Advancing Public Health Policy without Violating Federal Lobbying Restrictions

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Local health departments (LHDs) know there is no one-size-fits-all strategy to achieve their goals. From childhood obesity prevention to immunizations, every effort requires active partnerships with voluntary health organizations and community-based advocacy groups to do the following:
- Research, analyze, and report on policies that can improve health outcomes;
- Educate the public, collaborators, and government entities about evidence-based strategies; and
- Implement these strategies and policies to benefit the public's health.

LHDs are prohibited from using federal funds to lobby pursuant to federal law and related rules, including the Centers for Disease Control and Prevention (CDC) Additional Requirement #12 (AR-12) and Office of Management and Budget (OMB) Circulars A-87 and A-122. In December 2011, Congress amended Section 503 of the Consolidated Appropriations Act of 2012 (Section 503), which further restricted the use of federal funds for lobbying activities at the local government level (similar to AR-12) and the executive branch of governments.1

These changes in federal law, combined with recent allegations of improper lobbying by CDC grantees, have created confusion in the field about using federal funding in evidence-based policy environments. In fact, at the request of Congress, the CDC’s Communities Putting Prevention to Work (CPPW) grant program was investigated by the Government Accountability Office (GAO).2 Under CPPW, the CDC awarded a total of $559.2 million to LHDs and non-profit organizations, yet the GAO found only two small instances of unallowable costs related to lobbying, which were remedied.3

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Myriad federal laws, lobbying allegations, Congressional investigations, and distinctions between lobbying and policy work can be confusing for LHDs. Many LHDs remain concerned that engaging in any policy work violates federal law. These concerns are misplaced.

As the GAO report confirmed, most efforts to improve public health policy remain completely allowable. Organizations can use federal funding for policy work without lobbying, and organizations can educate and inform both elected officials and the public about evidence-based policy or strategy options that will improve health outcomes. Nonpartisan education, information, or research is (and has always been) allowable with CDC funding.

The following Q&A provides the basic rules and key practices LHDs need to engage in policy work while avoiding lobbying activities.

What is the difference between “policy work” and “lobbying”? Many times, these two terms are used interchangeably—and that is not correct. The CDC defines “policy” as a law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions. Policies can solve problems, improve systems, or foster innovation. Thus, policy work broadly comprises research, analysis, and communication to develop, assess, or reassess problems and solutions.

Some policy work does involve legislation and lobbying, but often that is not the case. While every law seems to define lobbying somewhat differently, there are in general two types of lobbying activities:

- **Direct Lobbying:** Any communication with any government official or employee for the purpose of influencing deliberations or actions by federal, state, or local legislative or executive branches. This generally includes trying to affect a politician’s view on a specific measure.

- **Grassroots Lobbying:** Any communication, including advertising, flyers, letters to the editor, or other statements in the media, asking members of the public to contact their elected representatives to urge the support of or opposition to specific government actions.

In general, LHDs are prohibited from using federal grants for direct and grassroots lobbying. For example, an LHD may not use federal funding for advertisements urging the public to contact their representative to vote for the Farm Bill. Similarly, they may not use federal funding to send e-mails or letters urging members of Congress to vote for the Farm Bill. Lobbying activities are related to pending legislation, specific legislative proposals, or other formal government actions.

Another layer of complexity is the different legal definitions of lobbying under Section 503, OMB Circulars, and IRS Rules. LHDs must be cognizant of their various funding sources and the applicable rules for each source.

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What type of policy work is allowable?

In a revised AR-12 issued in July 2012, the CDC set forth several examples of allowable policy work for state and local governments and non-profit organizations. Nevertheless, questions persist about what type of policy work is allowable. Here are some common questions:

- **Are LHDs allowed to participate in coalitions?**
  
  Yes. LHDs may participate in coalitions formed to address public health issues such as obesity, unhealthy housing, or exposure to secondhand smoke. Coalitions share information, research, best practices, success stories, policies, and any other content that may help their members solve a particular issue using evidence-based strategies. In fact, coalitions serve an important purpose to examine policy options, debate the merits of proposed solutions, and build consensus about public health issues. LHDs, however, must track and allocate staff time appropriately. Staff time paid by federal funding should not be allocated for participating in coalitions formed for the sole purpose of passing legislation or when, at times, a coalition conducts some direct or grassroots lobbying.

- **Can LHD employees use federal funds to comment on pending legislation?**
  
  It depends. State and local health departments may comment on pending legislation in three distinct ways, provided that commenting on legislation is within the scope of their grant or contract:
  
  1. In the case of legislation in a jurisdiction, the LHD may be able to comment as part of the normal and recognized “executive-legislative relationship” with the legislative body.
  
  2. If a legislative committee or similar government body invites the LHD in writing to testify or submit comments on pending legislation, it may do so.
  
  3. The LHD may comment in the form of nonpartisan analysis and education, evidence-based policy options for a legislative body to consider, or broad education to the public.

- **Does the executive-legislative relationship exception apply to an LHD providing services to another jurisdiction (different county/city) that does not have its own health department?**
  
  This is unclear, and each LHD should analyze its particular situation. Section 503, unfortunately, does not take into account unique state and local relationships and does not further define a “normal and recognized executive-legislative relationship.” Official CDC guidance states that “state and local health agencies funded by the CDC are permitted to work directly on policy-related matters across their equivalent branches of state or local government” based on normal and recognized executive-legislative relationships. Further, health departments may work “with their own state or local government’s legislative body on policy approaches to health issues, as part of normal executive-legislative relationships.”
However, many LHDs provide services, including evidence-based policy work, to other jurisdictions based on historic relationships or through multi-jurisdiction arrangements. Each health department will need to assess whether that relationship is a “normal and recognized executive-legislative relationship.” Because each situation will vary, LHDs should ask themselves the following:

1. Does state or local law form an executive-legislative relationship between the health department and other jurisdictions?

