Building Public Health Law Capacity at the Local Level

Diane E. Hoffmann and Virginia Rowthorn

In the early days of HIV awareness, prior to universal precautions, as a local health officer, I was supervising an openly gay employee. The county executive (in his formal capacity) asked me the HIV status of the employee and threatened my employment if I did not reveal it. I was reluctant to do so, believing it would be an invasion of the employee's privacy. I contacted the county attorney who advised me that I could reveal the employee's HIV status to the county executive but he was not willing to put his guidance in writing. Ultimately, I spoke with the employee's attorney and was given permission to reveal the employee's HIV status. The experience, however, left a bad taste in my mouth. I felt the county attorney was acting politically in support of the county executive rather than doing what was legally appropriate. He certainly did not act as an advocate for the local health department!

***

Early in my career as a local health officer, I was told there was an outbreak of the Noro virus in one of the dorms at the local university that was housing summer campers, and that several campers had been sent to the local emergency department because they had been vomiting. We determined that someone had left the camp (probably the sentinel case) before we had a chance to act. The virus was rapidly spreading among the remaining campers. We discussed the possibility of quarantine with the county attorney and the university attorney, but none of us had a very good understanding about what we could or could not do in that regard. We requested voluntary compliance, but the camp director failed to comply. There were other consequences than just the ill campers to be considered. Students would be returning to the campus within the next 30 days and because of the risk of contracting the virus, the professional sports team that was to come to the campus the following week, cancelled. This was a significant economic loss for the community. After it was really too late, I learned that, as the local health officer, I have significant authority to act in this type of situation. I would have handled it differently if I knew legally what I could have done.

***

I am currently dealing with a noncompliant homeless person with infectious TB. I would like to keep the person in a restricted environment as he is not showing up to take his medication. Because this is a state issue, I have been working with the state attorney to get an order to isolate the person in restricted housing. The only restricted housing in the state, however, is a state facility, which is full. The state attorney is loathe to write the order as she knows there is no available bed. I suspect an outside attorney would push for a bed, and the state would have to find one. If I cannot get the order, then this

Diane E. Hoffmann, J.D., M.S., is a Professor of Law and Director of the Law & Health Care Program at the University of Maryland School of Law. Virginia Rowthorn, J.D., is the Managing Director of the Law & Health Care Program at the University of Maryland School of Law.
person is at-large. All I can do is appeal to the head of the state health department as he is the only one who has authority to obtain a court order to quarantine this individual.

I. Introduction

Each of these vignettes illustrates some of the difficulties that local health officials have had because they did not have access to adequate legal advice or because the legal advice that was available was tainted by conflicts of interest. While the availability and quality of public health legal advice clearly differs from jurisdiction to jurisdiction, experts in this area assert that public health law expertise may be lacking at the local level. According to the Public Health Law Association (PHLA), a non-profit organization established to advance the use and understanding of law to protect and improve the public’s health:

[t]he successes and failures of public health practice are immediately apparent in our towns, cities and counties. On a daily basis, this is where contagious diseases are tracked, water is fluoridated, and many other public health initiatives are implemented. It is in these localities, however, where public health legal capabilities are the weakest. All too often, there is minimal legal support provided to local health officials. Public health staff may work for years having little or no access to an attorney. This is true even though most of their authority and responsibility is defined by statute and regulation. At its heart, much of public health in modern societies involves the application of administrative law within a regulated environment. Where access to legal services does exist, counsel is rarely conversant with public health capabilities or the relevant public health case law.1

Similarly, Wilfredo Lopez and Thomas Frieden have written that because “public health law can be nuanced and require specialized knowledge” a public health officer “often needs immediate access to expert legal advice. A lawyer in a remote location and perhaps with other priorities cannot always provide the kind of service or the degree of specialized legal professionalism necessary in public health practice.”2 They further point out that public health law “is not a field of law practiced outside of government” and as a result, expertise in public health law practice typically comes from years of on-the-job training and experience.3 Access to attorneys by local health officials can also vary significantly. Some health department officials can only call an attorney with approval of the county executive; others have their attorney on speed dial. Often access is constrained by resources, government structure (reporting requirements), or tradition (the local public health officer may historically have been reluctant to access an attorney).

