# The Association of Ohio Health Commissioners

# Public Health Policy Platform

March 2018

AOHC

Association of Ohio Health Commissioners, Inc.

Public Health

Prevent. Promote. Protect.

## Table of Contents

**1. Introduction** ..... 3

**2. Justification** ..... 4

2.1 Ohio Public Health Capacity Funding ..... 5

*2.1.1 Priority Funding Considerations* ..... 6

2.2 Integrated State and Local Public Health Systems ..... 7

*2.2.1 Priority Integration Considerations* .....

2.3 Enhanced Community Linkages ..... 6

*2.3.1 Priority Community Considerations* ..... 7

2.4 Tobacco, Alcohol, and Drug Abuse Prevention ..... 8

*2.4.1 Priority Tobacco, Alcohol, and Drug Abuse Considerations* ..... 8

**3. References** ..... 9

**4. Appendices** ..... 11

Appendix A. Financing of Local Health Districts ..... 12

Appendix B. Foundational Public Health Capabilities ..... 13

Appendix C. Access to Quality Health Care Services ..... 14

Appendix D. Environmental Health ..... 16

Appendix E. Emergency Preparedness and Infectious Disease Protection ..... 17

*Emergency Preparedness* ..... 18

*Infectious Disease Prevention* ..... 18

Appendix F. Addiction and Abuse Potential ..... 19

*Tobacco* ..... 20

*Substance and Alcohol Use and Abuse* ..... 21

# 1. Introduction

Ohio Local Health Districts (LHDs) are charged with the primary responsibility of preventing illness and injury, promoting a sustainable public health infrastructure, and protecting the health and well-being of their respective communities. In order to address the breadth of these responsibilities, the Association of Ohio Health Commissioners (AOHC) is committed to providing leadership and advocacy efforts on behalf of, and in conjunction with, the state's 117 LHDs (AOHC 2016). Given the health climate of Ohio in 2018, AOHC has identified a number of overarching public health infrastructure needs. The implications associated with the following items are far-reaching, and remain critical to LHD service efficacy.

AOHC actively supports voluntary national accreditation to standardize the delivery of public health services, to ensure appropriate services are provided to the public, and to provide a mechanism that ensures LHD's continue to meet the most rigorous practice standards available. However, there is concern that mandated accreditation will produce gaps in both public health and safety net services throughout the state, should several LHD's not become accredited by 2020.

The current public health model is nearly 100 years old and, given the financial handicaps prevalent across Ohio's public health efforts, the shift to an accredited public health system will likely require more than five years.

## 2. Justification

### 2.1 Ohio Public Health Capacity Funding

*AOHC supports the increased funding of LHDs by way of dedicated inside millage, community benefit dollars of an amount no less than five percent of the corresponding total, excise tax from tobacco and sugary substances, respectively, and the ability to issue licenses and/or permits for activities with health implications.*

LHDs may be funded through a number of mechanisms, which may include fee-for-service, inside millage, community levy, and/or local, state, and federal grant awards. Given the current fiscal reality of LHDs, a combination of the aforesaid funding mechanisms is often necessary. Despite this need, an increase in unfunded service mandates by the Ohio Department of Health (ODH), in conjunction with delayed grant fund disbursement periods, and the unfunded workload associated with accreditation efforts by way of the Public Health Accreditation Board (PHAB), has pushed a number of LHDs to consolidate, close, or both. A total of 41 LHD programs are mandated by ODH, yet ODH operating budget support for LHDs provides $0.18, or $0.38 per PHAB-accredited LHDs, in direct funding, and both are contingent on a minimum LHD per capita spending of $3.00 in local funds.

Despite programmatic spending to attenuate poor health outcomes associated with the use of tobacco and the consumption of sugary substances, LHDs are omitted from the receipt of said purchase taxes. Moreover, LHDs remain unable to produce, and subsequently manage, licensure and permits for commercial activities associated with potentially poor health outcomes, despite the additional funding opportunity (Appendix A).

### *2.1.1 Priority Funding Considerations*

i. A standardized, state-wide cost methodology for all health department programs, incorporating direct, indirect, and anticipated costs.

ii. A standardized cost methodology for new and/or emerging programs where no explicit fee-setting authority yet exists, incorporating direct, indirect, and anticipated costs.

iii. The ability for local health districts to contract for mandated services, and to participate in shared services agreements and other efficiency measures.