2. Is there a law, agreement, or other document creating a legal duty for the health department to provide public health services to the other jurisdiction?

How do LHDs ensure they are not lobbying?

Here are a few tips for using federal funding for appropriate policy work:

- **Read and reread the grant documents.** The most important thing is to make sure the activities are permitted by the grant itself. Federal law requires LHDs only to demonstrate that federal funds were spent on allowable activities under the grant. In one case, the CDC found that a grantee’s testimony before a legislative committee was not permitted under the terms of the grant, regardless of any anti-lobbying rules. In that instance, the grantee should have used non-federal funds for such testimony.

- **Allocate time and effort appropriately.** LHDs must clearly and accurately report their activities to the CDC. LHDs should develop a cost allocation plan, use a time tracking system, and assist staff with articulating activities and health outcomes. This will allow LHDs to allocate federal funding properly to allowable activities but allocate other types of funding (non-federal) for unallowed activities (such as lobbying). Reports should not include jargon or vague statements that could be misconstrued as an unallowable cost.

- **Consult with legal counsel and other organizations.** LHDs should consult with their legal counsel about interpretations of law and application to the specific grant and related activities. However, if legal counsel is not available, LHDs should consult with other public health organizations and resources (see sidebar).

**References**

1. Section 503 of Division F, Title V, of the FY 2012 Consolidated Appropriations Act (Public Law 112-74).
5. Non-profit, tax exempt organizations must also comply with the Internal Revenue Code and related regulations pertaining to restrictions on lobbying activities. This article considers anti-lobbying rules only under federal grant awards.

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**ADDITIONAL RESOURCES ON SPECIFIC RULES/LAWS**

- ChangeLab Solutions’ website includes a free legal memorandum and webinar on anti-lobbying rules presented by Edward (Ted) Waters and Susannah Vance of Feldesman Tucker Leifer Fidell LLP.
  http://changelabsolutions.org/publications/complying-anti-lobbying-rules
- Official CDC Guidance and AR-12
- OMB Circular A-21 “Cost Principals for Educational Institutions”
  http://www.whitehouse.gov/omb/circulars_a021_2004
- OMB Circular A-87 “Cost Principals for State, Local and Tribal Indian Governments”
  www.whitehouse.gov/omb/circulars_a087_2004
- OMB Circular A-122 “Cost Principals for Non-Profit Organizations”
  www.whitehouse.gov/omb/circulars_a122_2004/
Administrative Preparedness

By Andrew Roszak, JD, MPA, Director, Pandemic and Catastrophic Preparedness, National Association of County and City Health Officials; Sara Rubin, MPH, MA, Program Analyst, Pandemic and Catastrophic Preparedness, National Association of County and City Health Officials; Samantha Morgan, MPH, Senior Program Analyst, Public Health Preparedness; and Jennifer Nieratko, MPH, Senior Associate, ICF International

Introduction

All disasters are inherently local and require a coordinated response at the lowest jurisdictional level within an impacted area. Much like the operational public health responses to events such as natural disasters, terrorist acts, and public health emergencies, the administrative response to such events requires planning, coordination, and execution. While a great deal of planning focuses on operational preparedness, successful response to a disaster also relies on “administrative preparedness.” Administrative preparedness is the process of ensuring that fiscal and administrative authorities and practices that govern funding, procurement, contracting, hiring, and legal capabilities necessary to mitigate, respond, and recover from public health threats and emergencies can be accelerated, modified, streamlined, and accountably managed. Successful planning and implementation of administrative preparedness can ease the acquisition of goods and services, hiring or assignment of personnel, disposition of emergency funds, and legal determinations needed to respond to and recover from a disaster or public health emergency.

State and local health departments are often challenged to administer emergency preparedness and response funding. For example, during the 2009-2010 H1N1 influenza response, the Centers for Disease Control and Prevention (CDC) allocated $1.4 billion to state and local health departments through the Public Health Emergency Response (PHER) grant. Much of this funding directly

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supported H1N1 response activities, so health departments had to develop and implement mechanisms to process funding quickly and efficiently.

To understand better the administrative preparedness needs of state and local health departments, the National Association of County and City Health Officials (NACCHO), the CDC, the Office of the Assistant Secretary for Preparedness and Response (ASPR), and the Association of State and Territorial Health Officials (ASTHO) commissioned the Harvard School of Public Health to conduct a series of interviews. More than 755 informative statements from state and local health officials led to the identification of common administrative barriers associated with the administration of emergency preparedness and response funding. Many respondents reported that the complexity of grant processes prevented funding from being allocated in less than 60 days. Based on these findings, ASPR, ASTHO, CDC, and NACCHO are collaborating to offer strategies and resources to help health departments build and improve their administrative preparedness capacity and capability.

By addressing administrative challenges, health departments can improve their overall capacity to prepare for and respond to emergencies. The following section offers an overview of key themes of administrative preparedness.

A Starting Point: Know the Players

Early identification of key stakeholders is essential for administrative preparedness but is also difficult to accomplish. In recent years, thousands of seasoned public health professionals have lost their jobs, and preparedness programs have been eliminated or scaled back nationwide. The elimination of such positions has also led to the loss of institutional knowledge about administrative, legal, and contracting processes. Since 2008, local health departments have lost nearly 40,000 employees, with more than 5,000 positions eliminated in the second half of 2011 alone. State health departments have seen similar reductions in workforce. Loss of personnel poses a challenge in institutionalizing mechanisms and procedures that enhance administrative preparedness.

