee on Public Health Strategies to Improve Health generated documents related to all three topics. Released in 2012, the third document, *For the Public's Health, Investing in a Healthier Future,* addresses resources needed to ensure a "robust population health system."[7]

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[5] Appendix C.
[6] http://www.cdc.gov/nceh/ehs/ephli/core_ess.htm.
[7] http://www.iom.edu/Reports/2012/For-the-Publics-Health-Investing-in-a-Healthier-Future.aspx.

A key feature of the third document was the IOM committee's recommendation for the development of a "minimum package of public health services." According to the IOM committee, this basic set of public health services must be made available in all jurisdictions. The package can be broken down into two subcategories: 1) foundational capabilities and 2) the basic programs.

The foundational capabilities, such as information systems, community health planning, and policy development, are elements supporting public health programs. The report metaphorically compares these to the trunk of a tree, with the basic public health programs as the branches. Unfortunately, the current public health funding structure is based primarily on categorical grants that underfund the foundational capabilities (the trunk) and focus on the programs (the branches). The IOM committee recommended the CDC and other funders develop a mechanism to appropriately fund the foundational capabilities.

Basic programs are those every public health department should maintain and operate. This would include, but are not limited to, maternal and child health promotion, communicable disease prevention, and environmental health.

The IOM committee did not provide a detailed listing of foundational capabilities or basic programs for inclusion in a minimum package of services. Instead it deferred their development to other stakeholder groups for careful stakeholder input and creation. In December 2012, the National Association of County and City Health Officials (NACCHO) developed the statement of policy entitled "Minimum Package of Public Health Services.[8] The NACCHO statement suggested the package be available nationwide for LHDs, LHDs in conjunction with state health departments, or through partnerships. Also, the package should build upon the three core public health functions and the ten essential public health functions. And, NACCHO posited the package could establish a consistent basis for investments in LHDs. The entire listing of foundational capabilities and basic programs is located in the Trust for America's Health issue brief, "Define 'Foundational' Capabilities of Public Health Departments."[9]

Part of the Committee deliberations also included reviewing documents produced by the Public Health Accreditation Board (PHAB), the national accrediting organization for public health departments. PHAB is a nonprofit organization dedicated to improving and protecting public health by advancing the quality and performance of health departments. Released in May 2011, PHAB's *Standards and Measures* document serves as the blueprint for national public health department accreditation and organizes its public health standards into 12 groupings called "domains."[10] The first ten domains address the ten essential public health services, while Domain 11 addresses management and administration and Domain 12 addresses governance.

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[8] http://www.naccho.org/advocacy/positions/upload/12-18-Minimum-Package-of-Benefits.pdf.
[9] Appendix D, and http://healthyamericans.org/assets/files/Define%20Foundational%20Capabilities03.pdf.
[10] http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf.

The Committee uses the core public health functions and ten essential services as the foundation for activities. After the release of the NACCHO Statement of Policy, "Minimum Package of Public Health Services," the Committee deliberated over adopting the package as a foundation for the Texas public health system. The Committee discussed how all these pertinent national standards and guidelines mentioned above could provide direction and relevance to the present-day public health system in Texas. After careful review, the Committee advanced recommendations for the "…development of the foundation for a statewide public health system." Taking the twelve PHAB domains and overlapping them with the "Minimum Package of Public Health Services," the Committee created a document entitled "Foundational Public Health Capabilities/12 Accreditation Domains."[11] Incorporating key elements from both the PHAB and the minimum package, the document provides a roadmap for the future of public health in Texas, and ensures residents receive basic public health services. Taken from the minimum package, the document lists seven basic programs LHDs should provide.

The Committee's action culminated on July 19, 2013, when a letter was forwarded to all Texas local public health officials seeking their opinion regarding the adoption of these concepts as the foundation for the public health system in Texas.[12] Attached to the letter was a copy of the "Foundation Public Health Capabilities/12 Accreditation Domains" document. The letter queried directors as to whether or not the seven basic programs should be required across the state. After reviewing the comments received, the committee will take appropriate action steps in the upcoming year. The Committee views the proposed adoption of these principals as an important step toward improving the Texas public health system and the health of Texas citizens.

[11] Appendix E.
[12] Appendix F.

SECTION III: Current Committee Projects

Texas Public Health System

The Committee is in the process of engaging stakeholders in the development of a model or standard public health system in Texas. The Committee reviewed the three documents discussed in Section II and drafted an outline of foundational capabilities to consider in the development of the public health system.[13] The document describes a comprehensive outline of services that could presumably be offered by local health departments (LHDs) statewide. The Committee's goal is to gain stakeholder support and input into the development of the minimum package of services a LHD in Texas should provide.

Health Authorities

The local health authority (LHA) survey conducted during the Committee's first year revealed several issues regarding LHAs that need addressing. The Committee established a workgroup to define the issues. The workgroup determined the LHA's role needs clarification for LHA appointees to better understand their jurisdiction and required duties.

The workgroup determined LHAs should be required to complete an annual training promulgated by DSHS. Also, the workgroup concluded Subchapter B of Chapter 121 of the Texas Health and Safety Code pertaining to health authorities needs revision. The Committee is in the process of formulating recommended revisions for DSHS' consideration for the next legislative session.

Syndromic Surveillance

Syndromic surveillance systems seek to use existing health data in real time to provide immediate analysis and feedback to those charged with investigation and follow-up of potential outbreaks. The Center for Disease Control and Prevention (CDC) reports using syndromic surveillance for: early detection of outbreaks; following the size, spread, and tempo of outbreaks; monitoring disease trends; and providing reassurance that no outbreak occurred.[14]

The Committee is working with a stakeholder workgroup to develop a statewide syndromic surveillance network. The workgroup agreed on a structure for the syndromic surveillance network. This includes a single unified statewide system with two hubs, and bidirectional sharing of information and data between LHDs and the hubs, and the hubs and DSHS. The workgroup proposed establishing two advisory groups to provide direction to the hubs, and a Syndromic Surveillance Governance Council (SSGC) to provide overall structure, operational parameters, and future direction of the statewide syndromic surveillance network.[15] Currently, the Committee is working with DSHS to appoint the SSGC members so developing the overall structure and operations of the network can begin.

