Assessment of Staffing, Services, and Partnerships of Local Health Departments — United States, 2015

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Beginning in 2008, the National Association of County and City Health Officials (NACCHO) periodically surveyed local health departments (LHDs) to assess the impact of the economic recession on jobs and budgets (*1*). In 2014, the survey was expanded to assess a wider range of factors affecting programs, services, and infrastructure in LHDs and renamed the Forces of Change survey (*2*). The survey was administered in to January–February 2015 to 948 LHDs across the United States to assess budget changes, job losses, changes in services, and collaboration with health care partners; 690 (73%) LHDs responded. Findings indicated a change in LHD infrastructure: compared with the previous fiscal year.* Overall, LHDs reported 3,400 jobs lost; 25% of LHDs reported budget decreases; 36% reported a reduction in at least one service area; and 35% reported serving fewer patients in clinics. In addition, up to 24% of LHDs reported expanding population-based prevention services, and LHDs reported exploring new collaborations with nonprofit hospitals and primary care providers (PCPs).

The public health and clinical care environment is evolving in part in response to the Patient Protection and Affordable Care Act (ACA). Section 501(r)(3) of the Patient Protection and Affordable Care Act (ACA) requires that nonprofit hospitals conduct and report on a community health needs assessment (CHNA) every 3 years to maintain their tax-exempt status (*3*). The ACA also requires that a CHNA take into account input from stakeholders that represent the broad interests of the community served by the hospital, including those with special knowledge or expertise in public health, such as LHDs. New systems of care with PCPs intended to improve patient outcomes and reduce costs have also been developed in recent years. These include State Innovation Models (state-based, multipayer health care payment and service delivery models), patient-centered medical homes (primary care delivery models that are patient-centered, comprehensive, team-based, accessible, and focused on quality and safety), and accountable care organizations (networks of health care providers voluntarily responsible for providing coordinated care to patients) (*4*).

An online survey was distributed during January–February 2015 to a statistically representative sample of 948 LHDs across all regions of the United States, representing approximately one third of all LHDs. LHDs were stratified by state and size of the population served (small [<50,000 persons], medium [50,000–499,999], and large [>500,000]). Hawaii and Rhode Island were excluded from the study because they have no LHDs. Survey topics were identified by NACCHO's executive leadership, and several partner organizations provided input on the highest-priority topics, which included changes in LHD budgets, staffing, and services provided from the previous year; changes in clinical service delivery; third-party billing for clinical services; collaboration with nonprofit hospitals; and collaboration with PCPs (*5*). A survey instrument with 16 closed-ended questions was developed, reviewed by subject-matter experts, and piloted. Responses were self-reported and were not independently verified by NACCHO. Nationally representative estimates were weighted to account for sampling design and nonresponse. Information about the survey methods is available in the survey's technical documentation (*6*).

The survey was completed by 690 (73%) top executives from 353 small, 271 medium, and 66 large LHDs. All surveyed areas except the District of Columbia and Massachusetts achieved a response rate of ≥50% (*6*). Overall, 23% of LHDs reported a lower budget in the current fiscal year compared with the preceding fiscal year, and 27% reported that they expected budget decreases to continue into the next fiscal year (Table). LHDs reported 3,400 jobs lost during 2014 (1,300 [38%] because of layoffs and 2,100 [62%] because of attrition). Since 2008, a total of 51,700 jobs have been lost. The number of lost jobs in 2014 was most marked among large LHDs: 61% of large LHDs reported at least one job lost, followed by 41% of medium LHDs and 26% of small LHDs. Approximately one third (36%) of LHDs reported reduced services in at least one program area during 2014. More LHDs reported reducing rather than expanding clinical services such as immunization (14% reducing versus 12% expanding), diabetes screening (14% versus 11%), or high blood pressure screening (11% versus 8%).

Approximately one third (35%) of LHDs reported serving fewer patients in their clinics during 2014 than 2013 (Table); this varied by state (Figure 1). However, a larger proportion of LHDs reported expanding population-based prevention services: 24% of LHDs expanded obesity prevention services, and 23% reported expanding tobacco, alcohol, and other drug prevention services.