## 2.2 Integrated State and Local Public Health Systems

*AOHC supports the enhancement and integration of all-hazards preparedness planning, readiness assessments, and response efforts.*

Despite the swift addition of emergency preparedness as a public health component following the terrorist attacks on September 11, 2001, staple preparedness programs, such as the Public Health Emergency Preparedness (PHEP) and the Assistant Secretary for Preparedness and Response's (ASPR) Hospital Preparedness Program have experienced funding cuts upwards of 31% (NACCHO 2017). Additionally, hospital emergency preparedness and all-hazards planning efforts still lack integration with daily public health tasks (Plough et al. 2013). As LHDs serve as the foundational component of a preparedness program (IOM 2012), financial support for LHD health surveillance infrastructure, emergency planning initiatives, community engagement, outreach, and coordination, and internal response capability assessments must reflect this given responsibility.

### *2.2.1 Priority Integration Considerations*

i. A persistent legislative push for both continued and enhanced LHD PHEP funding.

ii. Work with both local and state partners for the cross-utilization of emergency preparedness resources for opiate crisis purposes.

iii. The development of a mechanism for a PHEP Savings Account, at the state level, for the carryover of PHEP funding to be used to reimburse actual response costs accumulated by LHDs during emergency response efforts.

iv. A legislative push for the ability of LHDs to declare a public health emergency.

## 2.3 Enhanced Community Linkages

*AOHC supports immunization efforts and epidemiological surveillance, response, and research through clinical-community linkages and shared-service agreements that connect health departments, healthcare providers, and community partners, providing for continuous service delivery and data collection, increased integrative systems of care and shared services, LHD reimbursement, and utilization of behavioral healthcare providers.*

Community engagement through disease surveillance and epidemiological investigation have long been core public health components (Wójcik et al. 2014), and thus remain, core LHD functions. Additionally, the coordination, collaboration, and delivery of immunization programs has been a significant public health achievement in the last century, both domestically and abroad (Schlipköter and Flahault 2010, Frieden 2015). With the following success in mind, epidemiology and vaccination efforts must not be left to rest on their laurels. Modern public

health threats, affected by epidemiological, sociodemographic, educational, behavioral, legal, fiscal, and political considerations, require mechanisms for fluid data collection and dissemination across a coordinated, community-based continuum of care, and such a model is not feasible without the collaboration of LHDs, healthcare providers, and community partners.

### *2.3.1 Priority Community Considerations*

*i.* The incorporation of social justice principles into public health practice, in order to improve health outcomes and health equity.

## 2.4 Tobacco, Alcohol, and Drug Abuse Prevention

*AOHC supports increased medical coverage for comprehensive drug and tobacco treatment, passage of Tobacco 21 legislation, and supports local health department drug abuse efforts.*

Tobacco use remains the leading cause of preventable death in the United States (HHS 2014), and roughly a quarter of Ohio residents are current smokers (Israel et al. 2014), despite the well documented comorbidities associated with tobacco use (HHS 2014). Passage of Tobacco 21 legislation, which proposes raising the minimum legal age for tobacco purchases to 21 years of age, has demonstrated youth smoking declines in states that have since adopted the legislation (Morain et al. 2016), and should likewise be adopted in Ohio. The abuse of alcohol, affecting upwards of 20% of Ohio residents (County Health Rankings 2017), also warrants support, warranting collaboration between LHDs and their respective Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) Board.

In conjunction with concerns pertaining to tobacco and alcohol, Ohio is currently faced with an Opioid epidemic. In 2015, Ohio experienced the second highest overdose death rate in the nation, subsequently led the nation in heroin overdoses (CDC 2017). Within the following year alone, the illicit use of heroin, fentanyl, and carfentanil was responsible for 4,050 overdose deaths (ODH 2016). In light of this continued epidemic, AOHC supports all efforts to reduce the incidence, prevalence, and consequences of Opioid abuse, in addition to those efforts pertaining to tobacco and alcohol use and abuse, respectively.

### *2.4.1 Priority Tobacco, Alcohol, and Drug Abuse Considerations*

i. Effective enforcement efforts for SmokeFree Ohio that include adequate funding for timely complaint investigation and fine recuperation.
ii. Increase investment in youth and adult mass media tobacco campaigns.
iii. An increase in tobacco taxes, and matching taxes on smokeless tobacco.
iv. Support of tobacco-free campus policies, with respect to schools, colleges, multi-unit housing, and public spaces.
v. Increased Fetal Alcohol Syndrome screening.
vi. Increased awareness and distribution of Narcan kits to friends and family members of current opioid abusers.