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[13] Appendix E.
[14] http://www.cdc.gov/mmwr/preview/mmwrhtml/su5301a3.htm.
[15] Appendix G.

SECTION IV: New Committee Recommendations

Recommendation A(1): The Committee recommends to the DSHS Commissioner that the Tuberculosis (TB) Program be encouraged to work with the local health departments to implement in their contracts PHAB Model Standards and Measures.

Progress to Date: Completed.

Discussion: The TB program and the Contract Management Unit worked with the Committee to include PHAB Model Standards and Measures in their TB contract work plans.

Recommendation A(2): The Committee recommends to the DSHS Commissioner that the TB Program support efforts to recognize the work inherent to handling and tracking the latent Tuberculosis infection (LTBI) cases.

Progress to Date: Completed.

Discussion: The TB Funding Formula Workgroup has included a plan to track LTBI cases and report them so that they may be taken into account in near future.

Recommendation B: The Committee recommends to the DSHS Commissioner that the agency work with the Committee to inform and educate third party payors about local health departments (LHDs) in order to eliminate barriers to entering into contracts with them for billing purposes.

Progress to Date: The Committee wrote a letter to the DSHS Commissioner and HHSC Executive Commissioner requesting assistance. DSHS responded in agreement and suggested the Committee work with Regional and Local Health Services (RLHS) Assistant Commissioner.

Discussion: The issues associated with local health departments contracting with third party payors for billing and reimbursement of public health services are complex and may vary by jurisdiction. These unresolved issues directly impact local health department services such as immunizations, TB, and sexually transmitted infection (STI) testing and treatment. Insured persons who seek these services are turned away because of inability of the LHDs to bill insurance plans, thus resulting in missed opportunities to prevent disease associated cost of preventable infectious illnesses.

Recommendation C: The Committee recommends to the DSHS Commissioner that the agency work with the Committee to: give greater definition to the scope and duties of the syndromic surveillance governance council; determine appropriate applications, such as

RODS, BioSense, ESSENCE, to use within the statewide network; provide formal assessment of the current syndromic surveillance network infrastructure and recommendations to integrate the current infrastructure into the developing statewide network; determine optimal number of hubs required; and develop standard operating procedures for data collection, ownership, due diligence of investigational methods, and transfer of data to corresponding LHDs/DSHS Health Services Regions.

Progress to Date: A workgroup met on December 6, 2013, and agreed upon a network structure. That structure was presented to the Committee for comment. Small changes were suggested and the Committee agreed to charge DSHS with establishing the governing council.

Discussion: Changes in the provision of syndromic surveillance services resulted in a need for a formal assessment of the network infrastructure, and recommendations for developing and integrating the existing infrastructure into a statewide network. The network's governing structure will develop standard operating procedures for data collection, ownership, due diligence of investigational methods, and transfer of data to corresponding LHDs/State regional offices.

Recommendation D: The Committee recommends to the DSHS Commissioner that the agency work with the Committee to establish a funding formula for the Public Health Emergency Preparedness (PHEP) funds that are allocated to local health departments.

Progress to Date: The Community Preparedness Section Director gave an overview and history of the current funding formula for these dollars on February 13, 2014.

Discussion: Senate Bill 127 charges DSHS to work with the Committee to develop funding formulas for federal and state funds appropriated to DSHS for allocation to LHDs, local health units, public health districts, and DSHS Health Service Regions' regional headquarters. When determining the formula, DSHS and the Committee must consider population, population density, disease burden, social determinants of health, local efforts to prevent disease, and other relevant factors.

SECTION V: Future Committee Considerations

Senate Bill 127

Senate Bill 127 passed during the 83rd Legislative Session. The bill authorized the Committee to work with DSHS to develop funding formulas based on specified criteria for federal and state appropriated funds. Senate Bill 127 calls for the Committee and DSHS to evaluate the feasibility and benefits of capping the percent of public health funds spent on administrative costs at local health departments (LHDs), local health units, public health districts, and DSHS Health Service Regions. The bill requires the Committee, in partnership with DSHS, to evaluate the public health functions provided by the state, LHDs, local health units, public health districts, and DSHS Health Service Regions. Lastly, the bill requires DSHS to develop a policy allowing flexible use of personnel and other resources during disaster response activities, outbreaks, and other public health threats.

DSHS and the Committee recently established a partnership to evaluate public health functions in the state. Using a phased approach, DSHS Division for Regional and Local Health Services (RLHS) in conjunction with LHDs will conduct a strategic process to delineate the role of governmental health in Texas and develop a plan for a coordinated health system. The first phase will examine DSHS and LHD missions, what services governmental health provides; how these services are provided, how they are measured, and how they can be improved.

DSHS is working with the Committee to develop funding formulas for federal and state appropriated funds. The Committee is reviewing the Public Health Emergency Preparedness (PHEP) and Local Public Health Services (LPHS) contract funds. The process is in the early stage of seeking input from stakeholders to develop the criteria for the formulas.

Sunset Advisory Commission

This year, Texas DSHS is under review by the Sunset Advisory Commission. Through Sunset, the Legislature looks closely at the need for, performance of, and improvements to the state agency under review.[16] The Sunset Commission evaluates the agency, completes a report, schedules public hearings, and presents recommendations to the Legislature. A Sunset bill on the agency is compiled and processed through the normal legislative processes.

The Committee views Sunset as a unique opportunity to assist with its public health initiatives. For example, one initiative is to provide statewide funding for public health activities. Most public health funding is categorical and designated to individual programs, such as Immunizations. In addition, the complexity of DSHS' budgeting process and program-specific funding does not provide a mechanism to fund foundational local public

[16] https://www.sunset.texas.gov.

health. The Committee and DSHS are working in conjunction to increase viable funding for public health in Texas. The Committee looks forward to working with Sunset to create a sustainable public health system in Texas.