In this paper, we grapple with designing a structure of legal service delivery that would increase public health law capacity at the local level, i.e., the ability of local health departments to access and utilize public health law expertise to improve public health services.

In Part II, we provide background information on the structure of local health departments, an overview of the legal issues confronted by local health departments, and how these departments obtain legal assistance. In Part III, we review several possible models for increasing the capacity of local health departments in public health law as well as mechanisms for delivery of legal information and advice. In Part IV, we develop a list of criteria for evaluating these different models and delivery systems and apply them to the various options. Based on our analysis, we recommend a mechanism for delivery of public health legal services that best fits our criteria.

In preparing this paper, in addition to reviewing the relevant literature, we interviewed over 20 local health officials and county/municipal attorneys as well as individuals at several national organizations that support local health departments or local attorneys, including the Public Health Law Association (PHLA), the National Association of County & City Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the National Association of County Boards of Health (NALBOH), the Centers for Disease Control (CDC), the Department of Health and Human Services’ Health Resources and Services Administration (HRSA), and the International Municipal Lawyers Association (IMLA).

II. Background

A. Structure of Local Health Departments

NACCHO provides the following operational characteristics of a functional local health department:

1. monitors health status and understands health issues facing the community;
2. protects people from health problems and health hazards;
3. gives people information they need to make healthy choices;
4. develops public health policies and plans;
5. enforces public health laws and regulations;
6. helps people receive health services;
7. maintains a competent public health workforce;
8. evaluates and improves programs and interventions; and
9. contributes to, and applies, the evidence base of public health.

How a local health department carries out these functions is largely dependent on its structure and funding. These structural variations are as different as the towns, cities, counties, and states the departments serve. Similarly, the experience of local health departments in obtaining legal advice is also dependent on the governance structure of the local health department and its relationship to county, municipal, and state government agencies. This relationship is most often determined by state constitution and statute. There are three generic models of local health department governance — centralized, decentralized, and hybrid — that define the relationship between local health departments and their state health agency. Under a centralized model, local health departments are units of the state health agency or the state health agency may regulate, or carry out, public health activities at the local level. In a few states, there are no local health departments and the state health agency is responsible for all local public health activities. In a decentralized model, most of the authority for regulating and carrying out public health functions is housed within a local government entity, i.e., county, town, or municipality. Typically, this authority is carried out by the local health department. The local health officer, who runs the department, may report to the local executive, mayor, or county executive, or to a local board of health. In some states, that reporting structure is ambiguous, with the local health officer reporting to more than one individual. The hybrid model includes (1) states in which the responsibility for regulating and carrying out public health functions at the local level is shared between state and local governments and (2) states in which different counties within the state have different relationships with state government depending on whether they are “charter” or “home rule” counties. Each governing model, regardless of how the category is precisely articulated, contains important variations that are likely to affect a local health department’s access to legal resources. For instance, where state health departments are involved, the local health department may be a stand-alone agency or a department within a broader agency providing an array of human services. Another variation across local health departments is their relationship to local health boards. These boards are composed of volunteer, appointed, or elected members that have varying degrees of responsibility over the activities of local health departments. Local boards of health are found in all but eight states. Affiliation between local health departments and local health boards predominantly occurs where local health departments are units of local government rather than state government.

The majority of local health departments (73%) serve a single county, city, township, or city-county jurisdiction rather than a multi-county district or region. However, there are some health departments, especially in the western United States, that serve multiple county districts covering large territories. In those cases, the director of the “local” health department may report to several county boards of health or a combined board of health, with representatives from each of the different counties. These geographic differences are important to understand when thinking about how best to structure a legal delivery system.

