

NACCHO Annual 2009
July 29 – 31, Orlando, FL

Networking Sessions Summary Report

Thursday, July 30
3:45 - 5:15 P.M.

NACCHO

National Association of County & City Health Officials

The National Connection for Local Public Health



Public Health
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Introduction

The National Association of County and City Officials (NACCHO) introduced “Networking Sessions” to the NACCHO Annual 2009 Conference program at the Rosen Shingle Creek Resort in Orlando, FL, as a new and different way for NACCHO members to communicate with each other.

Thirteen different 90-minute networking sessions were convened on the afternoon of July 30, 2009, from 3:45 – 5:15 P.M. These sessions were designed to be facilitated and highly interactive discussion groups and were developed to provide conference attendees sharing similar interests and concerns with an opportunity to meet and exchange ideas and information.

In order to help all conference participants and those who could not attend learn from these sessions, this document contains summary reports that include the following information:

- Session Topic
- Session Description (*as it appears in the onsite conference program guide*)
- Number of Attendees
- Discussion Questions
- Discussion Highlights

Session Topic: Accreditation and Certification

Session Description: This networking session discussion was an opportunity to explore two public health initiatives: national accreditation and certification. National Accreditation is the program under development from the Public Health Accreditation Board (PHAB) that will validate performance of public health departments. Certification applies to individual public health practitioners and is managed by the National Board of Public Health Examiners (NBPHE). This session provided a brief overview of both concepts, and included a discussion that focused on participant thoughts and reactions, including the impacts of each to local public health practice.

Number of Attendees: 45

Discussion Highlights:

- What is the difference between accreditation and certification?
 - Both credentialing and accreditation efforts are active in the public health community right now. Accreditation is a voluntary program that measures the degree to which state, local, tribal, and territorial *public health departments* meet nationally recognized standards and measures. Credentialing is a process that measures the knowledge and skills of *individuals* with graduate level degrees in public health. For more information on accreditation, visit PHAB's Web site at www.phaboard.org.
 - NBPHE was established in September 2005 as an independent organization and administers a voluntary certification exam for students and graduates of approved public health schools and programs. For more information on credentialing, visit the NBPHE Web site at www.nbphe.org/about.cfm.
- Accreditation
 - Kaye Bender, PhD, RN, FAAN, President and CEO of PHAB, provided a brief presentation on the progress of national accreditation, followed by discussion. Highlights include the following:
 - Proposed accreditation standards were developed by a workgroup comprised of state and local health department, and governing body, representatives. They were publicly vetted and revised based on public comment.
 - Proposed standards, measures, and documentation guidance were approved by the PHAB Board of Directors in July 2009.
 - An Assessment Process Workgroup developed the assessment process for accreditation.
 - A beta test will begin in fall 2009 to test the standards and measures as well as the accreditation process. Applications for participation in the beta test will be accepted through August 14, 2009.
 - The beta test will not result in accreditation.
 - Joint applications will be accepted.
 - Beta test benefits include priority placement in queue for accreditation; opportunity to influence the national program; expedited accreditation review; and funding from RWJF for QI project.
 - H1N1 could impact the beta test timeline and will be handled accordingly.
 - PHAB has been involved with the health reform discussion.
 - There will be a fee for "real" accreditation, but it will be a fraction of the value of accreditation and will be based on population size served. A Fees and Incentives Workgroup is determining recommended fees to the PHAB Board.
- Certification
 - Alan Melnick, MD, MPH, CPH, Health Officer (WA); Associate Professor for the Department of Family Medicine and the Department, gave a brief presentation on public health certification, followed by discussion. Highlights include the following:
 - There is not a relationship between accreditation and certification at this time.

- Domain 8 in PHAB relates to the workforce, but credentialing is not tied to any PHAB standards and measures.
- The exam is limited to students and graduates of accredited schools of public health (Council for Education for Public Health-accredited); this is a small part of the public health workforce.
- This is about competencies from graduates of schools of public health, not related to competencies in public practice. Though maintenance of certification might relate to practice.
- In the long-term vision, competencies for public health practice would be developed, but NBPHE may not be the appropriate group to develop these competencies.
- Started by the Association of Schools of Public Health and the American Public Health Association.
- Historically, public health has been a supplementary degree for healthcare professionals but now, many in the public health workforce do not have public health background.
- NBPHE is independent non-profit organization.
- Benefits include set standard for educational competence in the field; encouragement of continuing education in a field that changes over time; fostering of a professional community; increased credibility of self and agency; demonstration of personal competence and assurance of professional currency; and opening of doors for participation in workshops, conferences, and other professional activities.
- Exam covers discipline-specific domains and cross-cutting/interdisciplinary domains.
- Test-item writers are being solicited for now; participants need not be familiar with “test writing items.”
- Contact Alan Melnick or NBPHE for more information.

Session Topic: Big Cities Networking Session

Session Description: Our nation's largest urban cities face challenges that may be unique to their situations due to the economic downturn and pandemic. Don't miss this opportunity to come to a lively, provocative discussion with peers about issues, innovative techniques to overcome challenges, and recent successes.

Number of Attendees: 32

Discussion Questions:

What can NACCHO provide to Big City Health Departments?