APPENDICES

Appendix A

12-18

STATEMENT OF POLICY
Minimum Package of Public Health Services

Policy
NACCHO supports the development of an evidence- and experience-based minimum package of essential public health services and capacities that should be available nationwide from local health departments or by local health departments in conjunction with state health departments or through other partnerships. The minimum package of governmental public health services should consist of foundational capabilities and basic programs. **The minimum package of capacities and programs should be augmented by additional ones important to the department's community and given priority as a result of the community health needs assessment and health improvement plan**.

NACCHO believes it is essential that once such a minimum package of services is defined that the costs associated with adequately delivering it also be developed so that policy makers have a clear understanding of the financial, technological, and human resources necessary to assure the presence of these capabilities and programs for every community. The costs should be scaled to a jurisdiction's population size and capacity needed. Once developed and quantified, local health departments will require financial resources to provide these services. In addition, resources will be required for services provided through formal partnerships with neighboring local health departments and in arrangements with other community organizations or their state. Without those resources, local health departments cannot be expected to assure the delivery of the minimum package.

The minimum package should be built on the conceptual framework described by the three core public health functions[1], the ten essential public health services[2], the operational definition of a local health department[3], and capacities needed for public health preparedness. The foundational capabilities of the minimum package would be used by local health departments and their governing boards to plan and set priorities and as a framework for accountability and performance measurement, quality assurance and improvement and as the basis for standard setting by the Public Health Accreditation Board.

This minimum package should establish a threshold and a consistent basis for investments in governmental public health activity. The minimum package would be the public and population health equivalent of the essential benefits package established in the Affordable Care Act[4]. NACCHO believes that development of a minimum package of services for local health departments is an important first step to substantiating public investment in them. The minimum package of services should, as articulated in the Operational Definition, "describe the responsibilities that every person, regardless of where they live, should reasonably expect their local health department to fulfill."

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Foundational public health capabilities are those that support all program activities and facilitate a focus on the social determinants of health. These include:

- Information systems and resources (including disease and injury monitoring, surveillance and epidemiology, maintenance of birth and death data and systems to support electronic health records and data sharing with other clinical and community providers, informatics capacity, and the capability to maintain telephone, internet, social media, and other technologies for internal and external communication to inform the community, be informed by them, and reinforce healthy behaviors and lifestyles.
- Health assessment and planning (including community health improvement planning).
- Partnership development and community mobilization.
- Leadership, policy development, analysis, and decision support.
- Communication and public education (including health literacy and cultural competence).
- Marketing, branding, and outreach of LHD services to community and partners.
- Expertise in public health sciences, research, evaluation, interventions, and protections.
- Epidemiology capacity and expertise to support communicable and chronic disease prevention and control activities.
- Medical care experience and knowledge that fosters excellent and understanding relationships with clinical medicine partners in order to integrate public health and clinical medicine activities.
- Laboratory capacity or the ability to access adequate and appropriate laboratory capacity often provided by the state health department.
- Resource development (including grant writing, workforce development, and reimbursement, contracting, fee collection and supporting infrastructure, and/or local levy or other tax support).
- Organizational strategic planning, quality improvement and performance management, and quality assurance and improvement.
- Workforce development and training.
- Interaction with public health education and training institutions to develop the pipeline for the public health work force of the future.
- Human resources, facilities, administration, and governance expertise and tools.
- Financial management expertise and systems.
- Legal support and analysis expertise.

Basic programs are those mandatory programs provided by the local health department because no one else in the community provides them, or they are provided inadequately by others in the public health system despite efforts to encourage and incentivize others to do so. Basic programs are delivered on an adequate scale and quality to protect health on a population-wide basis within the local health department's jurisdiction. Basic programs are essential to achieving health equity and reducing health disparities in communities. For example:

- Communicable disease control (including disease detection, contact investigation, disease reporting, emergency disease response, provider education, outreach and education, trend analysis and communication to communities and medical providers, and quarantine authority).
- Chronic disease prevention (including outreach, tobacco control, and trend analysis and communication to communities and medical providers).

- Environmental health (including foodborne illness outbreak investigations).
- Public Health Preparedness and response (including disease control and public health hazard prevention and response).
- Vital Statistics collection, reporting, trend analysis and reporting to community and healthcare providers.
- Community Health Assessment, community health improvement planning and community activities such as Mobilizing for Action through Planning and Partnerships (MAPP) to inform communities about the public's health, needs and to lead the community in addressing population level issues.
- Patient safety and market oversight (including investigating and responding to outbreaks related to a health- or product-acquired infection or food borne illness).

There are other programs not part of the minimum package that create conditions that promote health that should be available in all communities but may not necessarily be provided by the local health department. Local health departments are, however, essential coordinators of these services (as identified in the parenthesis below) assuring that they are provided in their community. For example:

- Communicable disease control (including drug therapy and vaccination capacity).
- Chronic disease prevention (including health promotion of physical activity and better nutrition, health education and early intervention).
- Environmental health services, including licensing, inspection, and monitoring (air quality, drinking water, solid waste handling, sewage, lead screening and remediation, food safety including restaurant and public facility inspections, swimming pool/water feature inspections, school inspections, animal, rodent and insect control, nuisance abatement, drug lab site recovery and land use review).
- Public health preparedness and response (including emergency management, volunteer management, and vulnerable populations).
- Maternal and child health promotion (including WIC, visiting public health nurse and/or postnatal programs, children with special health care needs, prenatal and reproductive health programs, well baby and well child programs, public health child dental and dental sealant programs, and school health clinics).
- Injury prevention and control (including unintentional overdose, motor vehicle safety, intimate partner violence, senior fall prevention, traumatic brain injury, water recreation/safety, and safe household/maintenance programs).
- Mental health and substance abuse (monitor and assess).
- Clinical preventive and primary care services (including immunizations, medical and dental clinics, care coordination and navigation, reproductive and sexual health services).

NACCHO places a high priority on the development of the minimum package. The body developing the minimum package should, at a minimum, include national public health organizations representing local and state health departments and their governing entities, the public health community-at-large, foundations with a demonstrated interest in local and state governmental public health practice, federal government partners and governmental public health practitioners at the local and state level. The minimum package should define the exclusive work for local health departments and be informed by current state and local efforts now underway to develop such a package.

