NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

National Association of County and City Health Officials Public Health Transformation Sentinel Network Findings from Year 1 (2014-2015)

For more information contact:
transformation@naccho.org

Project Background

Local public health systems and practices are adapting and transforming in response to new trends and forces in the field, including a changing public health workforce, continued reductions in state and local budgets, and implementation of the Affordable Care Act (ACA). Specifically, the ACA offers new mechanisms for paying for prevention and linking public health and healthcare entities to define priority areas for investing in safe, healthy, and resilient communities. Hospitals and health plans are developing new value-based payment models, ranging from pay for performance to provider-sponsored plans. At the same time, local health departments (LHDs) are considering their unique value as service providers and/or coordinators of population health efforts to improve the quality and sustainability of their community's health system. For example, some health departments are developing new billing and reimbursement mechanisms and/or contributing to development of new networks of care, such as Accountable Care Organizations (ACOs), designed to provide coordinated, high-quality care to specific patient populations.

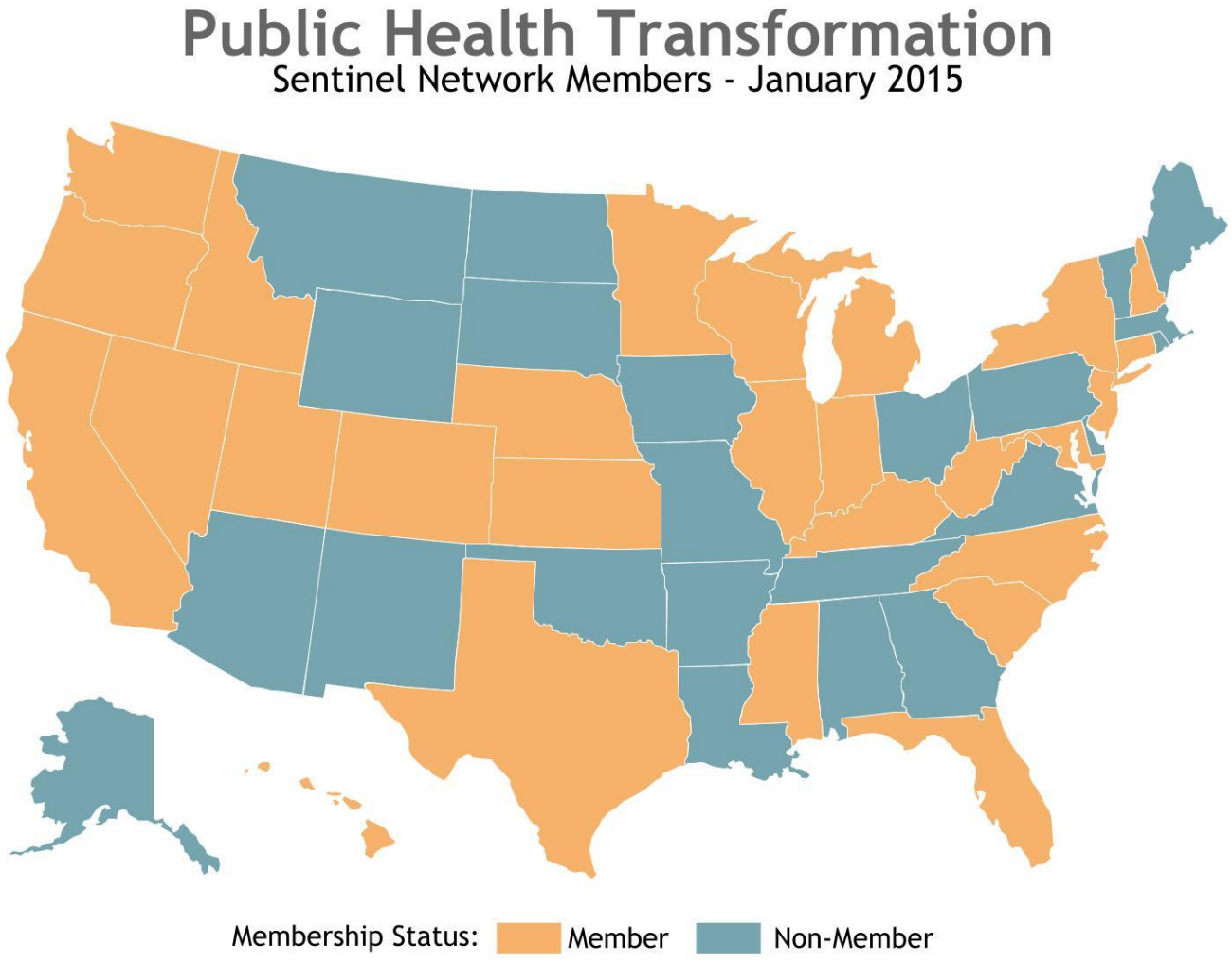
The National Association of County and City Health Officials (NACCHO) is the voice of the approximately 2,800 LHDs across the country. These city, county, metropolitan, district, and tribal departments work every day to protect and promote health and well-being for all people in their communities. NACCHO provides resources to help LHD leaders develop public health systems, policies, and programs to ensure that communities have access to the vital programs and services people need to keep them protected from disease and disaster. NACCHO is committed to ensuring LHDs have the resources they need to contribute to transforming the nation's healthcare and public health systems. The results presented in this and subsequent reports highlight local conditions and LHD approaches to improving population health and advancing the Institute for Healthcare Improvement's Triple Aim,[1] a three-dimensional approach to optimizing health system performance by enhancing the patient experience, improving the population's health, and reducing per-capita healthcare costs.