B. Overview of Legal Issues Handled by Local Health Departments

The variety of legal issues that local public health officials confront, and the types of law and legal issues with which attorneys and health officials dealing with local public health issues must be familiar, is considerable. Much of public health at the local level is based on statutes, regulations, and ordinances. These laws may be federal, state, or local. As an initial matter, those dealing with local public health issues must understand their authority, the source of that authority, and the limits of that authority. That understanding requires grounding in constitutional law, federal and state statutes, and regulations dealing with public health. Federal statutes include those that "(1) create federal public health infrastructure, (2) establish federal public health agencies, programs and services; and (3) appropriate funds supporting federal and state public health activities." At the state level, public health statutes, similar to federal statutes, establish the public health law infrastructure for the state, i.e., the role of the state and local governments in regulating and carrying out public health functions. State statutes also regulate various public health activities including nuisances, infectious diseases (reporting, monitoring, quarantine), sanitation, water quality, food quality, air quality (including smoking regulations), and emergency preparedness. Cities and counties may also have their own ordinances governing local public health matters. These often touch on similar issues.

In terms of the authority of the local officer, most state constitutions or statutes specify that the local health officer may exercise the state’s police power. Such powers may include the power to:
• regulate commercial and noncommercial activities as the Permit Issuing Official;
• issue...orders to abate environmental nuisances and, when not obeyed, to actually abate the nuisance and impose a lien on the offending premises;
• issue...orders to individuals to cease and desist from committing a nuisance,...and, if not complied with, to prosecute the person civilly or criminally;
• compel the attendance of witnesses and the production of records through the issuance of subpoenas in any matter before the health officer, including to subpoena records necessary to the conduct of an epidemiologic investigation;
• isolate individuals, quarantine premises, and even detain persons who present a danger of transmitting disease to others.**13**

Lawyers and local officials must understand when they can use these powers and how relevant laws at the federal, state, and local level relate to a particular issue. This requires familiarity with concepts of federalism and federal and state preemption.**14**

Because public health law is based primarily on statutes and regulations, those advising local health departments are likely to be confronted with issues of statutory interpretation and administrative law. Administrative law issues relate to the functioning of a regulatory agency. They include procedural issues that the agency must follow when meeting, making decisions, making rules, and enforcing them.

Lawyers advising local public health departments typically are called on to participate in policy development and enforcement of existing policy and law. For example, lawyers are asked to “advise on matters such as the agency’s legal authority to undertake a particular course of action, the exposure to liability inherent in the action or intervention, and the procedural prerequisites involved.”**15** Lawyers are often asked to review proposed health code changes or regulations to ensure that they are statutorily authorized and that the correct procedures are followed for their implementation.

In the realm of enforcement, lawyers are often called on to draft legal orders to compel certain behavior on the part of an individual or business, to draft subpoenas to individuals to appear in court and disclose certain information, and to appear before an administrative tribunal or court representing the health department.

In addition to these traditional public health activities, lawyers may also be asked to advise local health officers on a variety of other legal matters, including contracts, ordinance development, and grant funding. In carrying out their responsibilities, public health departments frequently contract with other entities ranging from (1) medical institutions and other health care practitioners to provide clinical services; (2) community-based organizations to conduct outreach and educational activities; and (3) suppliers and vendors for a whole host of services. Some jurisdictions may also issue grants for program evaluation or research. Because the local health officer typically runs a department with multiple employees, employment and human resource issues are another common matter, and local health officials typically rely on their legal counsel for assistance in handling these cases.

Conversations with local health officers confirmed that these are the primary issues for which they require legal assistance, although others also arise. Additionally, our interviews with local health officials revealed that, because of time constraints and other limiting factors, local health officials primarily seek legal assistance and advice reactively rather than proactively. In other words, public health officials use their attorneys to respond to situations rather than seek advice as to how the law could be used to create new public health initiatives or improve existing ones. Many of the attorneys we spoke to expressed a desire to be more proactive in dealing with public health matters, but typically did not have the necessary time or expertise to provide proactive advice or communicate proactively with public health officials.

C. Sources of Legal Assistance
Local health departments may receive their legal assistance in different ways. Primary sources for legal assistance include:

1. The state attorney general’s office or attorney in the state department of health (this may be an individual who devotes all of his or her time to public health or one or more individuals who devote a fraction of their time to public health issues);
2. The county or city attorney’s office (again, this may be an individual who devotes all of his or her time to public health or one or more individuals who devote a fraction of their time to public health issues);
3. A law firm on retainer to the local government.