Justification

In April 2012, the Institute of Medicine issued a report entitled "For the Public's Health: Investing in a Healthier Future" funded by the Robert Wood Johnson Foundation (RWJF)[5]. The report points out that American federal state, and local governments spent $8,086 per person on medical care in 2009 versus $251 in public health spending. The report makes ten recommendations including that an expert panel convened by the National Prevention, Health Promotion, and Public Health Council develop the components and the cost of a minimum package of public health services that every community should receive from its state and local health departments. The report also recommends that "public health agencies at all levels of government, national public health professional associations, policy makers, and other stakeholders should endorse the need for a minimum package of public health services." RWJF and others are interested in operationalizing the recommendations.

The development of the components and cost of a minimum package of public health services is necessary for the following reasons:

1. A minimum package articulates a vision of where local health departments aim to be in terms of structure and service delivery. With adequate funding, local health departments of the future will be a source of knowledge and analysis on community and population health; a convener, coalition-builder, and mobilizing force to build health considerations into all aspects of community planning and action; a steward of the community's health, assuring that policies and services needed for a healthy population are in place; and a partner of the clinical care delivery system in developing information about effectiveness and appropriateness of service delivery.
2. A minimum package provides visibility and a brand for local health departments assuring consistency from one community to another. At present, health departments and the work they do are often invisible. Local health departments are perceived as an amalgamation of disparate programs.
3. A minimum package is essential to substantiating investments in governmental public health because policy makers would know what they were investing in and what the return on investment would be. A minimum package creates clarity for policy makers on the minimum level of capacity that health department should have and the funding necessary to provide them. The foundational capabilities are currently supported in a piecemeal fashion through scraps of categorical funds. The intention is to move away from the siloed funding approach to something much more flexible to support the necessary foundational capabilities.
4. A minimum package would help guide program and job cuts when health department budgets are cut. Health departments continue to struggle to do less with less and are faced everyday with painful decisions on what to cut and what to keep. The package would inform that decision making.
5. With a minimum package, local health departments will be able to determine their workforce, training, and recruitment needs for the future. This may also influence schools of public health curricula to meet the workforce needs of governmental public health agencies.
6. Health departments will have a clearer idea of their technology needs in terms of information systems, epidemiology and laboratory capacity, finance and accounting management.

7. Health department quality improvement activities will be strengthened by having a minimum package in place across the country. This will facilitate cross jurisdictional sharing and adoption of quality improvement activities and outcomes.
8. A minimum package is essential to developing a common accounting and management framework for public health services. Without better financial information, public health departments are unable to link cost data to their organizational structures, staffing patterns, and service delivery models and thus limit their ability to enhance the productivity and efficiency of their operations.
9. As articulated in the Operational Definition of a Functional Local Health Department[3], "all local health departments exist for the common good, and are responsible for demonstrating strong leadership in the promotion of physical, behavioral, environmental, social and economic conditions that improve health and well-being, prevent illness, disease, injury and premature death, and eliminate health disparities. However, in the absence of specific, consistent standards regarding how local health departments fulfill this responsibility, the degree to which the public's health is protected and improved varies widely from community to community."

References

[1] Institute of Medicine, Committee on the Future of Public Health (1988). *The Future of Public Health.* Washington, DC: National Academy Press.
[2] Public Health Functions Steering Committee (1994). *Public Health in America.* Washington, DC: U.S. Public Health Services.
[3] National Association of County and City Health Officials (2005). *Operational Definition of a Functional Local Health Department.* Washington, DC: National Association of County and City Health Officials.
[4] Patient Protection and Affordable Care Act (PPACA) §1301(a). The essential benefit package for plans offered in the exchanges must include the following benefit classes: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
[5] Institute of Medicine, Committee on Public Health Strategies to Improve Health (2012). *For the Public's Health: Investing in a Healthier Future*. Washington, DC: National Academies Press.

Record of Action

Proposed by NACCHO Board of Directors
Adopted by NACCHO Executive Committee on behalf of the Board of Directors on December 19, 2012

Appendix B

Prevent, Promote, Protect
Building a Public Health Infrastructure in Texas

Wellness

- Nutrition
- Physical Activity
- Behavioral Incentives

Maternal Child Health

- WIC
- Family Planning
- Well-child

Chronic Disease / Prevention

- Obesity
- Hypertension
- Tobacco
- Diabetes

Infectious Disease

- STD
- Immunizations
- Hepatitis
- HIV
- Zoonosis
- Reportable Conditions
- TB
- Foodborne Illnesses

Safety / Injury Prevention

Environmental

- Air
- Day Cares
- Consumer (Restaurants)
- Water
- Septics
- Built Environment

Preparedness

- Exercise/Training
- Natural Disaster Resp.
- Evacuation/Sheltering
- EOC Support

Disease Surveillance

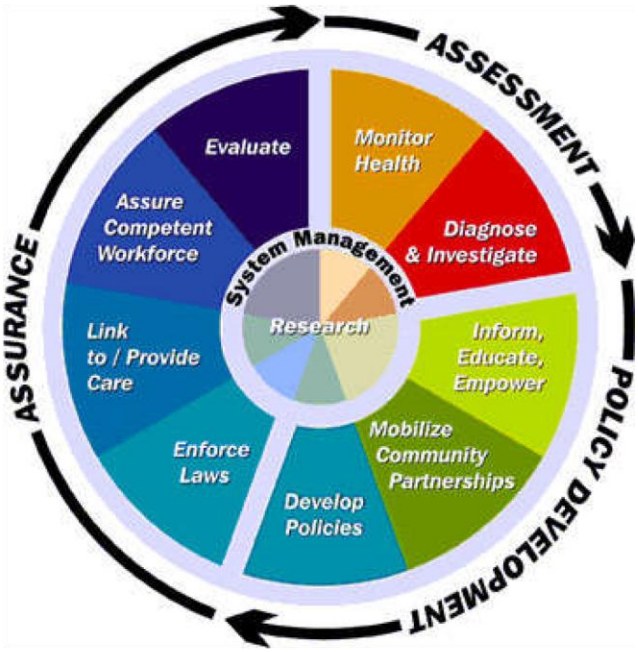
- Epidemiology
- Analytical Capacity
- Syndromic Surveillance
- Laboratory