To address administrative preparedness, a team of core personnel should typically include, at a minimum, select health department staff, procurement officials (or fiscal agent), and legal counsel. However, due to the varying organization of state and local governments, key individuals may be within the health department, in another governmental agency, or in an outside organization. The involvement of such personnel can vary greatly; some may be routinely involved in procurement, contractual, and grant management activities, while others may be involved only peripherally. Those not involved in day-to-day administrative processes may not firmly grasp the normal rules, procedures, regulations, or impact of a declared emergency on relevant legal and regulatory authorities.

Identifying personnel before an emergency and including them in planning discussions can clarify roles, responsibilities, and authorities. This approach can ensure that individuals understand expectations and their role in the overall response of the organization. Identifying individuals with emergency administrative responsibilities will enable increased accountability and better manage expectations during a response.
Procurement during Emergencies

During most emergencies, health departments must rapidly procure additional goods and services to enable an effective response. The public health and medical resources needed during an emergency are frequently different in character and quantity than those used to address routine circumstances. Additionally, many of the resources needed to respond to high-consequence, low-probability events often are not stored in standard stockpiles or other readily available sources. As a result, health departments must understand all procurement options that can enable the rapid acquisition of goods and services.

State and local governments frequently use term contracts to procure resources they use regularly. Term contracts allow health departments and other local and state government agencies to purchase goods and services at pre-negotiated prices from a prequalified group of vendors for the length of the contract. These contract vehicles allow agencies to enter into contracts without stipulating when or how much of a resource they may purchase. At the federal level, indefinite-delivery, indefinite-quantity (IDIQ) contracts serve a similar purpose.

According to a survey by the National Association of State Procurement Officials, 33 states have “state term contracts for commodities and services that might be needed in an emergency.” Term contracts are one method to accelerate procurement processes during an emergency. To maximize this option, health departments should assess what types of goods and services are likely needed to respond effectively to an emergency based on the hazard vulnerability analysis for their jurisdiction. Fiscal agencies may work with health departments to identify current term contracts that include likely needed resources and note their potential usefulness for emergencies. Additionally, health departments may assist fiscal agencies by providing lists of likely needed supplies that may be added to future contracts. Finally, health department and procurement officials may discuss the feasibility of establishing term contracts in advance specifically for those goods and services most likely to be needed during an emergency.

Another common procurement tool is cooperative purchasing. According to the National Association of State Procurement Officials, three types of cooperative purchasing exist: true cooperatives, third-party aggregators, and “piggyback” options. Piggyback contracts are most likely of the three options to be useful in an emergency. They are “[c]ontracts issued by individual government entities that allow other jurisdictions to use the contract (i.e., to "piggyback" on the contract terms and prices) they established.”

Cooperative purchasing offers the added benefit of saving time. Because competitively bid contracts preexist, the health department does not need to determine requirements, bid the proposal for response, or negotiate with vendors. Health departments and their procurement partners should maintain awareness of existing piggyback contracts that cover resources that may be needed for emergency response. Similar to other contracts, piggyback contracts are a procurement option for all levels of government and may be targeted toward specific resources.

Other Considerations

During emergencies, insufficient staffing becomes a critical challenge. Health departments quickly reach their surge capacity and need additional support. Numerous administrative and legal hurdles create obstacles to increase staff rapidly during an emergency, such as lengthy hiring processes, hiring freezes, furloughs, overtime restrictions, contracting requirements, and collective bargaining agreements. Additionally, the response to public health emergencies often requires the expertise of personnel with unique skill sets who may not be available locally.

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Often, funding received by health departments is designated for specific purposes, which creates challenges due to the limitations of categorical funding streams. For instance, all state health departments receive funding from the Department of Health and Human Services (HHS) for both general public health preparedness under the PHER grant and large-scale bioterrorist event planning under the Cities Readiness Initiative. Although HHS allocates both funding streams for preparedness purposes, health departments are limited by the specified parameters of each grant. For example, the PHER funds appropriated to state health departments for their H1N1 response were released in phases, with each phase targeted toward a specific category. This forced health departments to make planning decisions based on funding categories rather than perceived community needs.

**Conclusion**

Building and maintaining strong relationships with procurement partners, legal counsel, and grant administrators can enable effective emergency response and may aid in the routine execution of administrative tasks. Administrative preparedness authorities cannot be implemented independently but rather should be addressed at all levels of government to achieve a more efficient, effective public health response enterprise.

Moving forward, ASPR, ASTHO, CDC, and NACCHO will continue to explore issues related to administrative preparedness. NACCHO released two publications—Administrative Preparedness Authorities: Suggested Steps for Health Departments and Administrative Preparedness: Emergency Procurement Strategies for Health Departments (available at http://eweb.naccho.org/prd/?na487pdf and http://eweb.naccho.org/prd/?na485pdf)—to help health departments build their administrative preparedness capabilities. Recognizing the importance of administrative preparedness, NACCHO will continue to provide tools and resources that will enable local health departments to assess and improve their administrative preparedness planning and operations.

**References**

3. Ibid.  
4. Ibid.  
5. Ibid.  
Public Health Law and Accreditation

By Kaye Bender, RN, PhD, FAAN, President and CEO, Public Health Accreditation Board, and Les Beitsch, MD, JD, Director, Center for Medicine/Public Health, Florida State University College of Medicine

Most of us have sat through humorous presentations about antiquated public health laws still on the books for health departments. While laughable when we reminisce about public health, some of the examples are not that far from a present painful reality. Outdated public health laws can damage the standing of health departments in a time when credibility is most needed.