Public Health Transformation Sentinel Network

NACCHO formed the Public Health Transformation Sentinel Network (Sentinel Network) in fall 2014 to collect information and feedback regarding the role of LHDs in the transformation of the local public health system, including implementation of the ACA. Members of the Sentinel Network are familiar with local-level ACA implementation efforts across their state or region and have general knowledge about LHDs and their roles in the public health and healthcare systems. Sentinel Network members participate in regular surveys and conference calls designed to explore a number of

ACA-related factors at the local level, including the extent of implementation, facilitators and barriers to implementation, and innovative implementation strategies.

As of January 2015, the Sentinel Network consisted of 39 members from 28 states. Members were recruited from a range of organizations, including state associations of local health officials, state health departments, local health departments, public health institutes, universities, and primary care associations. In January 2015, 65% of the states represented in the Sentinel Network have expanded Medicaid coverage.



Methods

Sentinel Network members were asked to complete three surveys. Each survey was developed with support from NACCHO's Research and Evaluation Team, Public Health Transformation Workgroup, and the Centers for Disease Control and Prevention (CDC). The first survey was fielded in September 2014. The instrument included ten open- and close-ended questions that explored participant characteristics, the general status of ACA implementation in the state, and examples of LHD involvement. Thirty-six respondents from twenty-six states completed the initial survey. Eighty-six percent of respondents (n=31) indicated that they interacted with LHDs at least two to three times a month, and 64%

(n=23) indicated they interact with LHDS at least two to three times a week. Results from the first survey are provided on page 3.

The second survey of the Sentinel Network was fielded in March 2015. The instrument included five open- and close-ended questions that explored the following topics: (1) participant characteristics; (2) the types of skills, knowledge, and resources LHD leaders need; (3) the ways LHDs promote local public health to their communities; and (4) financial planning strategies. Twenty-two respondents from twenty states completed the second survey. In April 2015, NACCHO presented a preliminary analysis of the findings to the Sentinel Network members during a quarterly phone call. Eighteen members participated in the discussion. Results from the second survey are provided on page 5.

The third survey of the Sentinel Network was fielded in June 2015. The instrument included six open- and close-ended questions that explored the following topics: (1) Community Chief Health Strategists; (2) The identity of local health departments; (3) critical actions for local public health capacity building assistance and investment; (4) the integration of mental health care into health department services; (5) health department and financial institution collaboration; and (6) emerging trends for future surveys. Seventeen respondents completed the third survey. In July 2015, NACCHO presented a preliminary analysis of the findings to the Sentinel Network members during a quarterly phone call. Five members participated. Results from the third survey are provided on page 9.