Administrative/Business Operations/Capacity Building

- Technical Support
- Workforce Development
- Business Efficiencies
- Operations/Finance
- Fund Development
- Advocacy (Telling story)

Appendix C

Public Health Core Functions and 10 Essential Services



The following core functions of public health and ten essential services provide the framework for all activities of the Department:

Core Function 1—Assessment

Assessment, monitoring, and surveillance of local health problems and needs, and of resources for dealing with them

Essential Service #1: Monitor health status and understand health issues facing the community

Essential Service #2: Protect people from health problems and health hazards

Core Function 2—Policy Development

Policy development and leadership that fosters local involvement and a sense of ownership that emphasizes local needs and that advocates equitable distribution of public resources and complementary private activities commensurate with community needs

Essential Service #3: Give people the information they need to make healthy choices

Essential Service #4: Engage the community to identify and solve health problems

Essential Service #5: Develop public health policies and plans

Core Function 3—Assurance

Assurance that high-quality services, including personal health services, needed for protection of public health in the community are available and accessible to all persons; that the community receives proper consideration in the allocation of federal, state and local resources for public health; and that the community is informed about how to obtain public health, including personal health services, or how to comply with public health requirements

Essential Service #6: Enforce public health law and regulations

Essential Service #7: Help people receive health services

Essential Service #8: Maintain a competent public health workforce

Essential Service #9: Evaluate and improve programs

Core Function 4—System Management

Essential Service #10: Contribute to and apply the evidence base of public health

http://www.cdc.gov/nphpsp/essentialservices.html

Appendix D

ISSUE BRIEF

Define "Foundational" Capabilities of Public Health Departments

Current Status:

Public health departments around the country have the unique role and responsibility for improving health in schools, workplaces and neighborhoods, through identifying the top health problems and developing strategies for improvement.

As of 2012, however, the field of public health faces a new set of challenges and opportunities, including:

- Changes in the overall health system that emphasizes cost containment and improved health, and expansion of the number of individuals with insurance coverage for direct preventive services;
- Massive budget and workforce cuts at all levels of government;
- A growing focus on accountability, with higher expectations for demonstrating a return on investment in terms of cost and health improvement. This includes a movement toward accreditation to ensure that all health departments meet and can demonstrate a standardized set of core capabilities; and
- Adoption of new technologies, including electronic health records, which could allow public health to integrate and analyze data with the health system and other sectors to better identify health patterns, causes and cures for health problems, and "hot spot" areas with high rates of chronic diseases and costs.

Why Public Health Departments Matter:

- Where you live shouldn't determine how healthy you are, and public health departments serve as the unique and essential component of an integrated health system that looks out for the population as a whole, rather than focusing on the health outcomes of individuals alone.
- Public health is responsible for identifying the biggest, highest cost health problems and developing the most effective strategies for improving health.
- Public health departments bring together partners in states, counties, cities and communities around the country to assess community-specific needs, and to plan and implement activities designed to improve health outcomes and reduce health care expenditures.
- Public health plays an essential role in protecting Americans' health from threats ranging from bioterrorism to infectious disease outbreaks to extreme weather events.

Recommendations:

▲ **Strengthen the role of Health Departments as the chief health strategist in communities:** In response to the new challenges and opportunities confronting our nation in 2013, public health departments must assume greater accountability for the design and development of the overall strategic plan for improving health in communities. To do this, health departments must clearly establish their value and role in a reformed health system — especially in the identification, implementation, coordination and evaluation of cost-beneficial prevention programs and activities. Strengthening this role will also require a greater focus on efficient, effective practices for structure, organization, finance and delivery of public health,

JANUARY 2013

PREVENTING EPIDEMICS.
PROTECTING PEOPLE.

including on-going public health services and systems research to identify new evidence-based practice and approaches.

- **Define, prioritize and fully fund a set of foundational capabilities for public health departments at all levels of government:** Public health departments need the tools and skills that are necessary to provide basic public protections while adapting to and effectively addressing changing health threats. The Institute of Medicine (IOM) and the Transforming Public Health project, funded by the Robert Wood Johnson Foundation (RWJF), identified some of these foundational capabilities as developing policy, using integrated data assets, communicating with the public and other audiences to disseminate information, mobilizing the community and forging partnerships, cultivating leadership skills, demonstrating accountability and protecting the public in the event of an emergency or disaster.[1,2] Ensuring these foundational capabilities should become a primary focus of federal, state and local funding, even if it means restructuring some categorical funding streams, and funding must be maintained at a level to guarantee these capabilities can be effectively maintained and delivered.

- **Prioritize accountability for achieving and maintaining foundational capabilities through accreditation and other mechanisms:** Accreditation, continuous quality improvement and transparency are important parts of ensuring these foundational capabilities are met and maintained. Specifically, achieving voluntary accreditation from the Public Health Accreditation Board (PHAB) is a process where governmental public health departments can begin to demonstrate core competencies and accountability. In the future, accreditation could also be used as an important mechanism for states and localities to more easily and efficiently demonstrate that they have met the capabilities required for federal funding opportunities.

- **Integrate with health care providers to contain costs and improve health:** Public health departments must adapt to work with new entities and financing mechanisms in the reformed health system, such as by working with Accountable Care Organizations (ACOs) or within new capitalized care structures and global health budgets, to help improve health beyond the doctor's office.

- **Partner with other sectors and members of the community to make healthier choices easier in our schools, workplaces and neighborhoods:** Public health officials must work with other sectors, such as education, transportation and housing, to capitalize on the many opportunities to promote health and wellness where Americans live, learn, work and play.