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# Appendices

## Appendix A

**Financing of Local Health Districts:** *AOHC supports a greater commitment by Ohio to fund local health districts for these important protections that benefit all Ohioans using the following options:*

- Identification of funding for unfunded mandates (school inspections, nuisance complaints, animal bite reporting, etc).
- Acquisition of state funding consistent with current requirements to address foundational public health services and their availability to all Ohioans.
- Acquisition of state funding to implement and sustain state-mandated programs implemented at the local level (such as accreditation).
- Dedicated per capita funding, as opposed to levy or inside millage.
- Dedicated community benefit dollars of no less than 5% to support ongoing assessment, surveillance, and monitoring of community health and healthcare associated infections.
- Adequate state funding levels for the local government fund.
- Adequate and fair reimbursement from public and private payers.
- Excise taxes from tobacco, sugary substances, and medical transactions.
- Standardized cost methodology for programs where no explicit fee setting authority exists, reflecting full cost recovery for provided services.
- Permissive authority for local health districts to assume fiscal authority.

## Appendix B

**Foundational Public Health Capabilities:** *AOHC supports the Ohio 21C project, and its efforts to establish foundational capabilities, and the associated return on investment. Strategies supported by AOHC include, but are not limited to:*

- Maintenance of human resources for public health practice through intentional workforce development and leadership succession planning to demonstrate public health expertise.
- Identification of adequate state financial support of performance standards to assure foundational public health services, with a commitment to continuous quality improvement.
- Maintenance of strong and clear authority of local boards of health to adopt regulations to protect public health.
- Adoption of consistent educational qualifications, and FTE status, for all health commissioners.
- Development of integrated state and local health information technologies, data, and informatics.
- Increase the utilization of data for public health decision-making.
- Strengthening of the public health surveillance and epidemiological response infrastructure.
- Maintenance of all-hazards preparedness planning, readiness assessment, and response.
- Designing collaborative community partnership that directly affect the social determinants and health inequity.
- Serving as a local expert to inform policy, system, and environmental change.

## Appendix C

**Access to Quality Health Care Services:** *AOHC supports efforts to better connect and integrate public health, physical and behavioral health, and social services. AOHC advocates for strategies that improve access to quality and universal health care services, especially for vulnerable populations, such as children, the economically disadvantaged, and seniors. These strategies include:*

- Prioritization and strengthening of preventive health services across the lifespan, with particular focus on decreasing chronic disease in Ohio.
- Oral health care, mental health, and pharmaceutical access.
- Reimbursement for newborn home visits clinical services.
- Assessment, evaluation, and development of community health care delivery system based on sound, evidence-based principles.
- Mandated immunization requirements.
- Expansion of, and better collaboration with community health centers, with an emphasis on screening, prevention, and wellness.
- Supporting research on integrative systems of care, such as coordinated care organization models, primary care medical homes, community-based primary health care, and regionally-based health improvement collaborations.
- Encouraging collaboration and coordination between sectors (community health assessment and the community health improvement plan).

- Encouraging clinical-community linkages that help connect healthcare and behavioral healthcare providers, community organizations, and public health agencies to improve access to prevention, early intervention, and chronic behavioral health care services.
- The incorporation of social justice principles and public health practice, in order to improve community health outcomes and health equity.
- Strengthened services for the medically handicapped.

## Appendix D

**Environmental Health:** *AOHC supports environmental health professional practices that assure safe drinking water from private wells and proper household sewage treatment systems, environmentally sound solid waste management, risk-based and educationally-focused food safety programs and swimming pool programs, effective animal vector and pest control, and other programs and strategies that assure a healthy and safe environment. Additional strategies may include:*

- The assessment, evaluation, and development of environmental health programs based on sound evidence-based principles.
- Consistent cost methodology across all environmental health programs, allowing for the inclusion of existing costs, both direct and indirect, in addition to anticipated costs.
- Standardization of food safety training, and consistent oversight by an agency that is risk-based and focused on industry education.
- Utilization of foodborne outbreak data to inform and improve food safety programs.
- Increased recreational water rule enforcement with the inclusion of all public aquatic facilities in swimming pool rules and regulations.
- Standardization training and education pertaining to the laws and rules associated with household sewage treatment systems.
- Collaboration with local solid waste districts and other local entities to identify funding sources for solid waste enforcement.
- Maintenance of environmental health program compliance, and public access to data

monitored electronically through ODH IT-supported technology.