In some cases, local health departments may consult an attorney at the state level for some issues and an attorney at the local level for other issues. This may happen, for example, when the local health official...
seeks advice on how to implement a state-mandated public health program that the local attorney is unfamiliar with. The complexity of some cases may also require the involvement of several lawyers at both the state and local level. The specific structure of the local department and its relationship with state and local government determines how the department obtains legal assistance. Sometimes local health officials are uncertain which lawyer is most appropriate for a given issue.

We spoke to several local officials who shared with us their experience obtaining legal advice. Excerpts from these conversations are presented below. The excerpts represent the experiences of local health officials from jurisdictions in different parts of the country with different governance structures. We asked the interviewees where they obtained legal advice and assistance, how often they encountered questions for which they needed legal assistance, and their assessment of, and satisfaction with, the accessibility and quality of the legal advice they received.

FROM A LOCAL HEALTH OFFICER AT A WESTERN CITY/COUNTY HEALTH DEPARTMENT GOVERNED BY A BOARD OF HEALTH:

The state mandates that the county attorney is my lawyer; the county sheriff is my enforcement arm. I have a county attorney assigned to the board of health. She spends approximately 20 percent of her time assigned to the board, including attending all board of health meetings. Legal questions come up on a daily basis. I don't necessarily talk to the lawyer assigned to us that frequently, but I have a system in place by which we compile those questions and prioritize them and give them to the county attorney on a scheduled basis. However, if I have a high priority issue, I put out a 911 and she gets right on it. When I first started, people told me that asking for advice from the county attorney was like entering a “black hole.” That was not acceptable to me or to the attorneys, so we worked on alleviating the problem and created a compliance office.

SATISFACTION:

At this moment, I am satisfied with the legal assistance that I receive. I have been the health officer here for over ten years. But my level of satisfaction is tied to what is happening in the county attorney's office. When I started, I had a lot of support from the county attorney's office: the county attorney actually sat on the board of health, then, he delegated that function to someone else (which was very appropriate). However, the structure that we have means that our legal assistance is subject to the political whim of the county attorney. So, there is a potential for problems but I haven't really experienced any. The legal issues that confront us are very complex. Sometimes it isn't totally clear who has the authority to deal with them. There is a very veiled interface between the state and local jurisdictions. Our county is experiencing significant growth, and we are dealing with many issues surrounding planning, development, water, and Superfund sites. Sometimes the issues involve many jurisdictions.

In terms of the expertise of the county attorney that I have been assigned to work with, when I started I was first assigned a rather junior attorney who was kind of paralyzed by the magnitude of the public health office issues and power we have, e.g., quarantine. Her paralysis got in the way of what I needed and the county attorney stepped up to the plate. What I've done is work with the county attorney and organized some training for the more junior lawyers in the county attorney's office. We have brought in others, e.g., NACCHO, to provide training on what public health law is and what authority we have. Locally, I have supported development of literature and training of our attorneys via the Internet. Also, we supported the county attorney so that he could attend a public health law conference [i.e., it came out of our budget].

FROM A LOCAL HEALTH OFFICER IN A MIDWESTERN STATE IN A COUNTY THAT OPERATES AS A MUNICIPAL CORPORATION:

The corporation has a number of central service departments funded by the county and staffed to provide legal support for the County Commissioners. The legal services department includes four attorneys. They take on all legal issues that the corporation encounters. For example, they may work with us on a county ordinance to make a more effective emergency services system for the county; assist us suspend a license; issue a restaurant permit; or monitor compliance with a tobacco control regulation. One of the attorneys in the Corporation Counsel's office is assigned to work with our staff on these kinds of issues. One of our staff members
prepares contracts and resolutions to go to the board. They are then reviewed by Corporation Counsel. So, basically, we have county in-house legal services.

When we have, on occasion, sought advice from state attorneys, we were told that state attorneys advise the state, not the counties, and that they don't necessarily have the county's best interest at heart.

SATISFACTION:
In terms of access, basically they are overwhelmed with our work. We could use more of them.