Survey 1 Results

Local Reaction to the ACA

Sixty-five percent of respondents (n=22) indicated that LHDs in their states were "making changes to the way they operate" in response to ACA. When prompted to provide examples of such changes, respondents described a range of activities. Many indicated that LHDs were engaged in outreach and enrollment activities related to Medicaid eligibility expansion. For example, one respondent stated that in response to the ACA, "some local health departments had staff become [Certified Application Counselors] to better assist the local population." Other LHDs engaged in Medicaid expansion-related activities by identifying and accessing eligible populations and educating the community about healthcare utilization.

While some respondents indicated that LHDs in their states were moving away from providing direct clinical care, others said LHDs were exploring opportunities to bill for services and contract with health insurance providers. Deciding whether or not to provide direct clinical services required knowledge of the extent to which the needs of the community were being met, conducting analyses to determine what programs and services were financially viable, and exploring IT options (e.g., electronic medical records).

In addition, respondents reported that LHDs were engaging with clinical care providers in new ways. Some LHDs were considering opportunities to engage in coordinated care models that integrate clinical care and public health, such as ACOs and Coordinated Care Organizations (CCOs). Forty-two percent of respondents were aware of LHDs in their state that were exploring involvement in such models. Also, LHDs were collaborating with hospitals for community health assessment and improvement planning processes.

The survey also asked members to describe the forces that influence LHDs decisions to "change the way they do business." Respondents noted that LHDs remain driven by their commitment to the core functions of public health, namely to assure health, equity, and security for all people in their communities. As the public health and healthcare systems change, LHDs must also reconsider their role in assuring that the fundamental needs of their communities are

met. LHDs may define their role as helping community members understand, obtain, and access healthcare coverage, while others may focus on facilitating system change to improve accessibility, affordability, and sustainability. One respondent noted that the ACA provided an opportunity for LHDs to "provide 'new' services that could potentially help provide some financial solutions… while providing a needed service in the community."

Forces that Drive or Impede Change

The most commonly mentioned forces of change were related to LHD budgets. A majority of respondents indicated that the impetus for changes in practice might emerge from the need to simply make ends meet. Respondents noted that funding for public health is being threatened. Federal and private public health funding tends to be inflexible and categorical, and ACA-related funding tends to focus on clinical care. As one respondent described, "Funds that should be going to prevention and overall population health are being used in the healthcare system." However, the ACA's focus on cost savings prompted some respondents to state that LHDs may be able to provide certain services (e.g., diabetes or asthma education) more effectively and efficiently than private healthcare providers. One member explained that "Medicaid is the largest single portion of the [LHD] budget, so cost savings and return on investment are large drivers."

With regard to funding, LHDs were faced with competing pressures. By expanding their role as a healthcare provider (i.e., providing and seeking reimbursement for billable services), LHDs could draw from more reliable and sustainable funding streams. However, newly insured individuals might access healthcare services at locations other than the LHD, which could lead to a decrease in revenue generated. At the same time, many of the public health programs and services provided by LHDs are not traditionally reimbursable, and grant funding for such public health initiatives is inconsistent.

Respondents said change within LHDs might be impeded by the reality that many staff have "learned to survive in a culture of scarcity" or are uncertain about the future of public health. Some LHD leaders are not clear about what changes could or should be made or how to go about facilitating change. One respondent stated that "Many [LHDs] are reluctant to give up traditional public health programs despite coverage expansions that should be providing many of these services via Medicaid or through private insurance." Likewise, some LHDs are not accustomed to working closely with healthcare partners (e.g., insurance providers, hospitals), which could deter their involvement in the development of ACOs or similar coordinated care models. This is further complicated by the fact that local public health is often not named as a stakeholder in federal and state legislation. As one respondent said, "[LHDs] may not be proactively included at certain planning tables. This makes working across sectors and building partnerships with the clinical system more challenging, because the potential value-add roles of [LHDs] and its community partnerships may not be understood or tapped into."