Discussion Highlights:

- Advocacy
 - Assist with a national agenda for urban centers
 - Infrastructure, emergency preparedness, and health equity are important issues.
 - Address resource allocation on the state level.
 - Big cities often feel ignored at the state level because state health departments assume that they have resources.
 - Send talking points around health reform, and talk with Congress as a whole.
 - Convene so we can work together on a policy initiative:
 - Can serve as an effective voice for advocacy.
 - Political clout – need the big cities, NACCHO would be stronger by fully engaging the large health departments.
 - Help to facilitate the development of a practice agenda for public health.
 - Use the weight of the big cities to advocate for initiatives/policies.
 - Missing an opportunity to utilize the power of numbers in big cities.
- Networking/resource sharing
 - Develop a clearinghouse to swap materials, so everyone does not recreate the same public service announcements, educational materials, etc.
 - Create a venue to share and exchange information, tools, research, model practices so all can benefit.
 - Big cities want to do more sharing of information. Do not want to reinvent the wheel.
 - Look at where there are problems and learn about what other health departments have done.
 - Provide forum for largest cities and urban groups to gather on a regular basis:
 - Find out what others are doing in regards to funding and infrastructure. Need information to take back to local officials in jurisdictions.
 - Provide a forum to discuss how other cities are funded. Data are not available; there is not a way to compare what happens in other cities.
 - Provide a forum for top leadership in 20 biggest cities with a face-to-face personal discussion.
 - Develop list services or other forums for programmatic people, to connect an offline, quick way to get it out there, CFO to CFO, program to program, etc.
 - Create a workgroup for big cities to figure out how we move forward and benefit from participation in NACCHO.

Session Topic: Building Disaster Mental Health Capacity in Local Public Health Departments

Session Description: The goal of this session is to explore opportunities for local health departments to collaborate with community-based organizations to build and sustain a robust disaster mental health program. We will look at what is needed to respond to critical incidents and other public health emergencies and comply with local, state, and federal performance standards.

Number of Attendees: 13

Discussion Question:

What are the challenges in addressing addictions, disaster mental health, etc?

The purpose of this session is to better understand the integration of mental health and public health. Mental health intersects with other public health activities. NACCHO would like to learn about some of mental health programs that attendees may be initiating.

Discussion Highlights:

- A few participants identified positive aspects associated with working within a mental health division of a local health department, whereas, most participants did not have this organizational setup and stated frustrations at working within their current system.
- Attendees described non-traditional mental health services provided by their communities in disasters, such as faith-based organizations, MRCs, school districts, crisis/suicide prevention, youth counseling, and camps.
- Participants stated the need for funding and infrastructure to provide mental health training to their LHD staff.

Session Topic: The Business Model for Health Informatics and How it Can Support Quality and Performance Improvement

Session Description: There is an increasing interest in, and impetus for, the use of informatics in local public health. Informatics can be defined as leveraging information technology to improve the use and processing of information. When you are faced with shrinking budgets, such expenditure may seem like an unaffordable luxury. This session is a chance to discuss these challenges with your colleagues and discover that informatics means more than simply spending money on IT. It is a fundamental shift in the way you manage your information and carry out business processes, which can then support public health decision-making. The opportunity to see how other local public health departments have made the change may lead you to see that not only is this a necessary investment, it is also one that can lead to dramatic quality and performance improvement and lowered costs in all areas of your work.

Number of Attendees: 19

Discussion Highlights:

- Approaches to planning an information system
 - From whom do you need to get buy-in when planning an information system?
 - User involvement (bringing in the best people who understand the business perspective and the IT perspectives).
 - IT and programmers who are comfortable with the technology have to be involved, and you have to have a cooperative health department to make it work.
- How can you convince the aforementioned people of the need for an informatics system?
 - Health information exchange
 - Sharing with others: hospitals, doctors, etc. (using their resources to help your information needs)
- Are there others in your area (other government departments or nearby LHDs) with whom you should work to build an informatics system?
 - To get people to agree (24 counties in Minnesota Counties Computer Consortium), they stayed in state and strongly pushed their vendor to tell them how much they could do with so much money, and then they shared that information with each other. They pooled the money and on an ongoing basis upgraded information systems and infrastructure for the systems. Sharing the money and delivering cost effective improvements. (Sum is greater than the collective abilities) The barrier they face is the lack of standards. All assessors in MN use the same system, so they continuously add to the pool to be able to make these upgrades.
- Where would look to obtain funding for your informatics system? Are you counting on the stimulus package?
 - Minnesota Counties Computer Consortium
 - Asking for fewer dollars from the health department since they are addressing IT problems together.
 - They use an outsourced vendor.
- What other barriers do you anticipate to implementing an informatics system?
 - Education: everyone should be an informatician. A significant portion of HD staff are not comfortable with computers. (Let's get staff comfortable with email, MS Word, etc.)
 - Different types of IT development, each with pros and cons:
 - Sharing and developing systems and practices (borrowing, etc.)
 - Scrum development (rapid application development)
 - Standardization (the need for it, making sure all are speaking on the same terms, including business processes)
 - Public Health Data Standards Consortium: just got funded, and they lobby for information systems for public health agencies (Dr. Ana Orlova runs the consortium); NACCHO is a member and information can be found on the NACCHO site.

- Outcomes
 - What makes for a successful informatics system?
 - Cross-jurisdictional outcomes
 - Compatibility
 - Multi-directional
 - Making data actionable and usable
 - Standards
 - There must be flexibility in the system
 - The data or systems must work internally and externally
 - There must be discernment in the system; it has to be meaningful
 - The system has to be intuitive and easy so it can be used
 - What types of outcomes do you expect?
 - Return on investment
 - Make everything more efficient
 - More real time information
 - Identify the proper avenues for the outcomes
 - Create partnerships outside of your organization
 - How will efficiencies be realized?
 - Better flow of information
 - Cultural change may take place
 - Production should increase
 - Implications are driven by the leadership
 - Involved staff in the buy-in phase
 - How would you calculate the return on investment?
 - Turning existing data into usable information
 - Do more things
 - Processes should improve
- How would these systems help your health department make decisions in your work?
 - Building local metrics or indicators
 - Create prevention systems out of this data
 - Help leverage different types of partners
 - Get organizations thinking about sharing information
 - Become a more necessary or credible source of information for others
- Additional comments
 - Need should dictate what systems are going to be implemented rather than the other direction.
 - Technology is the easy part, semantics are often more difficult.