*Fiscal years vary across LHDs in the United States.

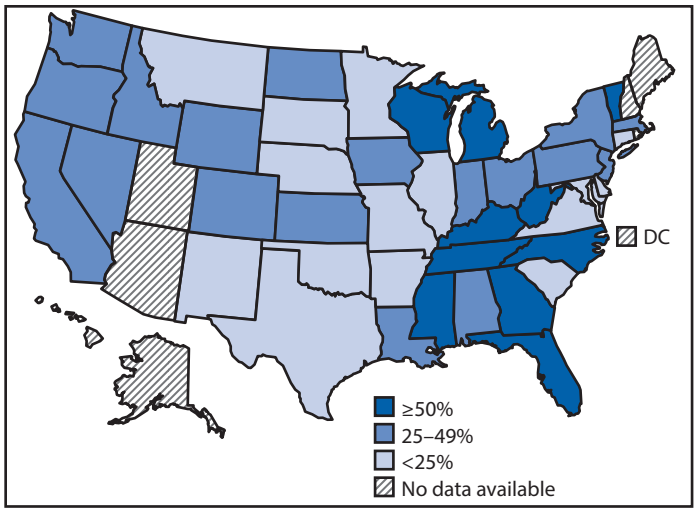
TABLE. Number and percentage of 690 local health departments (LHDs) reporting recent budget changes, job losses, changes in services, third party billing practices, and collaboration with nonprofit hospitals and primary care providers, by size of population served — National Association of County and City Health Officials Forces of Change survey, United States,* 2015

Factor	No. of LHDs responding†	Unweighted no.	Size§ of population served by LHD (%)			
			All	Small	Medium	Large
Budget changes						
Lower budget than the previous fiscal year	666	151	23	22	23	25
Expect lower budget in the next fiscal year	632	171	27	25	28	33
Higher budget than the previous fiscal year	666	143	21	17	28	16
Expect higher budget in the next fiscal year	632	109	17	15	20	19
Job losses in 2014						
Lost at least one job because of layoffs and/or attrition	657	227	34	26	41	61
Changes in services provided in 2014						
Reduced services in at least one program area	679	251	36	35	38	38
Expanded services in at least one program area	679	361	53	48	59	58
Reduced immunization services	657	98	14	14	14	21
Expanded immunization services	657	82	12	14	12	4
Reduced diabetes screening services	255	37	14	14	15	15
Expanded diabetes screening services	255	31	11	6	18	23
Reduced high blood pressure screening services	412	44	11	10	12	15
Expanded high blood pressure screening services	412	36	8	6	14	1
Reduced obesity prevention services	458	35	7	9	7	6
Expanded obesity prevention services	458	110	24	17	31	28
Reduced tobacco, alcohol, and other drug prevention services	514	46	9	11	6	11
Expanded tobacco, alcohol, and other drug prevention services	514	118	23	20	27	23
Changes in clinical service delivery in 2014 compared with 2013						
Served fewer patients	626	221	35	34	37	33
Served the same number of patients	626	269	43	44	40	44
Served more patients	626	136	22	21	23	24
Served fewer patients with insurance	662	46	7	7	7	6
Served the same number of patients with insurance	662	186	28	29	29	25
Served more patients with insurance	662	258	38	37	39	45
Current third-party billing for clinical services						
Bill public payers only	610	149	23	21	24	38
Bill public and private payers	610	428	66	66	69	53
Bill private payers only	610	3	0.5	1	0	2
Do not bill	610	63	10	12	8	7
Collaboration with nonprofit hospitals on community health needs assessments						
Currently collaborating	621	367	58	49	67	67
Discussing collaboration	621	59	9	8	8	24
Not engaged in discussion or collaboration	621	72	12	13	11	9
Involvement in nonprofit hospital implementation plans						
Involved in nonprofit hospital implementation plan	515	313	60	58	61	60
Listed as partner in implementation plan	402	402	47	43	49	52
Participated in developing the implementation plan	402	168	41	41	43	29
Listed as conducting an activity in the implementation plan	402	402	20	16	24	21
Used the same implementation plan	402	39	10	9	11	5
Active collaboration with primary care providers (PCPs)						
Encouraged PCPs to use evidence-based public health services	663	411	61	58	63	76
Provided population health statistics to PCPs	661	316	47	39	54	59
Used clinical data from PCPs	643	148	23	21	23	32
Participated in State Innovation Model initiative activities	659	66	9	4	14	23
Participated in patient-centered medical home activities	658	63	9	6	12	19
Participated in accountable care organizations	657	53	8	7	9	9

