Capital Area Rural Health
ROUNDTABLE NOTES

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New Data and Analysis of the Rural Infrastructure... also on this website.

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From the Bottom Up: Building a Sustainable Public Health System

In modernizing the public health system, policymakers would do well to concentrate a considerable portion of this year's six-fold crash funding increase for bio-terrorism on the system's basic need for infrastructure and sustainability, according to discussions at a February 27th Capital Area Rural Health Roundtable.

The February Roundtable underscored public health's serious handicaps in rural regions, where 20 percent of the nation's population stretches over more than 80 percent of the land mass. It is also where public health meets the road – burdened with broad responsibilities, more terrain, and few alternative resources.

"Local agencies are the "delivery arm" of public health, said Mary Wakefield, R.N., Ph.D., and somewhere between 48 and 60 percent of those agencies are rural. Wakefield is a member of the National Advisory Committee on Rural Health (NACRH), a sixteen member expert panel which issued a report in February of 2000 that called rural public health exceptionally hamstrung, under-funded and lacking in trained personnel.

While rural agencies operate at the front line of the system, they're at the back of the line for funding, said Wakefield.

WAKE-UP CALL

For two decades, the nation's preventive health and sentinel warning system has been left on the back burner of public policy, partly a victim of its own success in reducing infectious disease, said Dean Rosen, who was invited to open the forum. He is minority staff director for the Subcommittee on Public Health of the Senate Health, Education, Labor and Pensions Committee and a key staffer to Tennessee Senator Bill Frist.

As global travel has increased and immunization programs waned, Frist, a transplant surgeon, has led a Congressional effort in the last few years to address the nation's renewed vulnerability to infectious disease, especially from a bio-terror assault.

Rosen said the importance of the public health system has been difficult for the public to grasp, but last fall's anthrax crisis created a visceral awareness of its critical role.

Rural is where public health meets the road – burdened with broad responsibilities, more terrain, and few alternative resources.

On October 15th when an anthrax-laced letter arrived in Senator Tom Daschle's office, Rosen said he was in Tennessee with Senator Frist and key state emergency and public health officials. It was the first time for many of them to be in the same room, he said, and **they were confronted by the fact that Tennessee public health had "no rapid means of communication**, either by fax or internet with hospitals, providers, or public health counterparts in labs across the state."

ENHANCED FEDERAL SUPPORT

Rosen said last year's Congressional "vision" to close national gaps in public health over a ten-year period through the Public Health Threats and Emergencies Act* is now on fast-forward. In December, Congress appropriated $1 billion in grants

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for 2002 – to be available to all states as "enhanced federal support for state and local infrastructure."

Until recently, however, there has been little comparative data on rural public health that might guide states under the new emergency grants – of which 20 percent in planning funds is already being released by the Department of Health and Human Services.

NEW RURAL DATA

The Roundtable forum offered a follow-up to the NACRH report with a new study by the National Association of County and City Health Officials (NACCHO). It compares rural and urban data contained in a 1999-2000 survey of local public health agencies, with a focus on workforce, services and programs.

Presenting the report, NACCHO Senior Research Associate, Anjum Hajat, said the data so far corroborate the National Advisory Committee's description of rural public health, especially in terms of workforce and financial resources.**

Looking at average and median expenditures, urban agencies spend at least twice as much annually as small town agencies, according to Hajat, (with small towns comprising 33% of all local agencies, large towns 15%, and metro agencies comprising 52%). She also noted what she called "huge differences" in the sizes of their workforces, with metropolitan agencies averaging 139 full-time equivalent staff compared with 24 in small town agencies and 33 in larger towns.***

Both rural and urban agencies express a priority need for public health nurses and environmental scientists.

Hajat also said that while urban and rural agencies all provide some environmental health, communicable disease control, and child health services, rural agencies are much more involved in providing maternal and child health services. In fact, **a larger share of rural agency budgets is dependent on revenue from services**.

Finally, Hajat also said local hospitals and practitioners were cited by a substantial number of rural agencies as key partners in the ability to carry out their missions. "The importance of rural providers [to public health] can't be dismissed," she said.