Session Topic: Health Equity and Social Justice: Future Directions for Practice

Session Description: Participants in this session will strategize about the best ways to advance the issue of health equity and social justice at NACCHO and among local health departments (LHDs), given the success of the PBS documentary series *Unnatural Causes*, the formation of the LHD National Coalition for Health Equity, new and potential initiatives, the economic crisis, lessons from developing strategies in LHDs across the country, and political opportunities. How does local public health tackle the root causes of inequity in the distribution of disease?

Number of Attendees: 17

Introductory Remarks from Facilitator:

Purpose of the session is to have an informal conversation among us, with free form dialogue about strategies for health equity in our respective health departments in both practice and awareness among staff.

NACCHO has been working on health equity issues for about a decade. The goal is to enhance the capacity of LHDs to act on the root causes of inequity in the distribution of illness: racism, class structure, sexism, and power imbalances. We say inequity not disparity because disparity just says a difference. Health inequity results from social injustice.

A major focus is to begin to think about going beyond targeting the consequences of health inequity and explore the driver and the role local public health can play in these larger debates. We've done a number of things recently. We formed the LHD National Coalition for Health Equity to enable LHDs to collaborate among themselves and self-identify. The idea is to bring colleagues together and develop action plans. We want to devise policy work for LHDs to work on.

NACCHO is also producing a new version of the book *Tackling Health Inequities through Public Health Practice: Theory to Action*—updating the case studies from LHDs. It will be available in February 2010 from Oxford University Press. We are continuing to work closely with the California Endowment to see how to assist those departments in CA to generate models for technical assistance. We are also seeking to work with journalists to see how we can have a bigger presence in the media by reaching out to journalists who are already working on this issue and to have them come together with LHDs to brainstorm about engaging their colleagues and also write longer pieces. We would like to work with local radio stations to increase our presence.

The series *Unnatural Causes: Is Inequality Making Us Sick?* has enabled people to have a conversation with this topic. We have worked closely with the filmmakers to move the agenda forward.

Over the next year or so, we're going to develop an assessment survey to identify what LHDs need to do to work on the root causes of inequity in their everyday practice. This will happen some time in late autumn. With funds from the California Endowment, we are helping fund the San Francisco Health Department in developing a guidebook for health impact assessment—something relatively new in the U.S. The W.K. Kellogg foundation has funded the Ingham County Health Department in Michigan to support other LHDs to engage in dialogue processes with their staff.

NACCHO produced a document, *Guidelines for Health Equity*, and will develop indicators for those guidelines, organized around the essential services, to enable LHDs to recognize how to begin acting on the root causes of health inequities.

Tony Iton (Facilitator): I want to talk about how I got fixated on this work. After three to four years in public health, when I began at Alameda County, I noticed that the reports being generated by each division were really disparate because they had disparate formats. I tried to standardize the epidemiology report. I saw that the reports looked better, but the information was the same. We are good at describing

what we see but doing little to change the outcomes. One of the first things we did was evaluate how the disparities changed over time—I use disparities because that is the term used by the establishment (CDC, HHS, etc). We took death certificates and went back 40 years and looked at life expectancy. We expected to see a narrowing of the gap between black and white. However, we actually saw a widening of the gap and now it is 8.9 years difference. This was surprising. We had to repeat the study. So, we asked, “Can we explain this?” We couldn’t. We tried to factor in AIDS and homicide and removed those categories and it made no difference. Things killing people were chronic diseases. So this was not a magical disease killing people earlier; people were dying of the same things everyone else was but just dying earlier. This phenomenon got worse over time. We just mapped life expectancies and found hot spots of data in places we could have predicted. The hot versus cold spots difference was 10 to 12 years between lowest and highest. We had this new information about how the life expectancy gap was growing. We didn’t know what to do about it or how to talk about it because it goes against all the common wisdom.

Our report was about *health* not *healthcare* and focused on the social determinants of health and included transportation, housing, etc. Life looked just like the death map. Still, we realized that we’re just describing it—not changing what we do. We changed staff internally and then developed another strategy around community organizing and building power in “death hotspots” because what was missing was people suffering consequences with diminished power.

Discussion Highlights:

(P = Participant)

- P: We can’t impact this until we get a better national dialogue about chronic stress and racism. Can NACCHO enter into the debate on race?
- P: Locally, we can have policies and plans developed through a community process, but implementation is difficult without funding. People want to do this work, even when there is no money. We do a lot with limited funding.
 - P2 Response: It’s a mistake to think that health equity is tied to funding. It has to be infused into everything we do. The lack of funding is not an impossible barrier because the issue is less about physical improvements in the community and more about the participatory process, getting people to see that they share interests with their neighbors and that they can make change when they harness power.
- P: What about those health departments that aren’t quite ready for this work? What can be done, what needs to be done by peers or NACCHO?
 - Facilitator: Peer to peer will be very helpful. Even in meetings and discussions, I learn something new each time. Want to know all the tactics they’re using. It makes sense to learn from people who have already learned from what they’re doing. Why reinvent the wheel? The LHD National Coalition for Health Equity Web site will help people do this connecting (<http://healthequity.naccho.org>).
 - Facilitators: Most of the LHDs we work with are people who are asking for help. We have to help each one adapt to its circumstances. We want to lead by disseminating the best examples. We want to establish the peer models. The departments that just don’t care are lower priority for us; the priority is to help the people who want help.
- P: Can NACCHO talk about places that are achieving this? Comparative examples are really helpful.
 - Facilitator: Yes. Collecting those and looking at those is key.
- P: The problem is the celebration of how unequal our society is so that people don’t see it as a problem. It’s very hard to pitch the idea that an egalitarian society is good for everybody. What are the stories you use to advance concepts of equity? How can we use qualitative and quantitative data to figure out what’s in it for the average white guy?
 - Facilitator: Historically, social transformation doesn’t come from persuading people in power that they should give some of it up because it’s good for them. Not the civil rights movement, not the women’s movement. We’ve now depoliticized struggle and made it seem as if change is about fixing problems or the consequences of inequity. We have to frame the conversation and reclaim