The Public Health Accreditation Board (PHAB) developed the accreditation standards and measures based on the 10 essential public health services framework, with the additions of capacities in administration and governance.\(^1\) PHAB is a national performance standards-setting organization that works by consensus. The standards are designed to guide a peer review process that recognizes both current practice and “stretch” standards. The public health department accreditation process was designed to assess the capacity of state, local, tribal, and territorial health departments to manage their public health functions. That process begins with the health department describing and validating its public health authorities. For public health laws, rules/regulations, ordinances, and other such authorities, accreditation provides a lens through which the jurisdiction can examine these important tools and assess how well they support the health department’s work.

Because legal authorities form such a significant basis upon which health departments function, PHAB includes the following areas in Domain 6 as part of the accreditation process:

1. Review existing laws and work with others to update as needed. Public health laws should keep up with changing public health knowledge, practice, and emerging issues. Health departments should have the capacity to review their laws and propose updates to reflect these changes.

2. Educate individuals and organizations on the meaning, purpose, and benefit of public health laws and how to comply. As the backbone of public health in their jurisdictions, health departments have the responsibility to understand relevant public health laws and to facilitate the public’s compliance with them, beginning with education as the least prescriptive legal approach. Laws that are applied consistently, like immunization laws, can have a direct impact on the health status of the population served and set the tone for proactive public health legal remedies that improve health.

3. Conduct and monitor the enforcement of public health laws and coordinate notifications of violations among appropriate agencies. Whether or not health departments have direct enforcement responsibilities, they do have a role in monitoring compliance with significant public health laws. If they have regulatory responsibilities, then they should have a consistent approach to conducting their enforcement activities. The latter is often the subject of health department quality improvement plans. In either case, if public health laws are aimed at improving the health status of the population or preventing disease, then the health department should know how effective the laws are at achieving those goals.

4. Monitoring trends and patterns in the enforcement and impact of public health laws forms, in some ways, a “legal epidemiology” practice for health departments. Understanding gaps in the application, enforcement, and impact of public health laws can be a powerful tool for health departments to use in accomplishing the overall mission of protecting and promoting the health of the public.

An accredited health department is one that has demonstrated the capacity to carry out the 10 essential public health services, to manage its resources and assets, and to engage its governing entity in appropriate activities to support its mission. Assessing and monitoring laws, ordinances, rules, and regulations for their impact on the health department’s work is an invaluable tool for health departments to use.

Public health law forms the basis for much of what public health departments do in their official governmental roles. Specific attention to public health law and its proactive deployment can provide health departments with excellent tools to significantly affect the health of the population they serve.\(^2\) Public health law and accreditation are powerful synergistic allies in this regard.\(^2\)

References


President’s Column

By Terry Allan, RS, MPH, Health Commissioner, Cuyahoga County (OH) Board of Health (Serving Greater Cleveland)

In June 2011, the Institute of Medicine’s (IOM’s) Committee on Public Health Strategies to Improve Health released a report titled For the Public’s Health: Revitalizing Law and Policy to Meet New Challenges.

The report details the growing recognition of the importance of law and policy in creating the conditions in which people can be healthy. The report describes public health law as a potential “driver” in facilitating population health improvement. The Affordable Care Act is the quintessential demonstration of this concept, as a national experiment unfolds across the country and the law catalyzes quality improvement, outcome-focused care, and prevention. The Public Health Accreditation Board (PHAB) acknowledges the significance of periodically reviewing and updating laws of public health importance in Domain 6 of its Standards and Measures, echoing Essential Public Health Service #6. These evolving national initiatives will have profound implications on how local health departments will serve their communities into the future and the types of services and workforce development advancements necessary to harness fully the power of public health in states and local communities.

Groundbreaking public health laws and policy decisions often require big investments to achieve the big returns that have reverberating impacts on health outcomes and society as a whole. In Ohio, the Smokefree Workplaces Act that passed by statewide referendum in 2006 represented a major public health victory in a hard fought battle, yielding a very protective law with substantial dividends delivered on the improvement of public health status and the economy of Ohio. The Ohio Department of Health released an analysis of the impact, refuting detractors in noting that there were no statistically significant changes in taxable sales for either restaurants or bars after the ban was instituted. The ban also achieved a 30-percent reduction in mean total percentage of emergency department visits for heart attack/acute myocardial infarction, post-ban.
The IOM report also discusses the deleterious impacts of preemption in which a higher level of government restricts or eliminates a lower level of government’s ability to regulate an issue. Recent state-level preemptions that hinder the ability of local communities in Ohio to raise tobacco product and sugar-sweetened beverage taxes or institute trans fat bans are examples of preemptions that hinder local governments wishing to make their own decisions on public health laws that can lead to decreased smoking rates, decreased childhood and adult obesity, and increased life expectancy and can save millions in healthcare costs for the treatment of chronic diseases. Sharing innovative practices from around the country that include novel approaches to public health law and policy changes and improve the health of communities is essential, while continued advocacy at the state level remains an important pathway to surmounting preemption.

As I am writing this column, Ohio is crafting its state biennium budget that is scheduled to be signed by the governor on June 30. The expansion of Medicaid is a major issue being hotly debated in the legislature and in many other states around the country. Efforts to equalize taxes on other tobacco products (OTP) (e.g., little cigars, hookah, pipe, and roll-your-own) with the taxes imposed on cigarettes are also being debated. Public health advocates have testified in support of the OTP equalization, which is also a significant health equity issue. According to recent Youth Risk Behavior Survey data in Cuyahoga County, little cigar use is higher than cigarette use among middle school students. This pattern is repeated among black (14.3%) and Hispanic (13.8%) students compared to white students (4.2%). In Cleveland City Schools, the cigar use rate is more than double the rate of cigarette use among middle and high school students. Raising OTP taxes statewide would decrease use among minority youth, and if efforts to dedicate some of the tax revenue generated to prevention were successful, many compounding public health benefits would occur.