As the services and programs provided by LHDs shift, workforce needs change, requiring health departments to hire new staff or retrain existing staff to support the LHD's emerging role in the community. Respondents expressed concern that LHDs lack the capacity, infrastructure, and workforce needed to engage in system transformation. For example, one respondent noted the need for staff adept at community engagement, navigating insurance markets, health economics, and other non-traditional public health skills. Respondents specifically noted a lack of informatics infrastructure and capacity to fully respond to some of the changes in the local public health and healthcare systems related to system integration, data sharing, electronic medical records, billing mechanisms, and performance management.

While much of the data reflected the barriers to change, respondents acknowledged that the current forces influencing public health, including the ACA, fostered innovation by providing an opportunity for LHDs to shape the changing public health and healthcare systems. As one respondent explained, LHDs might need to develop "new types of services and programs – to reinvent their purpose – that are systems-focused." A common example of this was the role of LHDs as

conveners, including bringing together hospitals and other partners to engage in community health assessment and improvement planning.

Sentinel Network members expressed interest in continuing these surveys to explore a variety of other topics. Several wanted to discuss LHD engagement with ACOs and the different arrangements that were possible. Funding continues to be a dominant theme. Members would like to acknowledge the shortcomings and limitations of current funding streams, brainstorm about small projects that are doable with their tight budgets, and address some of the capacity issues of smaller, more rural local health departments. They were also interested in learning how to leverage electronic health records in public health practice. Finally, they want to explore solutions to workforce and collaboration issues. For example, focusing on the changing public health roles related to supporting hospital community health needs assessments, joint investment strategies, the 18 BUILD health challenge grantee projects, and climate change. Moreover, one respondent was concerned about how rural LHDs were adjusting to the population-focused approach in public health and if other community sectors could help fill the gaps found in capacity. They said,

> *It seems there is a tough balance for smaller, more rural health departments that are being encouraged to embrace change in regard to shifting to a more population-focused approach. In addition, they face shrinking resources. What happens, though, in communities where there are higher numbers of insured (via ACA), but are medically underserved? Some study data indicate that those health departments truly remain the last source of service. So how we can help these health departments that are stuck between older models of direct service provision, while being pushed to move away from that model? Overall, it seems there remains a huge variation in capacity among local public health departments and wonder whether other sectors might move to fill that role if public health cannot (e.g., clinic systems will start hiring public health folks to focus on population health initiatives, etc.).*

Overall, members would like to continue seeing examples across states of different healthcare integration models.

Survey 2 Results

Public Health Leadership

The survey polled the Sentinel Network for the knowledge, skills, and resources that local LHD leaders need in order to actively engage with innovative health systems (e.g., ACOs, CCOs).

First, Sentinel Network members noted the importance of LHD leaders having strong situational awareness. LHD leaders should understand both the current and potential roles of the LHD in the overall system as well as the other major players and their values and priorities. Second, the survey results indicated that leaders need awareness of the different health system and payment models and the infrastructure (e.g., electronic health records, billing guidance) needed to support these models. In addition, leaders benefit from understanding certain conceptual frameworks, such as performance improvement and collective impact. Finally, leaders benefit from technical public health knowledge and experience. LHD leaders must have the knowledge to, as one respondent explained, “bridge the gap between clinical and public health perspectives.”

In order to put this knowledge to use, LHD leaders need access to the proper resources, information, and people. Sentinel Network members emphasized that leaders need to ensure their workforce has the appropriate skills to do the work needed in the community. For some health departments, this might mean hiring new staff with “non-traditional” public health skills (e.g., communication, community organizing, economics) or reassigning or retraining existing staff. In addition, respondents underscored the importance of strong, collaborative community partnerships. Many members

noted that leaders should have "skills in cultivating partnerships/collaborations across sectors" (e.g., business, healthcare, behavioral health). In order to make the best decisions with the community, LHD leaders need access to timely and accurate data, decision-making tools, and appropriate outcome and process metrics. Finally, LHD leaders need adequate funding to do the work and the ability to implement innovative strategies. For example, LHDs often play the role of the neutral convener or collect, analyze, and interpret data, but these functions are not always funded by public and private entities.