- control of the language on these issues. Marketing alone won't be the real answer because it takes time and truth. Instead, it has to be a larger conversation about what we do.
- P: Before working outside of the agency, you've got to make sure that your own staff is working consistently with these philosophies/ideals. How can I work with them at all levels?
 - Facilitator: We found that people get this intuitively once you explain it. Staff wasn't ready to work with communities. We developed an entire internal capacity-building process that starts with a strategic plan, followed by the creation of leadership tracks for staff and training managers. You need a public health 101 with all these issues to be effective. You need internal preparation in parallel with what you do in the community in order to be relevant to the community. A critical mass of people is necessary in the department.
 - P2: Yes, the leadership has to get it and promote it, but it must happen in parallel with community leadership. Doing this purely internally was a mistake.
 - P: Can NACCHO connect with other organizations?
 - Facilitator: NACCHO is part of the HP2020 Social Determinants of Health Workgroup at the CDC. For the first time, they will have an objective on the social determinants of health.
 - P: Is data a problem?
 - Facilitator: Data equals legitimacy. Public health needs to be held accountable. Less than 2 percent of health departments measure life expectancy because few people are prepared to collect that kind of data and manipulate it. The more people are using these tools, the stronger the argument becomes.
 - P: Santa Cruz wants to get a column in the paper this fall on the PBS series *Unnatural Causes*.

Session Topic: Health Reform: Initiatives and Innovations Resulting from State Level Health Reform

Session Description: This session will focus on how local health departments have functioned and modified their programming and services in states that have initiated state-wide healthcare reform. In addition, this session will provide participants with the opportunity to talk about what is going on in their state and what reform efforts are underway.

Number of Attendees: 10

Discussion Highlights:

- Healthcare reform in Massachusetts was discussed in detail.
 - In order to be eligible for care, MA residents must be documented and live below poverty level.
 - Residents of MA are required to have insurance or face a penalty.
 - Employers (businesses of a certain size) are required to provide reasonable insurance for employees.
 - Healthcare reform in MA has not affected local health departments, but has affected local hospitals. Money to reimburse hospitals for uninsured/underinsured (uncompensated care) is not available anymore even though there are still about 150,000 uninsured in MA.
 - In MA, a Blue Cross Blue Shield study found that healthcare reform eliminated disparity in access to doctors.
 - In MA, the insurance companies helped write the healthcare reform and have created products they sell based on the reform.
 - Hospitals taxed themselves to create a pool of money to care for the uninsured. This money went toward reform—it was the only way to make the “numbers” work. Other states and the federal government don’t have this pool of money.
- What is the role of public health?
 - Linking people to services.
 - Public health needs partners and collaborations to educate the community.
 - Dollars are not going to be defined as “for prevention.”
- What can public health do for healthcare reform?
 - Dr. Besser (CDC) stated that healthcare reform is going to change the way public health is conducted.
 - Prevention needs to be talked about. Public health needs more outcome data to prove that prevention is worthwhile.
 - NACCHO is trying to synthesize what can be proved and present the “big picture.”
 - NACCHO hired a full-time lobbyist who is taking recommendations from members.
 - The Association of State and Territorial Health Officials sent letters to Congress and the House.
 - Members can find a page about healthcare reform at <http://www.naccho.org/advocacy/health-reform.cfm>.
 - The National Association of Counties has passed resolutions in support of healthcare reform, which prevention may be a part of. Some local boards of health may have also passed similar resolutions.

Session Topic: The Local Public Health Workforce in Rural Communities

Session Description: Retaining and recruiting qualified public health professionals in rural communities have posed significant challenges to building the rural public health workforce. In July 2004, NACCHO hosted a rural dialogue that focused on workforce development, specifically recruitment and retention. The selection of the workforce topic in 2004 relates back to a December 2003 meeting where workforce was one of the top concerns of persons and organizations engaged in rural public health activities. This challenge of the public health workforce shortage is greater in rural areas as location, local educational opportunities, and a shortage of financial resources make recruitment and retention very difficult. This session will continue the discussion on challenges and solutions identified to address the workforce needs in rural communities.

Number of Attendees: 18

Discussion Questions:

Recruit

Where are the greatest deficiencies in the rural local public health workforce? What are the greatest challenges to addressing the deficiencies?

What collaborative efforts have you undertaken to address recruitment challenges (not limited to diversity)?

Have you formed any partnerships with local hospitals or nursing homes to help recruit nurses suitable for working at the population based level?

How have you worked with local community colleges, colleges, and/or universities to address recruitment issues?

How has or how would possible regionalization impact your workforce needs and challenges?

Do you see a role for NACCHO in recruitment of qualified and diverse staff?

Train/Retrain

Has your agency provided access to training programs (of any kind) that can enhance the qualifications of existing and entry-level staff? What type of training has been offered and for whom? What format has the training been in (distance learning, Web-based, CD-Rom, off-site courses, on-site courses, local universities)?

What type of training is needed and by whom? What is the best way to implement this training?

What are the focus/programmatic areas in which the training is needed?

Do you see a role for NACCHO in training or retraining of local public health agency staff?