The power of public health law and the lasting impacts on the health of communities is undeniable. As local health systems prepare for the challenges of the coming decades, local health departments must consider law and policy to be a major tools in their arsenals in creating the conditions in which all communities can be healthy.
I never considered becoming an attorney, yet “the law” and I have crossed paths at numerous times in my life. Some of those are stories for another time! While not wanting to become an attorney, I’ve always been glad to have a good attorney advising me.

In the early 1980s, as I began my first work with the (then) Michigan Department of Public Health (MDPH), I had my first intensive exposure to public health law. As a new nutrition consultant in the state’s Women, Infants, and Children (WIC) program, I was confronted with the small font of the Federal Register. I was asked to become familiar with and interpret federal laws and rules and to create and implement aspects of state regulation and policy to operationalize this important and growing federal program. As my assignments changed at MDPH, Medicaid Early and Periodic Screening, Diagnostic, and Treatment rules and regulations and those for the Title X family planning and Title V rape prevention programs became important. It wasn’t long before I had experience with both the intended and unintended consequences of law.

I never lost interest in, or curiosity about, the law over the next 30-odd years as my career moved through state and local government and then to non-profit and philanthropic enterprises. My employment as director of a local health department (LHD) opened my eyes to a whole new body of law. The Michigan Public Health Code described profound responsibilities for me and my staff and placed powers typically in the domains of the criminal and civil justice systems in my hands and mind. Wide-ranging authorities were at my disposal. Prevent disease, promote and protect health, said the Code. The inference was to discover both what ailed the community and what assets were available and then to move on to fix an imperfect world. Several years passed as I learned that by understanding my authority, employing the proper procedures and processes, and gaining the proper approvals from appointed and elected officials, the conditions that county residents experienced could be changed to make health easier. I used those authorities on multiple occasions when working closely with the county attorney assigned to my LHD. The law was a tool to improve the public’s health.
A whole new body of law is important in my current role as the executive director of NACCHO. Here, important laws surely pertain to the life and compliance of a non-profit agency. Nonetheless, creating conditions in which LHDs can be successful is an essential aspect of NACCHO’s mission as a leader, partner, catalyst, and voice for LHDs. As a result, many staff at NACCHO work with partner organizations and members to inform the legislative, executive, and judicial process so that policy positively affects LHDs while at the same time protects people, keeps them secure, and prevents harm.

Multiple resources have been constructed over the last decade to make legal assistance more readily available to LHDs nationwide, including assistance to local attorneys assigned to work with LHDs. Sometimes overwhelmed by a long list of governmental or non-governmental clients, and identifying their client as someone other than the LHD, local attorneys may need help fully appreciating how important the law can be for the health of people in their jurisdiction or better understanding how others are making use of the law.

As I discovered as an LHD director, equally important is the local health official’s in-depth understanding of the relevant law because when the local health official and his or her attorney are in close and effective partnership, health can become easier for populations. This issue of NACCHO Exchange illustrates the results of these relationships. We’d love to hear about your successes and challenges. Drop a note to publichealthlaw@naccho.org.
The Role of Local Health Departments in Education, Law, and Policy to Reduce Sugar-Sweetened Beverage Consumption

By Wendel Brunner, PhD, MD, Director of Public Health, Contra Costa Health Services, and Tracey Rattray, MPH, MSW, Director, Community Wellness and Prevention Program, Contra Costa Health Services

Sugar-sweetened beverages (SSBs) are a main driver of the obesity epidemic facing the United States. The average child in California consumes 38 pounds of sugar annually from SSBs alone. In the low-income Bay Area communities of Richmond and San Pablo (populations 104,000 and 29,000, respectively), a typical youth consumes over 150,000 calories of sugar from SSBs every year. Fifty-two percent of fifth-grade children in Richmond and San Pablo are already overweight or obese.1

Local health departments (LHDs), even when they may be constrained from directly advocating for any legislative policy, can play an important role in educating local elected officials, community leaders, and residents about health impacts associated with a proposed policy. LHDs can be a source of local data and frame national health issues in local terms. They carry credibility as protectors of community health with local residents, media, and policymakers.

Contra Costa Health Services (CCHS), the LHD for Richmond and San Pablo, worked with local leaders and residents to address SSBs through policy and education. Richmond and San Pablo city council members asked CCHS to provide information on health and SSBs. CCHS' reports to the city councils did not advocate putting an SSB tax on the ballot but rather described the impact of SSBs on the community's health. CCHS also listed a range of concrete community interventions to reduce obesity—which could be paid for by an SSB tax—in an appendix to the report.2 To address childhood obesity, the city council in San Pablo formed a task force to consider actions and policies. In Richmond, after considering the report from CCHS, the city council voted to put an SSB tax on the ballot in November 2012.

The SSB industry struck back with an over $3 million campaign to crush the Richmond tax measure, but the publicity, media, and community debate—largely framed by health analysis and local data from CCHS—set the stage for further local and statewide policy efforts including a state SSB tax.

CCHS educated San Pablo and Richmond policymakers and the public about the impacts of SSBs on residents' health in their own cities. The LHD had local data collected by schools on rates of childhood obesity. Using business licenses and environmental health records as a data source, CCHS mapped every SSB outlet in the cities. The LHD used statewide data from the 2009 California Health Interview Survey and Small Area Analysis using the demography of Richmond to estimate local adult obesity rates. These synthetic local data, while only an estimate (as CCHS clearly explained to the public), still realistically represent local conditions. The data were very significant for local city council members and community groups. CCHS used the same statewide data set and applied empirical studies relating morbidities and mortality to obesity to estimate the expected number of excess cases of chronic diseases and premature deaths in Richmond and San Pablo attributable to obesity.