- **Develop a public health workforce to meet modern demands:** The future public health workforce should be more versatile and better equipped to handle various public health challenges or threats. This workforce should have policy development skills, management/administrative skills, technological skills and communications skills needed to create the foundational capabilities that all health departments should have. Public health workers also must be able to draw from and work with other fields and overlapping disciplines such as education, transportation and the environment and receive continued re-training and professional development opportunities to meet evolving needs. In addition:
  - **The public health workforce measures in the Affordable Care Act (ACA) must be fully funded and implemented;**
  - **Public health curricula and job re-training must include developing skills in Health Information Technology (HIT), policy and legal areas, and cross-sector management; and**
  - **Training programs for health workers, including community health workers and HIT professionals, and in other sectors where programs impact health must emphasize the need for multiple sectors to work in coordination.**

- **Use modern technology to improve the ability to identify top health problems in a community and determine their causes and cures:** New data systems and electronic health records (EHRs) have the potential to revolutionize health tracking by making it possible to collect and analyze health data in real-time and allow interactive communication among providers, health departments and other sectors. Instead of continuing to have a series of siloed systems to track different diseases and other health problems, connecting different sources of data so they are interoperable and available in real-time could lead to breakthroughs in identifying health trends and patterns. In addition, public health must monitor a range of factors — from educational attainment to employment — that impact health outcomes even if they are not under the direct purview of public health.

▲ **Public health departments should only pay for direct services when they cannot be paid for by insurance:** Some public health departments provide direct services in their community along with other preventive programs. Since the ACA will expand the number of individuals with coverage and expand what services are covered by many insurance providers, public health departments should reassess their role in the direct provision of medical services (including the option of becoming a Federally Qualified Health Center), to ensure that they do not use their public health budgets to pay for services that could be billed to insurers or could be paid for through health center dollars.

DEFINING FOUNDATIONAL CAPABILITIES FOR PUBLIC HEALTH

In their April 2012 report, *For the Public's Health: Investing in a Healthier Future,* the IOM called for increased focus and prioritization among governmental public health agencies. They identified a set of "foundational capabilities" that included:[3]

- Information systems and resources;
- Health planning;
- Partnership development and community mobilization;
- Policy development analysis and decision support;
- Communication; and
- Public health research, evaluation and quality improvement.

Following the IOM report, a group of leading public health experts participated in the Transforming Public Health project, an initiative funded by RWJF to develop guidance for public health officials and policymakers to prioritize vital public health functions in a shifting political landscape.[4]

They summarized the foundational capabilities of public health as:

- Developing policy to effectively promote and improve health;
- Using integrated data sets for assessment, surveillance and evaluation to identify crucial health challenges, best practices and better health;
- Communicating with the public and other audiences to disseminate and receive information in an effective manner for health, including health promotion opportunities, access to care and prevention.
- Mobilizing the community and forging partnerships to leverage resources (funding and otherwise);
- Building new models that integrate clinical and population health;
- Cultivating leadership, organization, management and business skills needed to build and sustain an effective health department and workforce to effectively and efficiently promote and improve health;
- Demonstrating accountability for what governmental public health does directly and for those things that it oversees through accreditation, continuous quality improvement and transparency; and
- Protecting the public in the event of an emergency or disaster, as well as responding to day-to-day challenges or threats, with a cross-trained workforce.

The project also identified a set of additional important issues for public health departments to consider, which include:

- Maintaining a culture of continuous quality improvement;
- Improving coordination across all levels of government to foster synergy and efficiency;
- Building a better and cross-trained workforce that is more versatile and well equipped to handle a range of public health needs;
- Bolstering research, by capitalizing on improved technology to access and analyze data, to better demonstrate the value of public health and prevention services and programs; and
- Ensuring sufficient, stable and sustainable funding for public health, including leveraging resources from non-traditional sources that also have an interest in improving health, such as across government agencies and from the health care sector, private industry, non-profit fundraising and community development.

The project stressed that "prioritizing is the only way to take on new challenges in a time of declining resources." To be successful in the future, public health should focus on:[5]

- Ensuring what is being done is being done as well and as efficiently as possible;
- Coordinating across all levels of the governmental public health system and other government agencies and jurisdictions to maximize impact; and
- Cultivating and/or training a workforce that can deliver foundational capabilities when implementing programs.

PUBLIC HEALTH ACCREDITATION

The PHAB, created in 2007, has created a voluntary public health accreditation program for state and local public health departments.[6] This accreditation process is a major effort to improve and standardize core capabilities of health departments.

The PHAB administers the national public health department accreditation program for public health departments operated by Tribes, states, local jurisdictions and territories.[7] PHAB accreditations include domains (groups of standards that pertain to a broad group of public health services), standards (the required level of achievement that a health department is expected to meet), and measures (evaluation tools for meeting standards).

There are 12 domains. The first ten domains address the 10 Essential Public Health Services; domain 11 addresses management and administration, and domain 12 addresses governance.[8]

The 12 domains include:

Domain 1: Conduct and disseminate assessments focused on population health status and public health issues facing the community.

Domain 2: Investigate health problems and environmental public health hazards to protect the community.

Domain 3: Inform and educate about public health issues and function.

Domain 4: Engage with the community to identify and address health problems.

Domain 5: Develop public health policies and plans.

Domain 6: Enforce Public Health Laws.

Domain 7: Promote strategies to improve access to health care services.

Domain 8: Maintain a competent public health workforce.

Domain 9: Evaluate and continuously improve health department processes, programs and interventions.

Domain 10: Contribute to and apply the evidence base of public health.

Domain 11: Maintain administrative and management capacity.

Domain 12: Maintain capacity to engage the public health governing entity.

Standard 5.4 focuses specifically on preparedness and requires that public health departments maintain an all hazards emergency operations plan. In order to become accredited, a health department must:[9]

- Participate in the process for the development and maintenance of an All Hazards Emergency Operations Plan (EOP);
- Adopt and maintain a public health EOP; and
- Provide consultation and/or technical assistance to Tribal and local health departments in the state regarding evidence-based and/or promising practices/templates in EOP development and testing.

ENDNOTES

1 Institute of Medicine. *For the Public's Health: Investing in a Healthier Future.* Washington, D.C.: National Academies Press, April 2012.

2 RESOLVE. "Transforming Public Health: Emerging Concepts for Decision Making in a Changing Public Health World." 2012.

3 Institute of Medicine. For the Public's Health: Investing in a Healthier Future. Washington, D.C.: National Academies Press, April 2012.