POOR ALIGNMENT OF FUNDS, RESPONSIBILITIES

The Roundtable's guest speakers from the field said a major problem for rural agencies is a lack of funding and also a poor alignment of funding with responsibilities.

The NACRH's Wakefield said rural agencies have long been a critical part of the local health care safety net, yet they are caught between conflicting demands for population-based services and supporting a safety net of personal health services.

Meanwhile, the **distribution of national resources looks like an upside-down triangle to some people**, said Roundtable speaker Dick Morrissey, who directs the Kansas Department of Health and Environment's Office of Local and Rural Health. He said there is a good-natured joke that "the federal government has all the money, the states all the authority, and the locals the responsibility."

Carol Moehrle, R.N., director of Idaho's five-county North Central District Health Department, said there is a ring of truth to the perception in terms of the diminished options on the front lines.

A key problem, she said, is that federal funds for public health are largely tied to categorical programs for specific needs. Moehrle, who also chairs NACCHO's county forum, said that unless it is provided by the state, or by service revenue, there is little funding available for rural infrastructure in terms of training or equipment.

Meanwhile, local agencies spend a great deal of time managing separate funding lines for purposes such as Hepatitis C, and HIV prevention and treatment, diabetes, and care for women, infants and children. "We call these funding silos," said Moehrle. In her own five-county district covering 110,000 people in 13,500 square miles, **Moehrle manages 34 separate funding contracts, all with different**

** Passed in Nov. 2000 but not funded, the Public Health Threats and Emergencies Act (Frist/Kennedy) proposed grants to five states per year, and created the CDC blueprint for this year's greatly-expanded program.*
*** Hajat said a per capita analysis of the data will be forthcoming.*

**** The NACCHO study analyzed rural/urban differences by looking at rural census tracts, using the new RUCCA codes. (Rural/urban Census-tract Commuting Areas) The analysis showed 48% of local public health agencies to be rural. Measuring rural by county units shows 60% to be rural.*

tracking and reporting requirements, even though they may be carried out together at the local level.

"The money for infrastructure is what we've always lacked," she said, describing many rural agencies still situated in the basements of county court houses. "We need 'bricks and mortar'…core basic funding."

Balancing State and Local Needs

A new priority can also cause a loss in revenue. Moehrle cited her own experience with having to "pull a nurse" out of a revenue-earning immunizations program to help write an emergency response plan. She could not bill back that lost revenue to the planning contract. Moehrle said **a state might have more employees doing contract management than carrying out programs**.

There is "no agreed-on approach" to what the proper share is between a state and local health departments, said Kansas' Morrissey. "It's a political issue between states and local jurisdictions." He said **policymakers should look at funding local public health services in a way that makes their work "sustainable."**

Regionalization

The NACCHO report also showed that **rural public health agencies depend more heavily on local and state financing than do urban agencies**. But Moehrle and Morrissey said it is difficult to garner enough basic funding from those sources to sustain operations and train personnel without regionalization.

To ameliorate funding problems and manage a population of just over a million in 82,751 square miles, **Idaho has organized a statewide public health system grouped into seven administrative and funding districts for 44 counties**.

But not all states are the same, said Morrissey. Public health operations vary from centralized and state-run to locally autonomous, county-run agencies, to a mixture of each.

In Kansas, where there is "resistance" to the regionalization of services, it has not been feasible to create such funding districts, he said. The state has 99 county-based health departments. Almost half the population resides in four counties and 31 of 105 counties are frontier.

One of the Kansas strategies has been to create resources for local agencies. Since 1999, the Kansas Association of Local Health Departments and the state have worked to engage local agencies in the development of performance standards. So far, work has been completed for communicable disease, and administrative standards. The next step will be maternal and child health and environmental standards.

Ten years ago, in recognition "of their significant linkages," Kansas placed its state rural health, primary care, and local public health offices all in one state office – an office of local and rural health.