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Richmond city council members, the community, and the media responded to the report’s key points:

- The fact that 52 percent of city children are overweight or obese;
- The dramatic projected increase in rates of obesity as today’s overweight and obese children become adults;
- The corresponding projected increase in number of premature deaths due to obesity in Richmond;
- The key role of SSBs in escalating rates of obesity; and
- A map showing every SSB outlet in the city.

The media and SSB tax advocates used the local numbers as sound bites:

- Seventy-eight percent of Richmond residents live within a five-minute walk of an SSB outlet;
- A total of 198 SSB outlets are within walking distance of Richmond schools;
- The number of obese adults will double as today’s children grow older; and
- The percentage of all deaths in Richmond attributable to obesity will jump from 11 percent to 18 percent.

All the attention and discussion of SSBs during the campaign provided CCHS with an outstanding opportunity to work with community groups and the media to educate the public about the adverse health impacts of SSBs. CCHS held forums, developed fact sheets, and trained community advocates on the issues of obesity and the role of SSBs in damaging health. Even during an election campaign, LHDs may legally and appropriately respond to community concerns and use them as opportunities to educate and inform people about important public health issues.

Passage of an SSB tax in California with money going to obesity prevention could cause similar efforts to sweep across the nation. A tax could have the same kind of impact on SSB consumption that California’s tobacco tax-funded prevention program had on slashing smoking rates. In such circumstances, CCHS expected the national SSB industry to respond in force and cause this first SSB ballot measure to fail. That is exactly what happened.

The SSB industry and their allies spent over $3 million in a campaign against the tax. Much of the billboard and advertising space in Richmond was filled with anti-tax ads; unemployed youth were hired to distribute leaflets in neighborhoods; and small, mostly online local newspapers suddenly found money to publish and deliver print editions featuring front page op-eds against the tax. Although the SSB industry spent much of the money on outside consultants and advertising firms, enough was poured into Richmond’s low-income communities to cause a brief economic boomlet. Because of the particularities
of California law, the measure was written to have the tax revenue go into the City General Fund with a separate but legally non-binding advisory measure recommending the money be spent for obesity prevention. The SSB industry capitalized on this weakness, saying there was no legal guarantee the money would go to obesity prevention. The tax measure was eventually defeated by 67 percent of the vote.

A post-election Field Poll revealed that Richmond voters initially opposed the idea of taxing sugar-sweetened beverages 60 percent to 36 percent. A large majority (66%) of Richmond voters said they would favor a soda tax if its proceeds were devoted to improving school nutrition programs and expanding physical activity programs (Chart B) (The Field Poll, Feb. 13, 2013). In the state of California, 68 percent would support an SSB tax if proceeds were devoted to those programs.

From a public health perspective, the campaign was an enormous success. From the beginning, the LHD had set the frame for the debate. Virtually no one was arguing that SSBs were not a major contributor to the obesity epidemic—that became a given—but only whether a tax was the right response. The Berkeley Media Studies Group reports a total of 473 media items that covered or referenced the Richmond soda tax ballot measures between Nov. 1, 2011, and Jan. 31, 2013, including The New York Times, local blogs, Fox News, and local radio. Whether or not they agreed with the tax, most articles, editorials, and newscasts that covered the issue conveyed important public health messages: obesity has reached epidemic levels; SSBs contribute to the epidemic; and schools and communities need more sports and better nutrition programs. Much of the information and sound bites came from the LHD reports to the cities.3

LHDs are vital in advancing policies that are crucial to promoting health. Even when working within legal limits and constrained by local politics, LHDs can provide key local data on health conditions that grab attention of local policymakers and the media. They can set the terms of discussion and frame the debate for both advocates and opponents. LHDs are the only institutions whose sole responsibility is to improve the health of all the people in their communities. As such, they can be the credible source for health information and have influence in broad and diverse parts of the community.

References
2. Ibid.
3. For more information about how LHDs can use media to promote public health agendas, see NACCHO Exchange, Communicating the Value of Local Health Departments (Vol. 11, Iss. 2). Available at http://eweb.naccho.org/prd/?na446pdf
Keeping Kids Strong through The Arizona Partnership for Immunization

By Jennifer Tinney, Program Director, The Arizona Partnership for Immunization

Insurance coverage is expanding due to the Patient Protection and Affordable Care Act, but increased rates of insurance coverage do not always lead to increased access to healthcare. In Arizona, private providers administer about 70 percent of vaccines given, while public providers such as LHDs provide 30 percent. In some areas, private-provider vaccine programs have become such a financial strain that many private providers no longer offer immunization services. Instead, they often refer all insured children to local health departments (LHDs) for the childhood schedule. LHDs are looking for ways not only to respond to the increased demand for immunization services but also to ensure long-term sustainability. One successful approach has been billing third-party payers (e.g., Medicaid, Medicare, and private insurance) for health department services. A billing model used in Arizona provides an example of how stakeholders and community partners can work together to help LHDs overcome barriers.

The Arizona Partnership for Immunization (TAPI) is a public-private partnership of health leadership comprising health plans, LHDs, government agencies, non-profits, and vaccine manufacturers. TAPI’s approach to the billing system is intended to have an impact on the whole vaccine delivery system, not just one stakeholder. Improving LHD billing practices and vaccine reimbursement in the private sector are TAPI’s key goals. In addition, partnering with pediatricians from the Arizona Chapter of the American Academy of Pediatrics (AzAAP) has allowed LHDs to share vaccine payment system data, an important step in a much needed comprehensive system of access to care.