4 RESOLVE. "Transforming Public Health: Emerging Concepts for Decision Making in a Changing Public Health World." 2012.

5 Ibid.

6 Welcome to the Public Health Accreditation Board. In *Public Health Accreditation Board.* http://www.phaboard.org/ (accessed November 9, 2012).

7 Public Health Accreditation Board. Standards and Measures. Alexandria, VA: Public Health Accreditation Board, 2011.

8 Ibid.

9 Ibid.

Appendix E

FOUNDATIONAL PUBLIC HEALTH CAPABILITIES/
12 ACCREDITATION DOMAINS

Domain 1: Conduct and disseminate assessments focused on population health status and public health issues facing the community

- Health assessment and planning (including community health improvement planning).

Domain 2: Investigate health problems and environmental public health hazards to protect the community

Domain 3: Inform and educate about public health issues and functions

- Information systems and resources (including disease and injury monitoring, surveillance and epidemiology, maintenance of birth and death data and systems to support electronic health records and data sharing with other clinical and community providers, informatics capacity, and the capability to maintain telephone, internet, social media, and other technologies for internal and external communication to inform the community, be informed by them, and reinforce healthy behaviors and lifestyles.
- Communication and public education (including health literacy and cultural competence).
- Marketing, branding, and outreach of LHD services to community and partners.

Domain 4: Engage with the community to identify and address health problems

- Partnership development and community mobilization.

Domain 5: Develop public health policies and plans

- Leadership, policy development, analysis, and decision support.

Domain 6: Enforce public health laws

- Legal support and analysis expertise.

Domain 7: Promote strategies to improve access to health care services

- Medical care experience and knowledge that fosters excellent and understanding relationships with clinical medicine partners in order to integrate public health and clinical medicine activities.

Domain 8: Maintain a competent public health workforce

- Expertise in public health sciences, research, evaluation, interventions, and protections.
- Epidemiology capacity and expertise to support communicable and chronic disease prevention and control activities
- Medical care experience and knowledge that fosters excellent and understanding relationships with clinical medicine partners in order to integrate public health and clinical medicine activities.
- Laboratory capacity or the ability to access adequate and appropriate laboratory capacity often provided by the state health department.
- Workforce development and training.
- Interaction with public health education and training institutions to develop the pipeline for the public health work force of the future.

Domain 9: Evaluate and continuously improve health department processes, programs, and interventions

- Organizational strategic planning, quality improvement and performance management, and quality assurance and improvement.

Domain 10: Contribute to and apply the evidence base of public health

Domain 11: Maintain administrative and management capacity

- Resource development (including grant writing, workforce development, and reimbursement, contracting, fee collection and supporting infrastructure, and/or local levy or other tax support).
- Human resources, facilities, administration, and governance expertise and tools.
- Financial management expertise and systems.

Domain 12: Maintain capacity to engage the public health governing entity

Basic Programs

- **Communicable Disease Control** - Includes disease detection, contact investigation, disease reporting, emergency disease response, provider education, outreach and education, trend analysis and communication to communities and medical providers, and quarantine authority.

- **Chronic Disease Prevention -** Provide health education and health promotion policies, programs processes, and interventions to support prevention and wellness.

- **Environmental Health** - (including foodborne illness outbreak investigations). Investigate suspected or identified health problems or environmental public health hazards. This includes epidemiologic identification of emerging health problems and mitigation of outbreaks.

- **Public Health Preparedness and Response** - (including disease control and public health hazard prevention and response). Conduct timely investigations of health problems and environmental public health hazards and ensure access to laboratory and epidemiologic/environmental public health expertise and capacity to investigate and contain/mitigate problems and hazards.

- **Health Statistics** - Collection, reporting, trend analysis and reporting to community and healthcare providers.

- **Community Health Assessment** - Community health improvement planning and community activities such as Mobilizing for Action through Planning and Partnerships (MAPP) to inform communities about the public's health, needs and to lead the community in addressing population level issues.

- **Patient Safety and Market Oversight** - Including investigating and responding to outbreaks related to a health- or product-acquired infection or food borne illness.

Appendix F

Public Health Funding and Policy Committee

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

July 19, 2013

To: Texas Local Public Health Officials

Re: Concept Regarding Minimum Package of Public Health Services

During its last meeting on June 14, 2013, the Public Health Funding and Policy Committee (Committee) considered adopting the attached document as a recommendation for the development of the foundation for a statewide public health system. The document is a list of the twelve Public Health Accreditation Board (PHAB) domains overlapped by the foundational public health capabilities as outlined in the National Association of County & City Health Officials (NACCHO) Statement of Policy Minimum Package of Public Health Services (2012). See attached. It also lists seven basic programs that should be provided by local health departments as outlined in the NACCHO policy statement. Please note the Committee agreed to change the name of one of the basic programs from "vital statistics" to "health statistics" because the term better reflects the type of information local health departments collect and analyze.

Before making a formal recommendation, the Committee is seeking your opinion about the adoption of the concept as the foundation for a public health system in Texas. Specifically, we would like your comments regarding the mandatory basic programs and your opinions on whether these programs should be required in every area of the state to ensure the residents receive basic public health services across the state.

Please submit your comments to the attention of Leslie Phelps at Leslie.Phelps@houstontx.gov by Monday, August 5, 2013. The Committee would like to discuss the responses it receives during its next meeting on Friday, August 9, 2013.

Thank you for your valuable input regarding this matter.