In addition to knowledge and resources, respondents described the skill set LHD leaders must possess to engage in system change. Leaders should be able to communicate with a range of stakeholders (e.g., staff, the public, funders, elected officials, and partners). This entails having the ability to "bridge gaps", "speak the language" and frame messages in ways that resonate with different audiences. According to NACCHO's Profile 2013 survey, a majority of LHDs report some form of partnership in a range of programmatic areas, from Emergency Preparedness to Chronic Disease Education.[2] Numerous respondents noted the importance of having the ability to establish connections that foster mutual trust and accountability and support performance improvement and innovation. Respondents specifically named skills such as networking and negotiating as key skills for LHD leaders.

Public Health Branding

Sentinel Network members were asked to describe the messages used to make the case for the value of public health. With regard to public health, respondents aimed to convey to the public and partners the need to consider the health of the total population through prevention strategies aimed at addressing root causes of inequities and reducing risk and exposure to conditions that lead to poor health outcomes. Messaging about the role of the LHD in addressing the public's health focused on convening stakeholders and informing decision making through the use of data. As one respondent noted, LHDs want to be viewed as conveners in the healthcare system, balancing public health and clinical care perspectives to improve population health outcomes. This respondent stated:

> *Prevention and public health services are essential tools to keep health-related costs low in each community. Data consistently indicates access to quality clinical care accounts for 10% of the impact on health outcomes for a given population, while 30% of that same population's health is determined by health behaviors.*

Respondents emphasized that public health is not "one size fits all" and that "place matters" when it comes to health outcomes. LHDs specialize in considering the health of the community, or system, as well as the health of the individual. LHDs understand the local needs and the forces that shape health outcomes. In addition, LHDs see themselves as experts in care coordination because of their ability to connect individuals to resources to meet basic needs, like food, shelter, social support, and education.

Yet, improving population and individual health outcomes requires coordinated efforts within and among other sectors, a "backbone" role often played by local public health. One Sentinel Network member noted:

> *LHDs bring relationships, expertise, and roles that can be – and will need to be – tapped into and strengthened in order to reorient the health system toward prevention and wellness over time. We know our communities, local data, local politics, local health and human service provider systems, and our academic/business partners. Tapping into these relationships and established, trusted communications channels is going to be more efficient and effective.*

Members stressed the importance of effectively communicating the value of public health to their communities by appealing to local values. When prompted to share examples of messaging that resonated with stakeholders, members noted several local and state campaigns, such as Mississippi's "Public Health: Your First Line of Defense" (Figure 1) and Texas's "Public Health: Your Invisible Guardian" campaigns. The Texas campaign included a video that illustrated how a situation would be handled if public health were not a part of the health system.

Figure 1. Example Brand Messaging from the Mississippi Public Health Association

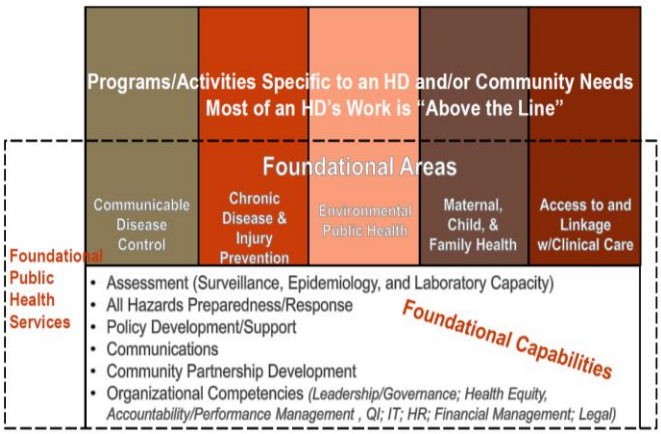
(Source: http://www.mspha.org/)