According to a cost analysis by the AzAAP, vaccines account for 40–45 percent of the overhead for a pediatric office with low rates of reimbursement. The American Academy of Pediatrics and the National Vaccine Advisory Committee have recommended that full payment for vaccines include the cost of the vaccine plus administration costs that cover storage, handling, ordering, managing, and insuring inventory. In Arizona, vaccine payments need to be 121 percent of retail cost for a provider to break even.

A survey conducted by TAPI indicated that about 50 percent of providers had referred a child to a public clinic for a vaccine because of the high investment in
vaccine stock and low reimbursement rates from private insurance plans. In Maricopa County, which serves 60 percent of Arizona’s population, the number of privately insured children visiting the LHD clinic has increased each year. LHDs are in jeopardy of not being able to provide the needed services to their community due to reductions in the Immunization Grant Program (Section 317) funding and policy changes, vaccine reimbursement, and barriers to contracting with private health plans. LHDs have found that the current vaccine reimbursement system is inadequate to cover costs. Payment lag time, vaccine price increases, and newer and more costly vaccines with smaller reimbursement margins are disincentives for LHDs to provide immunization services. Yet, LHDs are now required to fill gaps in provider coverage. For example, an LHD billed $35,000 in vaccine costs to one large health plan as an out-of-network provider and was reimbursed $2,800, requiring a $32,000 supplement from public funds.

To address the reimbursement barriers for both private practices and LHDs, TAPI encouraged Arizona health leadership to advocate for system-wide policy changes and legislation. Meetings with stakeholders involved those who provide vaccine delivery, including medical leadership and the community partners, which resulted in a comprehensive strategy for system change. In addition, stakeholders provided data that helped identify powerful policy changes. LHDs identified the need for a centralized billing business office, and TAPI took on that role for the LHDs in Arizona that were billing Medicaid and private health plans. Such LHDs had more than $150,000 per month in vaccine claims totaling over $2.5 million since the program began.

The primary focus of the business office is to ensure that TAPI can use the data collected to shape policies that support both public and private systems by increasing vaccine reimbursement payments. As the result of TAPI’s work, policy changes in the Arizona Department of Health Services and Medicaid made it possible for LHDs to (1) bill for vaccines without violating state and federally funded program requirements; and (2) require all Managed Medicaid Plans to contract with and reimburse LHDs for vaccine administration costs. Due to these policy changes, LHDs were allowed to bill for administration fees.

In February 2013, the Arizona State Legislature introduced HB 2430, Technical Corrections; Immunizations and Informed Consent, to amend Section 36-673 of the Arizona Revised Statues that relate to school immunizations (see www.azleg.gov/legtext/51leg/1r/bills/hb2430s.pdf). This legislation included modifications that would require private health plans to (1) cover vaccines at first dollar; (2) pay the Centers for Medicare & Medicaid Services’ administration rate for nurse time and supplies; (3) pay 121 percent of the retail cost for vaccines to cover the cost of managing stock; and (4) reimburse LHDs as an in-network provider regardless of contract status with third party.

The full reimbursement bill, which was met with significant opposition by health insurance plans, did not pass and was sent back to committee for review. While the Arizona State Legislature has expressed concerns over price mandates in private-sector contracts, progress has still been made. The bill compelled several health plans voluntarily to raise reimbursement rates on vaccines for all providers and to contract with LHDs after several years of failed negotiations.

In May 2013, the Arizona State Legislature did pass a modified portion of HB 2430 that required health plans to reimburse LHDs as in-network providers regardless of contract status, thereby enabling LHDs to be reimbursed more fully. Under the law, the following terms apply:

- An LHD may receive reimbursement for the costs of the immunization from the pupil’s or parent’s private health insurance coverage by entering into a contract governing the terms of reimbursement and claims with the corresponding private insurer.
- An LHD may enter into a contract with a private insurer on its own, in conjunction with other LHDs, or through a qualified intermediary.
- If an LHD chooses not to contract with a private insurer, the insurer is not required to reimburse the LHD for the immunizations.
- If an LHD does not respond to the request to contract from a private insurer within 90 days of the request, the insurer is not required to reimburse the LHD for the immunizations.
- If a private insurer does not respond to a request to enter into a contract with a LHD, with a coalition of LHDs, or through a qualified intermediary within 90 days of the request to contract, the private insurer must reimburse the LHD at the rate paid to an in-network provider.
- If a private insurer declines to contract with an LHD, with a coalition of LHDs, or through a qualified intermediary, the private insurer must reimburse the LHD at the rate paid to an in-network provider.

TAPI will continue to work on creative solutions to advance the full reimbursement bill in the 2014 legislative session while exploring other ways to support immunization reimbursement to protect both public and private providers.
Zoning for Health Equity in Baltimore City
By Emilie Gilde, Shriver Peaceworker Fellow, Baltimore City Health Department

TransForm Baltimore, a rewrite of Baltimore City’s 40-year-old zoning code, presented a rare and remarkable opportunity for Baltimore City Health Department (BCHD) to harness the power of zoning to develop healthy communities and reduce health disparities among them. The zoning code regulates the way land is used throughout the city. The proposed code simplifies and modernizes neighborhood designs and standards while improving the quality of built environments and preserving the character of Baltimore neighborhoods. To make healthy, livable, and walkable environments for all residents, the City Planning Department, with extensive involvement and advocacy by BCHD and the Commissioner of Health, worked to include in the zoning code robust provisions that increase public safety through the reduction of alcohol outlet density.

Baltimore City has roughly 1,330 alcohol outlets—nearly double the 625 recommended for its population size by the Board of Liquor License Commissioners. These liquor stores are over-concentrated in African-American neighborhoods and low-income communities, where, according to Neighborhood Health Profiles, residents experience deep health disparities such as shorter life expectancies.