Sincerely,

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

Attachments

cc: PHFP Committee Members

Appendix G

SYNDROMIC SURVEILLANCE WORKGROUP
SUMMARY OF ACTIONS

- ✓ Agreed with structure of network as presented (Attachment 2)
- ✓ Defined roles and responsibilities of Syndromic Surveillance Governing Council (SSGC) (Attachment 3)
- ✓ Agreed to overall goal of a single unified syndromic surveillance system including:
    - i. In the short run continuing to support RODS
    - ii. Upgrading ESSENSE
    - iii. In-depth assessment of syndromic surveillance systems in use throughout the state
- ✓ Agreed that the state should have two syndromic surveillance hubs; future hubs may be necessary and can be discussed by SSGC
- ○ Provide a formal assessment of the current network infrastructure and recommendations to integrate the current infrastructure with the statewide network to be developed – Referred for completion to technical working group once SSGC is established
- ○ Develop standard operating procedures (documentation) for data collection, ownership, due diligence of investigational methods, and transfer of data to corresponding LHDs/State regional offices. – Referred to technical working group once SSGC is established
- ○ Create two hub advisory groups (one per hub) to assist with ongoing regional strategy, operations, technical issues, etc. of interest to LHDs within each hub

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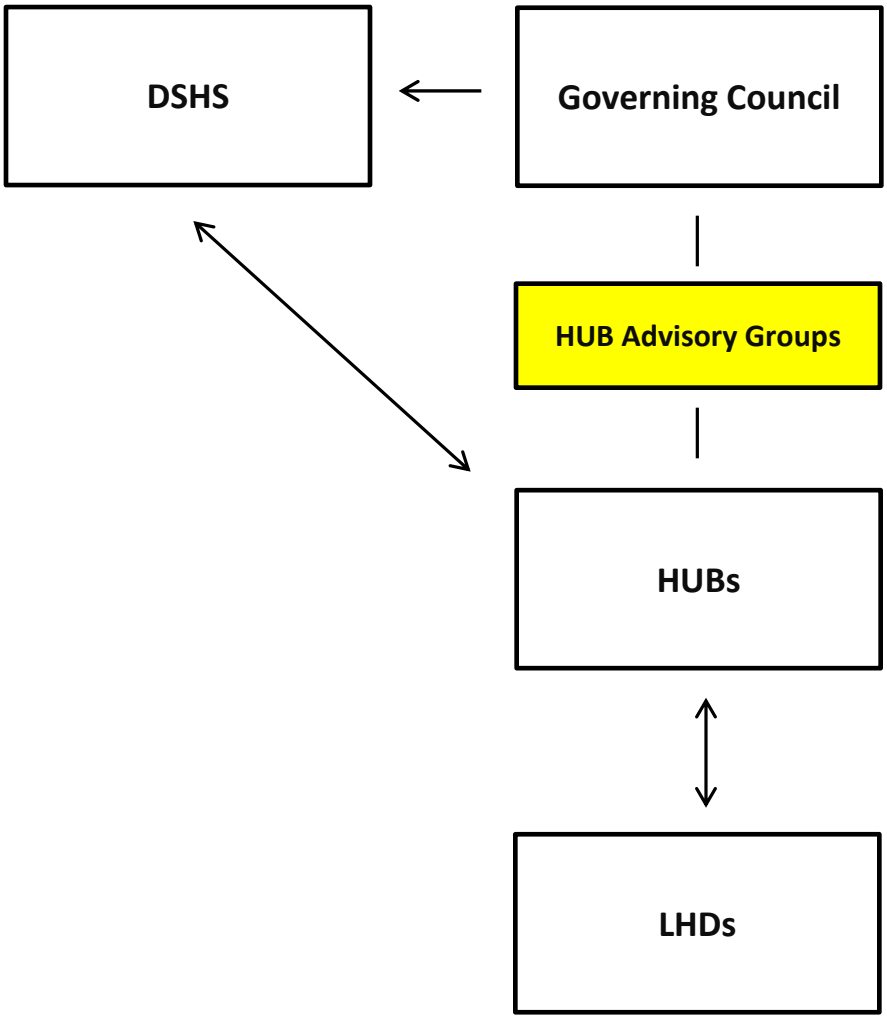
PROPOSED SYNDROMIC SURVEILLANCE NETWORK



ROLES AND RESPONSIBILITIES OF GOVERNING COUNCIL

I. Roles, responsibilities and requirements

The Syndromic Surveillance Governing Council (SSGC) provides guidance regarding structure, operational parameters, and future direction of the statewide syndromic surveillance network.

Responsibilities of membership to the SSGC are to align with the mission, participate in the creation of short and long term plans and contribute in meetings as workgroups are required.

Each member should have a thorough understanding of the mission, display commitment to the council's work, prepare for and participate in meetings, maintain confidentiality and send proxy to meetings or give notice of absence to the Chair in advance of meeting.

II. Mission

Our mission is to provide LHDs with the ability to assess outbreak risks, respond to public health emergencies, and use data to inform public health strategies and interventions.

III. Meetings

SSGC's regular meetings will be held on a quarterly basis. Special meetings may be called at the request of Chair. Notice of meetings shall be given to each member in person, by mail, email, telephone or facsimile at least fifteen (15) business days prior to such meetings. The members of the governing council may hold a meeting via conference call as needed.

IV. Structure

The structure of the SSGC will consist of two "Hub" representatives, three local health department representatives, one Department of State Health Services Central Office representative, one Department of State Health Services Regional Office representative, one provider representative, one local health department representative engaged in syndromic surveillance and one representative from a school of public health. The three local health department representatives should be one of each from a jurisdiction with a population of 50,000 or less, a population greater than 50,000 but less than 250,000, and population of at least 250,000. A jurisdiction shall not have more than one representative on the council. The structure may be altered, amended or repealed and new structure may be adopted by the affirmative vote of a majority of the members present at any regular or special meeting of the SSGC, provided that at least 30 days written notice of intention to alter, amend or repeal and adopt to new structure at such meeting is given to the members.

V. Terms of Members

The initial members shall volunteer for the positions for which they qualify. Once all members have been seated, their position numbers will be assigned through random selection (Positions 1 through 10). The Positions shall be divided into three Classes as follows: Class 1 shall include Positions 1 and 2; Class 2 shall include Positions 3, 4 and 5; Class 3 shall include Positions 6, 7 and 8; Class 4 shall include Positions 9 and 10 which shall be the standing positions of the two HUB members. The term of office for members serving in Class 1 shall expire on September 1, 2014 and on the same date on each third successive year thereafter. The term of office for members serving in Class 2 shall expire on September 1, 2015 and on the same date on each third successive year thereafter. The term of office for members serving in Class 3 shall expire on September 1, 2016 and on the same date on each third successive year thereafter. The process of all subsequent appointments or reappointments shall be determined after the establishment of the SSGC.