- Assurance of known and emerging vector-borne disease (West Nile Virus, Ebola, Chik-V) prevention, response, and educational activities.
- Implementation of comprehensive indoor air quality programs, including lead risk assessment and remediation, and advocating for resources to assist low income property owners.
- Creation of a revolving financial assistance program for on-site home sewage system repairs.
- Increased efforts to minimize disproportionate environmental risk exposures by different cultural or geographically disadvantaged communities.

## Appendix E

**Emergency Preparedness and Infectious Disease Protection:** AOHC must continue to advocate for increased LHD funding aimed at strengthening the public health surveillance infrastructure, and maintaining local public health emergency planning initiatives. In order to avoid complacency between emergency events, LHDs should remain active in community engagement and outreach, continued community agency partnership, and the evaluation of response capabilities.

**Emergency Preparedness:** *AOHC supports the continued emphasis on both local and state emergency preparedness efforts. Additional emergency preparedness strategies include:*

- A legislative push for continued, and enhanced, LHD PHEP funding.
- Funding for enhanced infectious and vector-borne disease surveillance.
- Work with local and state partners to utilize emergency preparedness resources in the opiate crisis.
- Development of a PHEP Savings Account, at the state level, for the carry-over of PHEP funding to be utilized during real world response emergencies.
- Push for the ability of Local Health Departments to be capable of declaring a public health emergency.

**Infectious Disease:** *AOHC supports the coordination and collaboration of immunization programs for persons of all ages to increase vaccination coverage rates, and thereby protect individuals and communities from vaccine-preventable diseases. Comprehensive and sustainable immunization programs should incorporate the following strategies*:

- Reimbursing public and private immunization providers for vaccine products, vaccine storage and handling, staff and administration supplies, and population and clinical activities using immunization information systems (IISs).
- Implementing education, training, and clinical procedures, designed to: (1) increase demand for immunizations among patients and parents, (2) promote strong vaccine recommendations by clinicians to patients, (3) minimize missed vaccination opportunities, (4) ensure vaccine series completion, (5) train community vaccination champions, and (6) reach underserved populations.
- Identifying and addressing immunization disparities by: (1) monitoring and responding to gaps and trends in vaccination rates, utilizing IISs and electronic health records, (2) supporting local health department epidemiologists and staff to continually measure the impact of immunization policies and interventions.
- Promotion of evidence-based efforts to improve statewide immunization rates.

## Appendix F

**Tobacco, Alcohol, and Drug Abuse:** AOHC supports all efforts to reduce the incidence and consequences of tobacco, drug, and alcohol abuse.

**Tobacco:** *Tobacco use remains the leading cause of preventable death in the United States and in Ohio, and secondhand smoke contributes to infant mortality, heart disease, cancer, diabetes, and many other health problems. Tobacco-related strategies include:*

- Comprehensive tobacco use cessation and reduction programs, including reduced sales to minors.
- Increase youth and adult mass media campaign investment.
- Increase tobacco tax, and matching taxes on non-cigarette tobacco products, to support tobacco use prevention and enforcement programs.
- Increased Fetal Alcohol Syndrome screening.
- Support of tobacco-free campus policies at schools, colleges, multi-unit housing, and public gathering places.
- The prohibition of electronic cigarette use in any place where the smoking of tobacco products is likewise prohibited.
- The enaction of Tobacco 21 Laws.

**Substance and Alcohol Use and Abuse:** *Substance misuse is the use of alcohol, or illicit or prescriptions drugs, in a manner that may cause harm to the abuser or those around them. Strategies associated with reductions in substance abuse include:*

- Expanded funding of evidence-based drug and alcohol abuse prevention programs.
- Mandatory assessment and treatment of persons convicted of DUI.
- Increased alcohol sales compliance checks to those under the age of 21.
- Methamphetamine lab cleanup and environmental tracking based on evidence-based practices.
- Comprehensive, coordinated efforts to stem prescription drug abuse and misuse.
- Advocacy for comprehensive behavioral therapy, medication, and recover support treatments.
- Continued funding for the expansion of naloxone to both first responders and community residents.
- Integration of substance use services with traditional healthcare.
- Increased state and federal funding for infectious disease prevention related to drug use and abuse.
- Medical professional training for screening and addressing substance misuse, and related health consequences.
- Policy and legislative privacy protections for overdose fatality review committees similar to the child fatality review.
- Reduced barriers to prescription drug drop boxes.
- Prohibit the expansion of marijuana beyond established medical applications.