* Hawaii and Rhode Island not included.
† Number of LHDs responding is smaller than total number of respondents (n = 690) because of missing values and/or because respondents could skip questions based on their responses to screening questions.
§ Small: serve <50,000 persons (n = 353 LHDs); medium: serve 50,000–499,999 persons (n = 271); large: serve >500,000 persons (n = 66).

During 2014, 38% of LHDs reported serving a higher percentage of insured patients than they had during 2013. Among sampled LHDs in 26 states that expanded Medicaid eligibility in 2015, 46% reported serving a higher percentage of patients with insurance, compared with 29% in states that did not expand Medicaid eligibility. Most LHDs (90%) bill third-party payers (i.e., Medicare, Medicaid, and private insurers) for some services; 66% of LHDs reported they billed both public

FIGURE 1. State* percentage of local health departments serving fewer patients in their clinics in 2014 compared with 2013 — United States



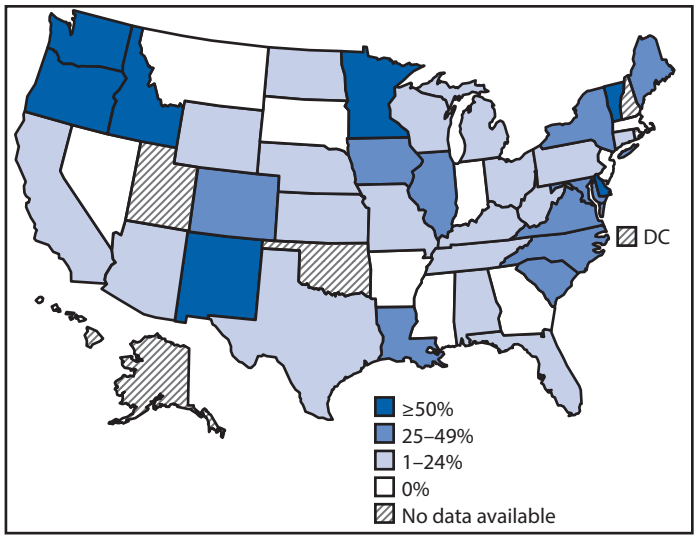
* Hawaii and Rhode Island excluded because they have no local health departments. Data from states with insufficient response rates (Alaska, Arizona, District of Columbia, Maine, New Hampshire, and Utah) not shown.

and private payers for at least some services, and 23% reported they billed public payers only. Respondents reported that the cost and complexity of establishing billing, the existence of a trained workforce, and information technology capacity were most important in determining billing practices.

Approximately half (58%) of LHDs reported that they were currently collaborating with nonprofit hospitals to conduct CHNAs. A smaller percentage (9%) of LHDs were considering future collaboration, and some (12%) were not engaged in discussions to collaborate. The remaining LHDs (21%) did not report having a nonprofit hospital serving their jurisdiction. In addition, among LHDs with a nonprofit hospital serving their jurisdiction, 60% were involved in a nonprofit hospital's implementation plan for the CHNA. Among these, 47% were listed as a partner in the plan, 41% participated in developing the plan, 20% reported that they were conducting an activity in the plan, and 10% of LHDs reported using the same implementation plan as the hospital.