Discussion Highlights:

- Staffing issues
 - Staff are cross-trained and have to wear many hats.
 - Many district-level staff serve an entire area.
 - Some have staff with epi functions; most have nurses at the LHD; most have environmental health; few have nutritionists; few have IT specialists; half have health educators.
- Where are the greatest deficiencies?
 - Health education
 - IT (one in the entire county – if he gets to it)
 - Biggest gap is for emergency preparedness – understanding and funding is a major gaps; not enough resources to do exercises.
 - Planning for people’s retirement – finding people to replace them.
 - Home visiting programs – travel is a huge cost factor.
 - Education of any kind to get across to people in rural areas – therefore, lots of on-the-job trained employees; don’t feel the need to further their education even if it’s free; they think they’re good enough.
 - Recruiting of dentists and nurses
 - Lack of staff to man much of the positions

- Prison health system
- Scarcity of staff in environmental health
- Nursing – salary is not good; funding to hire nurses is no good; hard to find nurses; losing nurses, you tend to lose 20-30 years of experience, which is hard to replace.
- No back-up support where nurses are concerned – if nurse is out sick, who takes over?
- Physicians are very hard to find in rural areas; don't stay for very long – tend to stay for two to three years
- "We are public health" campaign would be very helpful.
- Would be helpful to have one standard system – for example, environmental health uses different system than preparedness does.
- Tools and strategies for succession planning
- Resources for getting higher education
- Counties that are medically underserved and even the surrounding counties don't have those medical employees.
- What's working well?
 - Cross-training
 - Collaborating with other health departments
 - Privatizing
 - Sometimes hard to find someone within the county so have to go outside of the county to hire.
 - Regionalizing helps – districts with many counties – helps to connect some of the resources.
- Other issues discussed
 - Almost all participants indicate that they're down full-time equivalents. One indicated they lost 30 percent of staff since 1998. Others indicate they're at bare minimum. 33,000 people with 12 employees with eight that are full-time.
 - Important for counties like us to look at accreditation. Can't maintain a competent workforce and infrastructure on money that is not consistent and sustainable. You can hire someone on a 12-month period, but this is not responsible public health. CDC Public Health Emergency Preparedness money seemed like a lifesaver, but how do we keep this going if that money gets pulled?
 - When it comes to having to vaccinate for H1N1, will need to pull staff from places that will leave those functions hanging.
 - Border issues – there are some areas that require employees to live there, but public health does not know borders.
 - We're losing a lot of industries and therefore losing a lot of workforce.
- What are you going to do for H1N1?
 - Rely on pharmacists.
- Is there a role for NACCHO in any of this?
 - Communicate these issues to CDC
 - Infrastructure age – we're doing a lot of the build-up since 9/11. Would government consider funding some of the functions such as fire, police? For a long time there was funding on this – why can't we continue to rely on this from the federal government? NACCHO should lobby for permanent funding for this. We're not making enough noise, long enough, loud enough. Find us funding that's sustainable.
 - Prioritization of essential services during emergencies – which ones can be suspending, which can continue in an altered state? Put out this recommendation.
 - Look at funding not being restricted. At end of year, funding comes to buy stuff not people. We have so much stuff that we don't have enough people to use the stuff. We need both.
 - Lacking technology – not everyone has access to the Internet.
 - Community health centers – nation is proud of how much has been spent on these, but we don't have any. We are the only place where people can come for care. We weren't eligible to get any health centers. Try to get feds to notice that LHDs that some of us offer primary care services and deserve to be funded like FQHCs.
 - National health service core – need to get on board with this – we just missed the cut off for dental.

- More distance-based training
- Offer continuing education units.
- Have a major training calendar/schedule on what trainings are offered at NACCHO.
- Using volunteers – in FL, we had a “Bright Future Scholarship” program – the kids have to have volunteer hours – every fall, call the counselor and we need volunteers
- “Green Thumb” is now called “Community Senior Service Program” with federal dollars coming down in Missouri with three contractors doing training and agencies have opportunity to sign up – seniors 55 and up.

Session Topic: NACCHO's Advisory Groups

Session Description: Did you know that NACCHO has nearly 40 advisory groups? From preparedness to chronic disease to workforce development, members are actively involved in directing the association's work. Come mingle with peers – new and old – and learn about the benefits of engaging in NACCHO's leadership through service on advisory groups.

Number of Attendees: 11

Discussion Highlights:

- The group went through introductions and stated their involvement with advisory groups. The majority of the group had not been apart of an advisory group, but has a strong interest to do so.
- Current advisory group members discussed their experiences, including the type of work, time commitment, and benefits.
- Current members stated that advisory groups are a great way to know colleagues from around the country and to work with each other and learn from each other. They also highlighted the value of developing closer relationships with NACCHO staff and leadership.
- Participants asked staff logistical questions regarding how groups meet (in person, conference call, etc); who can participate (is it open only to members or can partner organizations sit on a group?), etc.

Session Topic: Policy and Advocacy: Organizing and Activating the Local Health Department Congressional Action Network (LHD-CAN)

Session Description: The goal of this session is to introduce the LHD-CAN, to give examples of successful advocacy by NACCHO members and give NACCHO members the opportunity to get involved in LHD-CAN. During this year when health reform and other issues affecting the future of public health are being debated, a unified voice for local health departments is more critical than ever.

Number of attendees: 7

Discussion Questions:

What are the benefits you derive or can derive from advocacy?

What are your advocacy challenges?

What can NACCHO do to help you?

Do you have suggestions for strategies to build the CAN?

Discussion Highlights:

- Eli Briggs, NACCHO Government Affairs Specialist, moderated the session. She began by discussing the function of the Local Health Department Congressional Action Network.
- The CAN is composed of NACCHO LHD members who will be prepared to contact Senators and Members of Congress when necessary. CAN members will receive guidance from NACCHO staff about current legislative developments and how to take effective action to influence policymakers.
- Terry Allan from the Cuyahoga County Board of Health discussed the legislative activities that he has been involved in over the past year. In May of this year, Terry was invited to testify about state and local pandemic preparedness in the face of the recent H1N1 public health emergency, before the US House of Representatives Committee on Oversight and Government Reform, an opportunity cited as a major success.
- Terry suggested using the H1N1 response as an opportunity to build relationships with legislators and members of the press.
- In an effort to illustrate the potential impact of the dwindling public health infrastructure, Bruce Pomer from California told one CA legislator that there wouldn't be an adequate number of LHD staff members to help with H1N1 response due to the fact that an estimated 900 public health positions were about to be lost.
- Eli reminded the group of the benefits of using data to get media coverage, citing that these data also helped to drive legislative action.
- Terry mentioned the benefit of getting to know congressional staffers, sending information to them, and presenting yourself as a resource for information.
- What is vision for the action network?
 - Immediate goal: Able to call on members at any time to respond.
 - Long term: Have forum where folks can share ideas, successes, challenges, tools, etc.
 - Have held a webinar and conference call. Planning to do so on a regular basis to keep people informed and facilitate peer to peer sharing.
- Suggestions on how NACCHO may be useful to LHDs
 - Pull out the specific provisions in the health reform bills that relate directly to funding LHDs
 - May be a need to make the distinction between clinical prevention and community prevention and determine which angle will help garner support for LHD practice from legislators.
 - Need to show the true value of LHDs, showing what LHDs do that no other entities do.
 - Learn from others and take information and best practices back to the state to advocate for additional funding.
 - Need to start directing strategy toward Obama appointees.
 - Need clarity regarding language in statutes, funding streams, federal language regarding funding.