With the knowledge that the U.S. Surgeon General and the Centers for Disease Control and Prevention both laud zoning codes as one of the most effective tools for promoting and protecting the public’s health, the Johns Hopkins Center for Child and Community Health Research conducted a health impact assessment (HIA), Zoning for a Healthy Baltimore, to explore the potential health impacts of the zoning rewrite. Along with impacts on obesity and related illnesses, physical activity and pedestrian safety, and diet/nutrition, the HIA identified the opportunity to right-size the number of liquor outlets throughout the city.

Community feedback through BCHD’s Neighborhood Health Initiative (NHI), the community engagement aspect of Healthy Baltimore 2015, bolstered HIA findings regarding place-based health needs. During city-wide NHI meetings, residents voiced their health concerns and top priorities. Residents in half of the City Council districts

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ranked liquor outlet density as one of their top 10 health concerns. While the zoning rewrite process had been underway for several years, the Commissioner of Health heard residents’ appeal for action and advocated for their concerns.

As a result of the HIA and community feedback, the zoning code rewrite proposal, now pending legislation in City Council and known as City Council Bill 12-0152, could dynamically mold the built environment to impact violent crime, obesity, physical activity, and diet/nutrition. The rewrite promises to reduce violent crimes and improve safety by restricting new alcohol outlets and reducing the density of existing establishments, aligning with the Healthy Baltimore 2015 goal of reducing the city-wide alcohol outlet density by 15 percent. Neighborhood designs help create pedestrian and bike-friendly streets that promote physical activity and keep residents safe. As included in the proposal, mixed use zoning will provide neighborhoods better access to healthy food establishments and encourage businesses to provide services within walking and biking distance.

Residents’ testimony at public hearings before the Planning Commission was continuously infused with support particularly for the alcohol outlet density reduction provisions. This support directly contributed to the Planning Commission’s lending its support to the current rewrite proposal with all of its proposed health provisions intact. The proposal is currently being considered by City Council, which will continue to hear public testimony before voting on the legislation in fall 2013.

References
Health Departments as Partners in Reducing Overdose Deaths

By Corey S. Davis, JD, MSPH, Staff Attorney, Network for Public Health Law

Drug overdose has increased nearly five-fold since 1990 and now claims the lives of over 36,000 Americans each year. The epidemic is largely driven by prescription opioids, which account for more overdose deaths than heroin and cocaine combined.1

Initial efforts to combat the epidemic have tended to focus on population-level initiatives such as prescription monitoring programs, opioid prescribing guidelines, and increased access to evidence-based pain care and addiction treatment. While these measures are likely part of the solution, the nature and severity of the problem also call for increased access to acute interventions, particularly emergency care at the point of overdose. In the opioid context, this means timely administration of the opioid antagonist naloxone, which in most cases quickly, effectively, and safely reverses non-fatal opioid overdose.2

Unfortunately, naloxone (also known as Narcan) is often not available where and when it is needed, at least partly because of laws and regulations enacted for other purposes. For example, many state medical practice laws discourage or prohibit providers from prescribing drugs to a person other than the intended recipient (a process referred to as third-party prescription) or to a person the prescriber has not personally examined (known as prescription via standing order).3 The result is that the friends and family members of a person at high risk of overdose—those most likely to be in a position to discover an overdose victim and provide immediate care—often do not have the standard treatment available.

To address this shortcoming, 13 states (CA, CT, IL, KY, MA, NC, NJ, NM, NY, OR, RI, VA, and WA) and the District of Columbia have recently amended state law to increase availability of naloxone. These changes, which are supported by organizations such as the U.S. Conference of Mayors, the American Medical Association, and the American Public Health Association, typically provide civil immunity to naloxone prescribers and lay administrators who prescribe or administer the drug in good faith. Most also permit third-party prescription, and many permit prescription via standing order. Some also permit or direct health departments to address the epidemic by increasing community access to the drug.4

The rapid and widespread enactment of laws to encourage wider availability of naloxone is welcome, but those changes will have little effect on overdose if they are not accompanied by action. While around 200 community-based organizations nationwide now distribute naloxone, they are not nearly sufficient to meet the need.5 Local health departments (LHDs) must assist in the effort. In states that have modified law to permit activities such as third-party prescription or prescription via standing order, LHDs should ensure that internal policies and procedures are modified to permit those potentially life-saving activities.

Even in states that have not yet modified their naloxone access laws, LHDs can take action. Under existing law, prescribers may prescribe naloxone to patients at risk of opioid overdose. LHDs with a prescriber on staff should encourage such prescription where clinically indicated, and those without should develop partnerships with community prescribers. Likewise, those departments with onsite pharmacies should ensure that naloxone is stocked and financially accessible, while those without should

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work to develop links with community pharmacists to ensure that naloxone prescriptions are filled. These activities, together with those of community organizations and other areas of government, can help reduce these needless and easily preventable deaths.

RESOURCES

- **Legal Interventions to Reduce Overdose Mortality: Naloxone Access and Overdose Good Samaritan Laws** (Network for Public Health Law)

- **Naloxone Overdose Prevention Laws Map** (LawAtlas)

- **Prescribe to Prevent**
  - www.prescribetoprevent.org

- **Naloxoneinfo.org**
  - www.naloxoneinfo.org

- **Overdose Prevention Resources** (Harm Reduction Coalition)
  - http://harmreduction.org/issues/overdose-prevention/

References


4. Ibid.


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*NACCHO Exchange*, the quarterly magazine of the National Association of County and City Health Officials (NACCHO), reaches every local health department in the nation. It presents successful and effective resources, tools, programs, and practices to help local public health professionals protect and improve the health of all people and all communities.

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