Public Health Financing

According to NACCHO's 2015 Forces of Change survey, 28% of LHDs across the nation reported cuts to their budgets in the current fiscal year for 2014, approximately the same proportion of LHDs that reported a reduced budget in early 2013.[3] At the same time, many LHDs could face a significant shift in demand for clinical-based services following implementation of the ACA. LHDs were once considered a primary provider of safety-net services; many private providers now are competing to provide care to these high-risk patients. Additionally, many LHDs continue to face budget cuts.[4] This transforming market has prompted many LHDs to consider the types of services they can provide and how these services will be sustained. LHDs continue to explore their options for covering the costs of their programs and services, including federal, state, and local public funds, social impact bonds, private grant funding, fee for service, reimbursement from insurers for volume or value, and many other schemes.

Though the specific programs and services provided by an LHD are typically driven by a community's needs, there are efforts underway (e.g., public health accreditation[5], foundational capabilities[6]) to define the core public health services that each LHD is advised to practice. When surveyed, 64% of 22 Sentinel Network members were aware of the foundational capabilities framework (Figure 2).

Figure 2. Foundational Public Health Services



(Source: http://www.resolv.org/site-foundational-ph-services/)

Although not a foundational public health service, clinical services are considered to be a foundational area. When NACCHO surveyed its members for the 2013 National Profile, five out of the top ten programs and services provided directly and most frequently by LHDs included billable clinical preventive services (Table 1).

Table 1. Ten Programs and Services Provided Directly and Most Frequently by LHDs

Rank	Program or Service	Percentage of LHDs
1	Communicable/Infectious Disease Surveillance	91%
2	Adult Immunization Provision	90%
3	Child Immunization Provision	90%
4	Tuberculosis Screening	83%
5	Environmental Health Surveillance	78%
6	Food Service Establishments Inspection	78%
7	Tuberculosis Treatment	76%
8	Food Safety Education	72%
9	Population-Based Nutrition Services	69%
10	Schools/Daycare Center Inspection	69%

N ranged from 1,949 to 1,975

During this time of transformation, LHDs seek to define their role in the health system. Thus, they are seeking guidance from a variety of sources to determine how or if they should continue offering direct services. In making this decision, many LHDs are considering their staff capacity, their finances, and their community's needs to determine the extent to which they should provide clinical services in the future. Several Sentinel Network members said that LHDs are researching billing and reimbursement plans as a means to continue clinical services. Additionally, approximately 37% of respondents are exploring or considering impact investing or social impact bonds (a contract with the public sector in which a commitment is made to pay for improved social outcomes that result in public sector savings). Several state and local health departments have turned to social impact bonds to fund successful programs or services on a larger scale.

Survey 3 Results

The LHD as the Chief Health Strategist

In May 2014, the Public Health Leadership Forum published *The High Achieving Governmental Health Department in 2020 as the Community Chief Health Strategist,* a report describing seven practices and skills associated with LHDs' evolving identities.[7] Sentinel Network members indicated the degree to which the seven practices are currently a part of the identity of local health departments (Table 2).

Table 2. Sentinel Network Members' Ranking of "Chief Health Strategist" Practices and Skills

Rank	Practices and Skills Associated with Local Health Departments' Identities
1	Collaborate with a broad array of allies – including those at the neighborhood-level and the non-health sectors – to build healthier and more vital communities
2	Adopt and adapt strategies to combat the evolving leading causes of illness, injury, and premature death
3	Develop strategies for promoting health and well-being that work most effectively for communities of today and tomorrow
4	Work with corresponding federal partners to effectively meet the needs of their communities
5	Build a more integrated, effective health system through collaboration between clinical care and public health
6	Identify, analyze, and distribute information from new, big, and real time data sources
7	Replace outdated organizational practices with state-of-the-art business, accountability, and financing systems

N=17

The practices most frequently identified as already being part of the identity of LHDs are related to collaboration and health promotion. During the discussion of the initial analysis, some Sentinel Network members suggested that, in reality, LHDs should work with state as well as federal partners to meet the needs of their communities. Respondents indicated that two practices—replacing outdated organizational practices and working with information from new, big, and real time data sources—were less commonly part of the identity of LHDs. During the discussion, Sentinel Network members noted that a lack of capacity, funding, and guidance may discourage many LHDs from engaging in these strategies.