Session Topic: Quality Improvement

Session Description: Quality improvement (QI) is the cornerstone of the Public Health Accreditation Board's (PHAB) voluntary accreditation program. This session is designed for those who have engaged in QI, as well as for those who are beginning to "test the waters." Join this session to discuss what it takes to move toward a culture of QI in local health departments, where the connection between voluntary national accreditation and QI will also be discussed.

Number of Attendees: 30

Discussion Questions:

What tools, strategies, resources, and other factors have led to successful QI efforts?

What challenges have been encountered and how were they overcome?

What advice or guidance can be offered to those who are new to QI?

What are the key elements of instituting a QI culture?

Discussion highlights:

- Tools, strategies, and resources
 1. QI tools
 2. Business process analysis (*Public Health Informatics Institute model*)
 3. Plan-Do-Check-Act (PDCA) cycles for improvement
 4. Logic models
 5. Work plans
 6. Rapid cycle improvements (RCIs)
 7. Committed board of health
 8. QI consultants

- Challenges encountered
 - *Fear of change.* Some LHD staff may feel that they are not in control as they are not the decision-makers at the health department, and may worry that QI will compete with other priorities and responsibilities.
 - *Too many tools out there.* Though there is a myriad of QI tools available, having staff use what make sense with their work and knowledge level helps to narrow down the most appropriate tools.
 - *Not enough staff time.* More emphasis should be put on the value of performance improvement as the benefits of QI greatly outweigh the time commitment from staff.
 - *Fear of failure.* LHDs don't want to fail at trying to improve performance, but failing is ok – it's part of the process.

- Advice and Guidance
 1. The board of health needs to be supportive and/or involved.
 2. A QI consultant is useful to help guide the LHD through QI processes.
 3. Other LHDs are doing QI – connect with agencies similar to yours to discuss experiences, challenges, and lessons learned.
 4. Train staff to have an agency-wide understanding of QI and what it means to the agency.
 5. Make QI valuable and important in staff's everyday work.

Session Topic: Sharing One Great Local Health Department Story: Improving Outcomes

Session Description: One story can resonate and be more memorable than mountains of data, and telling your LHD's story well can be an effective way to reach policymakers and the public. Join us for an hour of facilitated and open discussions with your peers on the importance of storytelling. How has it made an impact at your department? Share your story, hear your peers', and walk away with a new take on this old form of communication.

Number of Attendees: 8

Discussion Questions:

What kinds of things would you like to accomplish?

Discussion Highlights:

(P = Participant)

- P: very excited about storytelling session at NACCHO (San Antonio) in previous years, went back and asked for stories from people, and she got a low response rate.
 - She knows there are stories, she doesn't know how to get the stories and record them.
 - Discussions on implementation would be helpful.
- P: biggest problem is trying to get stories, also struggle with how to present stories, i.e., where to put them.
 - Only gets picked up in a small way.
 - Wants to see how others do this successfully.
 - Getting them out there and finding writers is difficult.
- P: Other participant explained it well and he thinks this is why it would be helpful.
 - He needs to figure out how to motivate staff to writing stories and getting them from people.
 - Shifting annual reports to something that is more than just charts and data, switching to actual stories.
 - How do you get people to share these stories?
- P: used to work in Marketing Communications and would like to be able to get people to tell stories so that everyone has an understanding about public health and what we do.
 - Would like to know how to encourage the front line public health worker to bring stories to the forefront because everyone can do it.
- Facilitator Rex Archer: the way that a story is told is not always that way that it can read; e.g., someone may be able to tell a story but not be able to write it.
 - P: how can we create ways to tell stories in ways that allow these kinds of people to flourish (video, audio, etc.)?
 - Rex: bring in partners/public/clients because people are more liable to listen to these individuals instead of public health officials.
- Handouts: President's column from when Rex was president
 - All employees in Rex's LHD get orientation, and the opening session is taking the concept of the sacred bundle and telling them that everyone has their own story (five ways to tell these stories).
 - (Could use handouts for employee orientation.)
 - Rex tells his employees in orientation about different people's stories and how public health started in US (Paul Revere) and England (John Snow).
 - There are stories about bad things happening in LHDs:
 - e.g., story about nurse driving to a site and getting into an accident and getting hurt and the nurses not letting them take them to the hospital until the vaccine got to site.
 - There are always bad things happening, but there are good things too.
 - What kinds of stories do you want to represent *your* health department?
- P: struggle to getting support from commissions
 - Fed government said they had commodities, he went and got some and got into the commodities business.