FROM A LOCAL HEALTH OFFICER IN A MID-ATLANTIC STATE WHERE THE LOCAL PUBLIC HEALTH ACTIVITIES ARE A SHARED STATE AND LOCAL ENTERPRISE:
Our state statute provides that the local health officer is nominated by the County Executive and approved by the state Secretary of Health. State law also establishes the County Council as the board of health (absent the County executive) but my boss is the County Executive (and technically I'm a state employee). The board of health is really perfunctory. It meets twice a year for about ten minutes. I provide them with an update of the department's activities but they do not take any action. Public health ordinances go the normal legislative route: passed by the County Council and signed by the County Executive.

In terms of where I go for legal advice, I use both the county law office and the state AG's [Attorney General's] office. Someone in the AG's office assigned to the state health department works with local health departments like ours. Also, I go to someone else in the AG's office who deals with environmental issues. In the environmental area, there is not an attorney who is assigned to work with local health departments, so I go to whoever is the subject matter expert — air, water, waste. At the county level, I go to someone in the county law office — I'd guess ninety percent of her time is spent on local health matters. I have labored at times trying to decide as between these three who will represent us, e.g., in dealing with a large restaurant with ongoing sewage spills, all three attorneys have some jurisdiction. We have actually made a matrix or decision tree of who we are going to call. In the end, we typically go to whoever will give us the quickest remedy. It's not the best structure.

SATISFACTION:
Not entirely, we could use more time and more expert attorneys to work with. The environmental attorney does not know what we do; the county attorney has some experience but generally these are junior people who require significant orientation and who subsequently leave — at times going into the private sector to represent violators! Attorneys in the state AG's office working on public health matters are competent but may have a conflict of interest. Things could be better.

In sum, sometimes I'm not satisfied because there are not enough attorneys and there is a delay in getting the advice we need; sometimes the attorneys don't have enough expertise; and sometimes I don't know which one to turn to.

FROM A LOCAL HEALTH OFFICER IN AN EASTERN STATE IN A NON-“HOME RULE” COUNTY:
In this county, the County Commissioners constitute the board of health. The board of health appoints the county health officer with the advice and consent of the state's Secretary of Health. For legal assistance we generally go to the AG's office (attorney assigned to the state health department), as most of those issues are in some way related to state programs. We could use the county attorney for a pure county issue, but that's very rare.

SATISFACTION:
As to access, I've been very satisfied; it's free and always available. The attorneys in the AG's office have been there for years. We know which ones to call for certain matters. They call back quickly and respond to emails. We have one hundred percent access whenever we need it. The quality of the services is difficult for a lay person (non-lawyer) to evaluate. Not being an attorney, I sometimes have a question as to whether we are getting the best legal advice we can get. There is a presumption that they [the attorneys] are well acquainted with the subject matter. Public health people are not as familiar with the law as we should be. If we were, we could ask the lawyers more intelligent questions. If there is a problem in the current structure, it is that health officers are uninformed about the law and, as a result, feel
like they don’t have any choice but to do what the attorney says. If legal issues come up when developing policy or drafting regulations, such as the meaning of a statute, attorneys tend to want to err on the side of being conservative and being safe. As a result, decisions about policy are sometimes made by attorneys and sometimes are more conservative than they need to be. Local health officials may be helped by having access to basic legal information. My impression is that there is little case law on public health matters in most jurisdictions but that the little [that exists] is very important. Most public health officers don’t understand the power that they have.

FROM A COMMISSIONER OF HEALTH FOR AN EASTERN CITY:

We obtain our legal advice from the local government counsel. About six staff attorneys consult with, and advise us, on a regular basis. One of these attorneys typically attends our twice-weekly staff meetings.

SATISFACTION:

I am satisfied with the arrangement but it clearly depends on a good departmental relationship with the city attorney. For us, it is a “one-stop shop for political and legal advice,” i.e., the advice considers the political ramifications for the health department and provides us with political cover. This is actually better, in my opinion, than having in-house legal counsel, as that can lead to too much exposure. I have, on occasion, consulted outside legal resources. I used a major law firm with a large health law practice as private counsel regarding Institutional Review Board (IRB) problems; I also consulted private attorneys regarding recommendations for legislation about certain over-the-counter medications. I have also consulted some of the centers located in academic institutions — schools of public health and law — and found them to be quite helpful on new, cutting edge issues.