LHDs also reported collaborating with PCPs. Approximately half (61%) of LHDs actively encouraged PCPs to use evidence-based public health services, such as interventions to reduce asthma triggers in children's homes; 47% provided population health statistics to PCPs; and 23% used clinical data from PCPs. Overall, less than 10% of LHDs were actively engaged in new systems of care with PCPs including State Innovation Models, patient-centered medical homes, or accountable care organizations. This engagement also varied across states (Figure 2).

FIGURE 2. State* percentage of local health departments actively engaged with primary care providers on State Innovation Models, accountable care organizations, or patient-centered medical homes — United States, 2014



* Hawaii and Rhode Island excluded because they have no local health departments. Data from states with insufficient response rates (Alaska, District of Columbia, New Hampshire, Oklahoma, and Utah) not shown.

Discussion

The severe United States economic recession (December 2007–June 2009) substantially affected the operating budgets of LHDs. Although the proportion of LHDs reporting budget decreases in the past year has decreased from its peak of 45% in 2009 (*1*), approximately one in four LHDs still reported budget cuts in the current fiscal year compared to the previous fiscal year. Since 2008, LHDs have collectively lost 51,700 jobs because of layoffs and attrition (*1*). For many LHDs, the cumulative effects of budget cuts and job losses experienced during and after the recession have not been reversed as the economy recovered. Consequently, the cumulative effects of years of budget cuts and job losses continue to reduce capacity at many LHDs and decrease the ability of LHDs to prepare for the future.

The ACA's expansion of insurance benefits is reflected in changes in patient volume at LHDs and percentage of patients at LHDs who have insurance. More LHDs reported a decrease in patient volume than an increase in patient volume, and LHDs reported serving higher percentages of patients with insurance, although neither trend has been uniform across the United States. Patients who have insurance might preferentially seek services at other sources of health care than the LHD. This might present an opportunity for LHDs to create new and expand existing partnerships. With the exception of a few states, LHDs are not currently engaged in new systems of care

Summary

What is already known about this topic?

The public health and clinical care environment is evolving in response to the Patient Protection and Affordable Care Act.

What is added by this report?

Local health department (LHD) infrastructure continues to be affected by budget decreases: one quarter of LHDs reported a lower budget in the current fiscal year compared to the previous fiscal year. LHDs reported 3,400 fewer jobs in 2014 than in 2013 and 51,700 jobs lost since 2008; 36% of LHDs reported a reduction in at least one service area, and 35% reported serving fewer patients in clinics. Up to 24% of LHDs reported expanding population-based prevention services, and LHDs reported they are exploring new collaborations with nonprofit hospitals and primary care providers.

What are the implications for public health practice?

Ongoing budget cuts and resulting personnel layoffs jeopardize the work of LHDs, which remain primary providers of health care services for many clients. As shown through their new collaborations with nonprofit hospitals and exploration of relationships with primary care providers, LHDs continue to build and explore critical local relationships that might benefit multiple stakeholders and their communities at large.

established by the ACA, such as accountable care organizations or State Innovation Models. The ACA requirement for nonprofit hospitals to complete regular CHNAs provides an opportunity for LHDs to collaborate with nonprofit hospitals. Less than 70% of LHDs are engaged in or exploring such partnerships, which might benefit multiple stakeholders and the community at large.

The findings in this report are subject to at least three limitations. First, the survey instrument includes only closed-ended questions about a limited number of topics. Consequently, other important factors not addressed by this survey might be affecting change in LHDs. Second, only descriptive statistics were presented, and no conclusions can be drawn about cause and effect. Finally, all data were self-reported by LHDs and not verified by NACCHO; therefore, the data are subject to reporting errors that cannot be identified or quantified.

LHDs face challenges and opportunities as the new public health and clinical care environments evolve. Some LHDs are adapting by reducing clinical services or expanding population-based prevention services; others continue to sustain clinical services by expanding reimbursement for those services through billing third-party payers. The ACA has also presented new opportunities for collaboration, and many LHDs are engaged in or exploring these new partnerships. Given the variations in LHD capacity to adapt to budget cuts, job losses, and reductions in clinical services while simultaneously having to implement their vision of healthy communities, LHDs will need to adopt diverse roles within their local public health systems (*7*).

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