- Women's Voter League: sat and talked to people about how much money people in this community had and how they were using it. Result: told LHD they would give support because they hadn't realized how many poor people there were.
- P: half-hour public health show on local cable network. Started out not being viewer-friendly. People were not getting it (gleaned from evaluations), brought in people from partners and got to telling people about how they were working together.
- P: going back to what Bill said about media, there used to be dedicated health reporters, and now there are not. There is one newspaper in her town and because Tulsa is so Tulsa-centric, this newspaper is great and has merged with OK City paper and sharing bylines.
 - Her newspaper has gotten away from human interest pieces.
- P: who do we really serve? Only state in the last election that had every single county completely red in the last election. They are not trusting of the government. They have no emotional connection to hard luck stories.
 - Everyone there is very independent and doesn't care about others going through hard times because they have gone through it themselves and think others should pull themselves up by their bootstraps as well.
 - Tulsa is a bit more liberal than other places; however, people are not sympathetic towards others.
- Rex: we are experiencing substantial changes in the media market.
 - Shoe salesman going to Africa to sell shoes; no one wears shoes there so he doesn't want to go; another man told the same and he wants to go because it is an open market without any competition.
 - News is turning towards less and less local items.
 - On the other side of the coin, news writers are being asked to do more with less and have less time so will be willing to take articles from others.
 - Human interest items may have to go to weekly throw away newspapers.
- Rex: book "Managing by Storytelling"
 - How managers can use their position to get across their point.
- Rex: Where is the interest in the group lie?
 - Both levels
 - P: professional level because we need to figure out how to tell a story with a high level of conciseness.
- Rex: PowerPoint slides, point number five (river parable and insanity test)
 - He will ask his employees to tell him one of these stories when he sees them in the hallway.
 - Tell him the insanity story and the river parable.
 - Old Indian story: put someone in front of a faucet with a bucket underneath, give them a spoon and tell them to empty the bucket, if they do not turn off the faucet, then they are insane.
 - Found bright green journal after football practice and they were journals of public health, found speech from Mark Malone who was the health director in Canada and this is the earliest version of the river parable that Rex can find.
 - Find babies in the river and start to rescue them, but continue to find more; public health should go around the bend and find out why all those babies are in the river.
- Rex: are there other public health stories?
- P: she realized how hard it is to talk about her job, learning how to do introductions
 - Orientation: think of something that inspired you and what keeps you coming back. The whole idea is that a story cannot be told once and made perfect; it has to be told over and over and practiced to get it right.
 - When something is so fundamental it makes it easier for them, and in their evaluations they will accuse others of not telling stories.
 - Gets them in the mindset to understand how to tell a story.
- Rex: in a training
 - Getting people into groups to tell different kinds of stories, e.g., failures, successes, things that were done well/not done well.

- P: think about what you want out of a storytelling process before you start; figure out what the messages are.
 - This will help with cadence, intonation, and people will understand what you are trying to accomplish.
 - In house FQAC: stalling on a program for planning for poorer people in the community because there was one who was person was a self-made millionaire because everyone who ever worked for him was a contractor so he never had to give anyone benefits.
 - From his perspective, he wanted people to pull them up by their bootstraps.
 - Bruce placed a 60-year old mill worker next to this man within touching distance
 - He was railing on about good for nothing people.
 - She chimed in and she said she was one of those good for nothing people, she told him that she lived on \$17/month.
 - She wanted him to know that she was happy for him to be part of the planning for it and she wanted to say thank you because he could make this place possible for her.
 - He was publically shamed and then became the champion for people like this woman because she put her hand on his shoulder.
 - This was the right level of storytelling and also her touch and proximity to the man.
 - Because he became the champion for all people like the woman who told him this story.
 - Proves the power of storytelling.
- P: this woman told a heartfelt story and walked away with her dignity.
 - And salvageable nature of this man and his ability to change his way of looking at the world and his obligation to help his fellow man.
- P: will he go tell his friend about this? Or would he be more liable to the parable stories?
- P: he would tell people that he got his “comeuppance.”
- *The Politics of Jesus*: regardless of what else you think, there might be something about this guy where he understands strategic communication because people are still following him 2,000 years later.
 - Give a name to the voiceless and name the demon.
- Rex: using stories versus too direct confrontation is very effective; not blaming people, but making sure they understand the story.
- P: good public health policy is taking what exists and building work around what happens and getting people to feel moved by what is happening.
 - Once you get there, you need to take it to a level higher than that.
 - We are not fulfilling our jobs as public health officials if we do not do so.
- P: data might not make a good story, but she has had things that come out that have caused her community to address health disparities.
 - North Tulsa: life expectancy is lower than other areas and most people are African American; this makes it a lost area.
 - 78 percent of diabetes cases are in this area.
 - Health director was astute in getting support from a person from wealthy family in Tulsa by driving him to this area of the city where he had never been.
 - He became an advocate for this particular area because of what he saw.
- Rex: the attempt is to say that data alone will not move people, it has to be other parts to a story; in this case, it was getting the guy into a car and showing him around.
 - Took Sunday school class down to a park and seeing all the homeless people in the park and hearing someone calling it “Jurassic Park.”
- P: experiencing the story
 - “Toxic Tour” in Detroit: got on a bus and people would show where their houses were and where there were areas that have caused people to become sick; showing where people had tried to plant things and were unable to because of toxic waste that was buried there.
- P: governor’s task force on early childhood education, had to do marketing for this program and would go to the houses and see children.

- One visit with teenage mother and all the issues that would come out and she experienced something that impacted her for the rest of her life.
- Getting people to tell their public health stories within their LHDs.
- P: does anyone do “ride alongs” with board members?
 - Board members think they have the ability to take action when in reality they do not.
 - No experience with showing them instead of telling and showing them.
- Rex: have done this with interns and elected officials to get them out to sites to do inspection and understand what public health does.
 - Getting people to register under a fake name and audit courses.
- P: created ride-along program with descriptions of what it was and given to the board members; however they have used it for the board members.
 - i.e., using it to show how they should rise the cost of restaurant inspection fees
 - New staff have also gone and done these kinds of things.
 - Gives the LHD a different way to communicate with the community because they are not contacting high-level individuals; they can really find out what is going on out there.
 - Make sure that they are matched up with quality individuals and keep it to what they do.
- Rex: any other questions that people want to throw out? Or is there anything that people might think about doing?
 - P: people experiencing things themselves is very important.
 - P: suggest that people have the opportunity to be on camera somewhere that they feel comfortable being and it doesn't have to be high quality; play it for the board of health, play it for commissioners and then you have a celebrity who is sending out your message.
 - Because they are the spokesperson, then they own it.
- P: has anyone used a blog and who has it been directed towards?
 - Rex: monitor blogs with PIO and make quick calls about what is going up there.
 - Facebook and other social media: it is a struggle to develop a good balance.