FROM A DIRECTOR OF HEALTH FOR A STATE’S DEPARTMENT OF HEALTH AND HUMAN SERVICES IN A STATE WITH NO LOCAL HEALTH DEPARTMENTS:

While the State has overall authority for local public health regulation and provision of public health services, we contract with community health centers, visiting nurses, and community-based organizations to deliver local public health services. Also, cities and towns play a role in vital records and Emergency Medical Services (EMS). Our department has its own legal staff. Depending on the issue, we also consult lawyers in the Department of Administration in the governor’s office or AG’s office. We have three attorneys in our department. They each have a good amount of experience in public health law; however, when they first arrived, they didn’t. I don’t think we ever hired a lawyer who had a background specifically in public health.

SATISFACTION:

I am generally satisfied with the quality of legal advice we receive. And although we are currently satisfied with our access to legal services, the state is in the process of restructuring the way that it delivers legal services so that our attorneys would be reporting to attorneys in the Department of Administration rather than to us. I have some concerns about that.

FROM A LOCAL HEALTH OFFICER IN A SOUTHWESTERN STATE:

I report to the County Manager. We have a board of health, but it is advisory only. The Board of Health recommends policy to the board of supervisors. My position is approved by the board of supervisors. We have no governance relationship with the State; we deal with the State primarily for contract management, technical assistance, and support, as requested. In our State, each County is required to have its own health department.

We use three attorneys in the county attorney’s office: one person for environmental issues (we use about twenty percent of her time); another for animal control issues (about five percent of his time); and another for everything else (we use about forty percent of her time and she is also the attorney assigned to the board of health). Legal issues come up for us weekly or every other week. Most involve personnel issues, public health nuisances, and contracts. The latter is constant. We receive lots of grants and all contracts must be reviewed by the County Attorney.

SATISFACTION:

Because we have three different attorneys, my satisfaction varies based on who I’m using. We are very satisfied with the one who spends forty
percent of her time with us; she is very engaged and very innovative. I’m somewhat less satisfied with the attorney who works on environmental issues — part of it is style, she is slow, not as experienced, and we are generally working at a fairly fast pace. The attorney working on animal issues is okay; he is relatively new but responds quickly.

FROM A DIRECTOR OF PUBLIC HEALTH IN A NEW ENGLAND TOWN WITH A BOARD OF HEALTH:
I’m part of the town government structure and report to the town manager. The board of health is advisory to me. In matters of public health I consult the board. I consult with the town manager for day-to-day operational matters, e.g., hiring and firing of employees. I have no relationship to the state in terms of governance. I get my legal advice from the town counsel who is a lawyer in a private firm on retainer to the town. I can call him whenever I need to. I usually tell the town manager when I’m calling counsel. Over the past six months, one month I called ten times but haven’t called since then.

SATISFACTION:
The town recently changed the firm it’s using for town counsel. I was satisfied with the old firm; the old firm was very interested in our issues, was right here, I could walk to his office, we became good friends. The new firm is not in our town, it’s an unknown quantity. This is all brand new. The old firm was very knowledgeable, but not perfectly knowledgeable. If they did not know something, they contacted the legal counsel for the state association of health boards or the state municipal association.

From these and other interviews we conducted with local health officials, several themes emerged that are relatively consistent across the range of health department variations. Those common themes include the need for accessible, timely legal assistance; the importance of developing a good working relationship with legal counsel; the importance of expert public health legal advice; the general reliance on local-level, rather than state agency-level legal advice; the value of a basic understanding of public health law on the part of local health officials; and the overlap of political and legal concerns at the local level.