Infrastructure Equals Connectivity…

A critical facet of infrastructure is sheer connectivity, according to the Roundtable speakers. The ability of local health departments to share specialized resources, like epidemiologists and laboratories, and to share and access data immediately is crucial to a modern system.

Moehrle and Morrissey said the **Health Alert Network has been one of the most useful federal grant programs for creating that kind of infrastructure**. Funded out of CDC since 1999, the program requires that 85% of the funds benefit local public health.

Kansas was one of the first states to receive HAN funding, said Morrissey and they have **used the funds to connect all 99 state health departments to the Internet**. "There were lots of last mile problems to overcome," he said, but 62 of those departments now have high-speed connections, and 97 have alpha-numeric pagers.

Joining the Health Alert Network in Kansas was voluntary, but after the anthrax crisis, almost everyone came on board, said Morrissey.

They are developing a secure web site and a local emergency contact database. The next step will be to "hook up" hospitals and other health care providers."

The HAN program represents the "first time rural needs have been written in to the terms of a program," said Moehrle.

Still, funding for infrastructure "can't just be a one-time thing," she added.

…Human Capital and Training

Not only do rural agencies lack funding and latitude for emergencies and known local problems, they lack money for training, according to Roundtable speakers.

The NACRH had reported that four out of five public health employees nationally have no degree, certificate or formal education in public health, a fact that Moehrle and Morrissey corroborated for rural areas.

"We're operating a system that's dependent on people without formal training," said Morrissey. **If there is one element that defines infrastructure, he said, it is human capital and the ability to put trained people in the right places** with the right combination of skills.

Trained personnel are just as important in rural areas as in urban ones, said Moehrle. "My environmental health specialist who drives a hundred miles to do a sewer inspection

needs just as much training as an urban one," she said.

Kansas has forged a new public health workforce training center, using volunteer instructors and the combined resources of Morrissey's Department of Health and Environment, the Kansas Association of Local Health Departments, and Kansas University's Public Management Center. The first class of 20 students graduated in December 2001 with certificates for 150 hours of training. Another 30 enrolled in January.

Meanwhile, a state steering committee is working on additional training resources, including bio-terrorism training and partnerships with more educational institutions.

PRIORITIES AND TRADE-OFFS

The large infusion of new money this year for bio-terror prevention will present new challenges, said Morrissey. Kansas, alone, will have "fifteen months to spend 12 million dollars." But he said that preparation will afford what's called "dual use" in public health with regard to the resources also needed for communicable disease.

Responding to concern raised by attendee Edwin Pratt of the National Association of Local Boards of Health that the Administration has simultaneously proposed to reduce federal agency personnel at CDC and also funding for rural-supportive programs, Frist staffer Rosen said the Administration has set a priority now on building a better surveillance and tracking system. In a period of deficit spending, he said, **"we're going to be in a situation where by definition we're robbing Peter to pay Paul." But "it's not a one-to-one trade-off."**

> **"We're operating a system that's dependent on people without formal training."**

He added that Congress is "unlikely to reduce significantly [its] commitment" to federal safety-net programs. "We'll know more going forward," he said, about what percentages of funding are needed in which areas, including "hiring more people and keeping them trained."

Asked about the progress in conference of House and Senate bills to provide additional support for public health infrastructure in the context of bio-terrorism and public health emergencies, **Rosen said he was optimistic there would be a new authorization within 4-6 weeks.** Provisions of H.R.3448 (Tauzin/Dingell) to address community water systems and those of S.1765 (Frist/Kennedy) to address agricultural safety will need to be integrated in some way, he said.

NACRH RECOMMENDATIONS

In response to questions, the National Advisory Committee's Wakefield said neither of the rural health advisory committee's recommendations for rural public health has been acted on so far.

Those recommendations were to the Secretary of Health and Human Services to 1) **create an interagency committee** of senior representatives from public health agencies and federal departments to identify ways to integrate public health funding streams to benefit rural communities, and 2) **support a dedicated funding stream for public health infrastructure that would have equitable distribution** for rural and urban departments at local levels.

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CAPITAL AREA RURAL HEALTH ROUNDTABLE

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