The concept of the LHD serving as the community's "chief health strategist" resonated with several Sentinel Network members. One member noted that their state health department's strategic plan adopted this perspective and made it a goal to support local health departments in becoming community health strategists. Their plan prioritizes engaging the community, working with data, and informing policy decisions, which other members also noted were key focus areas for their own departments. Members recognized the importance of building the agency's identity and brand in the community. One member said, "[We] are trying to do more and move more into that space… it's more about convening the other sectors that influence health, and being that sort of entity that's looked to as an entity that could do that convening, provide that larger data infrastructure and support."

When asked how other sectors would respond to the LHD asserting themselves in this role, many members on the quarterly call expressed uncertainty. In order to be seen as this convener, they said many health departments will need to re-brand themselves to better explain to other sectors the work they do. They explained that health departments are grappling with public perceptions, capacity, and funding issues, all of which stand in the way of being the "chief health strategist."

The report also provides critical actions for agencies interested in adopting the chief health strategist role. Respondents were asked to prioritize actions by degree of need among LHDs for capacity building assistance and investment (Table 3). Determining connections between primary care and public health emerged as the action where the most assistance and investment is needed. Sentinel Network members explained that health departments can play a strong role in the development of new systems of care, such as ACOs, but some technical assistance is needed to better understand these models and the potential roles of LHDs, and to initiate conversations and negotiate with healthcare partners.

Table 3. Prioritization of Need for Capacity Building Assistance among Local Health Departments

Critical Actions for Adopting the Role of Chief Health Strategist
1. Convene meetings of clinical providers and insurers to discuss potential linkages between population health and clinical care
2. Assess the demographic trends for the municipality and the populations with the greatest health disparities, and analyze their significance in relation to the current distribution of public health funding for the area
3. Assess the diagnoses, trends, and underlying causes of the leading illnesses, injuries, and premature deaths within a municipality and analyze their significance in relation to the current distribution of public health funding
4. Initiate an effort to strengthen internal management systems in ways that create transparent goals, and establish ways to measure progress in achieving them
5. Examine existing and emerging databases in the area that can offer information relevant to the health department's planning, programs, and policies
6. Conduct a planning process both internally and in partnership with others to review data and determine the likely needs of 2020 and consider what strategies to adopt to meet these needs
7. Invent or adapt job descriptions for positions likely to be needed in the future, including: information technology, expertise in big data systems, social media, and analyzing claims data from insurers; building coalitions and organizing communities; building bridges with other sectors including healthcare providers, non-health governmental agencies, large employers, and community-based organizations
8. Collaborate with new non-health-sector partners such as police officers and educators who have the potential to make an impact on the living conditions of some of the more vulnerable segments of the community

N=17

Integrating Public Health and Mental Health

Mental, or behavioral, health is increasingly recognized as critical to physical health. Whether or not mental health services were integrated with public health services in their communities, Sentinel Network members recognized the importance of aligning efforts. Most respondents indicated that public health and mental health are not or are only somewhat integrated at the local level. Survey responses on the integration efforts of public health and mental health averaged a 1.5 out of 3, with 3 meaning very integrated. Some LHDS had done more work related to integrating public health and mental health than others. The extent of the integration of services was primarily determined by whether or not a state had a State Innovation Model (SIM) grant. But several members recognized that it has been a challenge for LHDs to get involved with mental health efforts, even though they would like to. Some members attributed this to the intense focus on changes in the delivery system or to lack of experience in contracting their work.