Session Topic: Small Cities Networking Session

Session Description: Join the Small Cities Networking session for a lively and engaging discussion of issues that may be unique to small cities. Share success and challenges, and network with colleagues from across the nation.

Number of Attendees: 6

Discussion Questions:

What defines a small city?

What are some of the advantages to working in a local health department in a small city?

Discussion Highlights:

- What defines a small city?
 - Size of the jurisdiction?
 - Size of the budget?
 - Size of the population served?
 - The number of staff?
 - The population density of the area served?
- Attendees discussed the possibility of changing the name of the session to something other than “Small City Networking Session,” such as “Small Jurisdiction Networking Session.”
- What are some of the advantages to working in a local health department in a small city?
 - The majority of local health departments serve populations less than 50,000.
 - There is a greater need and opportunity for cross-training.
 - Health department employees in small cities are “close to the action.” The director gets to know his board members and many of the members of his community.
 - Health department employees in small cities are able to see the changes they make in their community, but at the same time are less able to illustrate those changes through data as the sample sizes are often small.
 - Directors of small health departments have more visibility in the community and possibly greater accountability to their community.
 - A small health department can change direction more quickly.
- Small cities experience a variety of forms of governance.
 - Members discussed the forms of governance for their health departments and recognized that there are a variety of reporting structures among small health departments. The relative advantages and disadvantages of a health board were discussed and most participants agreed that a health board was more hindering than helpful.
- Concerns and recommendations for small city health departments
 - Small health departments must have internal control over their Web site so that they are able to update information on their Web site quickly in the event of an emergency.
 - Having sufficient volunteers and a strong training program for them is extremely important in a small city when there are fewer health department employees.
 - All staff members at a small health department must be trained in emergency preparedness.
 - As a small health department, it is important to recognize gaps, such as those in environmental health or epidemiology and find people to help fill them.
- Recommendations for NACCHO
 - At the next NACCHO Annual, the person at the conference representing the smallest city (determined by area or people served etc) should win something “big” like a giant pencil.
 - There was some discussion that the session may be more valuable in a more informal setting.
 - Members of health departments from small cities would like to attract more members from small cities to the NACCHO Annual conference in the future.

Session Topic: The Effects of the Recession on Public Health Workforce

Session Description: This session is an opportunity for local health departments to share their stories of how the recession has impacted their workforce, particularly around staff retention, hiring, and trainings and exercises conducted.

Number of Attendees: 10

Discussion Questions:

How have your health department's staffing efforts been affected? (with follow-up questions regarding turnover rate)

Have employees been leaving your departments for jobs in the private sector?

Have employees been leaving your departments for jobs outside of public health?

Has your department been able to conduct scheduled trainings? How many, if any, have been canceled?

Has there been any drop off in workforce development opportunities (career enhancement)

Have you had to postpone or terminate scheduled pay raises?

Which areas of your health department have been affected most?

What do you see as the continuing issues that need to be addressed?

Discussion Highlights:

- There is an online application system in Florida and there are manpower issues going through hundreds of applications. It takes supervisors a long time to go through these applications.
- In FL, one third of funding from fed, one third from state, and one third from revenue. There was a half million cut in budget this past year but have been able to make up majority through established business model. Public health typically does not run a business model; able to make up for some of the budget cuts with revenue.
- Budget cuts are going to be handled differently in different counties, even within the same state.
- Departments are unsure if hired employees will stay once the economy gets better.
- Washington SACCHO: decentralized in Washington, hit hard by economy on state and local level. Bigger health departments are at a 25 percent production level, some close to 40 percent.
- Colorado: referendum(s) passed in 1992 have been slowly hurting the state by attrition. A recession creates a different base despite growth in certain programs. You can never really recover from the recession. Department has had to hire for Women, Infant, and Children activities with the reduction in other public health services. There is an increase in one area, and decrease in others.
- Maryland SACCHO: we have lost employees in all 24 health departments, hiring freezes for past two or three years and furloughs occurring. Unsure of turnover rate for whole state.
- Employees leaving the department for private sector jobs has not accelerated; it's almost been the opposite. There is more job security with government so people are hesitating. You used to be able to find other jobs within the agency or other state agency. There is not a huge increase in those leaving for jobs in the private sector.
- Trainings and exercises have been canceled because of budget and travel restrictions. Had to cancel orientation for new employees in Washington State. June preparedness exercise canceled in Maryland. Staff does not have time to volunteer for other activities or have been unable to. Training still going on in Colorado and Florida, but travel restrictions are in place (put into law in state of FL, "mission critical" travel is the only type allowed).
- Areas of health department affected most include the following:
 - Desoto County (FL): Environmental Health – development plan reviews, septic system control, subject permits (fees out of this process). Increase in primary care clients has given some more revenue. Staff increased in primary care. Are there standards for primary care, family planning, or immunizations and are they being met?
 - WA: "new public health" creating a new way to do business; need to identify what qualify as core services; discussions occurring on local and state level; core services will be kept and others may be let go.

- FL: counties do community assessment to see what services need to be provided by the health department.
- MD: departments having trouble keeping up with the 10 essential services and there is no trigger point in asking for help when we are failing in these areas.
- FL: what are we going to do when the recession ends? We need to be thinking about this now and have strategic plans for when we have new money. What can we do with this money and what are our plans?
- Rural versus urban: no “rural equation,” those departments essentially have to do everything and there is no process for these considerations.
- MD: need to look at the outdated funding structure (from the 1970s).