Collaboration with Financial Institutions

The Community Reinvestment Act (CRA) is intended to encourage banks to invest in community development. Respondents were asked to provide examples of financial institutions collaborating with public health departments or healthcare organizations for healthy community projects. About half of the respondents were aware of such collaborations in their states, though several acknowledged that the projects were not directly related to health. For example, in one community, banks were providing loans to low-income families for home improvements.

The Kane County Health Department in Illinois purchased technology to make a local farmers market more SNAP/EBT-friendly and submitted a proposal to a bank to double the spending power of customers using SNAP/EBT. The partnership helped the bank fulfill its CRA requirements and led to continued investment in this program.

Public Health Seattle-King County (Washington) developed the Communities of Opportunity initiative to improve health, social, racial, and economic outcomes through place-based strategies. The partnership includes financial institutions interested in bringing loan capacity and technical expertise to three targeted geographic areas with the poorest health outcomes.

Implications and Next Steps

Preliminary results from each scan were presented to the Sentinel Network for discussion via conference call. While the data indicate that LHDs are modifying or considering modifications to the way they do business in response to the ACA, members noted that local public health systems experienced pressure to transform prior to health reform. LHDs are also responding to budget cuts, accreditation preparation, and workforce changes. Amidst these other factors, the timeline of the ACA accelerates the need for local public health to define its role in the transformation of the nation's health system and the achievement of Triple Aim.

Sentinel Network members discussed a range of considerations related to transforming local public health departments, from integrating public health (i.e., policy, environment, and system change) and primary care (i.e., disease prevention and management) and identifying meaningful population health metrics to demonstrating the value of local public health to the other health system partners and balancing traditional public health activities (e.g., surveillance and response) with healthcare delivery.

As the public health field expands its understanding of the current context in which LHDs operate and the forces that influence their transformation, the following questions may be considered:

- What are the implications of the ACA for LHDs? How does the ACA interact with other forces experienced by LHDs?
- How can LHDs make decisions about what changes to make in the way they operate and sustain their agencies to achieve Triple Aim?
- How can LHDs ensure they have the capacity (e.g., workforce, infrastructure, resources) they need to take on the role they choose in the transforming public health and healthcare system?
- How can LHD leaders lead change within the LHD?
- How can LHDs ensure they collaborate with members of the local public health and healthcare systems? How do they demonstrate the contributions of public health to achieving population health goals and objectives?

NACCHO welcomes your contributions to this conversation. Please contact transformation@naccho.org for further discussion or with inquiries about the Sentinel Network.

Acknowledgements

This document was supported by Award Number U38OT000172 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of its authors and do not necessarily represent the official views of CDC. NACCHO thanks the following staff for their contributions to this project: Jessica Solomon Fisher, Maggie Gamble, Andrea Grenadier, Andrew Lahn, Nikita Malcolm, Laura Runnels, and Laura Snebold.

References

1. The IHI Triple Aim. The Institute for Health Care Improvement. http://www.ihi.org/Engage/Initiatives/TripleAim/pages/default.aspx. Accessed on January 16, 2015.
2. 2013 National Profile. Rep. NACCHO, Jan. 2014. Web.
3. Forces of Change: The Changing Public Health Landscape. Rep. NACCHO, June 2015. Web.
4. Local Health Department Budget Cuts and Job Losses: Findings from the 2014 Forces of Change Survey. NACCHO. Pg. 1
5. "Public Health Accreditation Board | PHAB." PHABOARDorg. N.p., n.d. Web. 25 Sept. 2015.
6. RESOLVE. Foundational Public Health Services (FPHS). Retrieved from: http://www.resolv.org/site-foundational-ph-services/. Accessed: May 22, 2015.
7. Auerbach, John, David Fleming, Thomas Goetz, Katherine Hayes, Paul Kuehnert, Jeff Levi, Herminia Palacio, Karen Remley, Josh Sharfstein, and Lisa Simpson. “The High Achieving Governmental Health Department in 2020 as the Community Chief Health Strategist.” RESOLVE. Public Health Leadership Forum, May 2014. Web.