III. Models and Mechanisms for Building Local Capacity in Public Health Law

In identifying and evaluating models for building local capacity in public health law, we took an expansive view of “public health law capacity” and considered resources and mechanisms that could provide information, education, legal opinions, and/or advice to local health officials and/or their attorneys. Based on this broad view, in this section we identify several potential models that could serve as vehicles for expanding public health law capacity at the local level. These models include: (1) a center/institute housed at an academic institution; (2) a national legal back up center; (3) a government run program; (4) a membership organization/association; (5) a non-profit organization or advocacy group; and (6) a pro bono panel or practice group. Below, we briefly describe these models and discuss various ways in which they might be used to deliver legal information and/or advice to local health departments. We also describe various mechanisms that these models might use to deliver public health law expertise or build public health law capacity at the local level.

A. Potential Models for the Provision of Legal Assistance to Local Health Departments
1. CENTER/INSTITUTE HOUSED AT AN ACADEMIC INSTITUTION

While no single model for an academic center exists, in the most general terms an academic center is located in a university and is staffed by attorneys and faculty members (often assisted by the work of students) with specific expertise in the center’s focus. There are several academic centers/institutes in existence that provide legal resources on public health issues. Some academic centers have a state and local focus while others have a regional, national, or even international focus. Examples include the Public Health Law Working Group (at the Institute of Government at the University of North Carolina); the Legal Resource Center for Tobacco Regulation, Litigation and Advocacy (at the University of Maryland School of Law); the Tobacco Control Legal Consortium (at William Mitchell College of Law); the Public Health Advocacy Institute (at Northeastern University School of Law); and the Center for Law & the Public’s Health (at the Johns Hopkins Bloomberg School of Public Health and Georgetown University Law Center). Below we describe three of these Centers which provide legal assistance to local or state health departments or attorneys who serve them.
i. Public Health Law Working Group, Institute of Government (University of North Carolina)

The Public Health Law Working Group, within the University of North Carolina's Institute of Government, provides legal and technical assistance to local health officers and local health department employees, county attorneys, local boards of health, state public health officials and employees, and other government officials and employees in North Carolina. The working group consists of two faculty members who are attorneys. They provide educational assistance, not “legal advice,” and do not have an attorney-client relationship with any local government entities. They describe themselves as “non-partisan” and do not function as advocates for specific positions.

The working group hosts the North Carolina Public Health Law Website,16 which provides legal information by topic on North Carolina public health laws, information about Institute of Government public health law trainings, annual summaries of significant North Carolina public health legislation, and contact information for Institute faculty with expertise in public health law. Each year the working group also organizes a health directors’ legal conference that targets local health officers and their attorneys and provides information to attendees on such topics as legislation affecting public health, HIPAA enforcement,17 patient medical records, local board of health bylaws, legal issues in communicable disease control, legal rights of animal control officers, Medicaid law, and smoking regulation. In addition to the health directors’ conference, the Institute has also hosted conferences on environmental law, health law and ethics, legal issues relating to nursing executives, and legal basics for health and social services directors.

The Institute is funded through a foundation (affiliated with the Institute), state funds (a line item in the state budget), and voluntary dues from counties. As to the latter, each year the Institute sends out a request for voluntary payment from county governments. The dues are relatively low (pennies per capita), and approximately 90% of counties pay the suggested amount.

ii. Maryland Legal Resource Center for Tobacco Regulation, Litigation, and Advocacy

The Legal Resource Center for Tobacco Regulation, Litigation and Advocacy (the Tobacco Center) at the University of Maryland School of Law was established in 2001 with funding from the state’s portion of the Tobacco Master Settlement Agreement (channeled through the Maryland Department of Health and Mental Hygiene’s Office of Health Promotion, Education and Tobacco Use Prevention). The Center provides legal expertise and resources to Maryland state legislators, state agencies, local governments, and community groups attempting to reduce smoking and its impact on public health.

The Center is staffed by a Director who is also a full-time faculty member at the University of Maryland School of Law. The Center employs a Deputy Director, Research Fellow, and part-time Clinical Law Instructor. In addition, approximately eight to ten students per semester participate in one of two different clinical learning programs that give them the opportunity to provide legal assistance to Tobacco Center clients.

During the Center’s first year of operation, Center staff completed a comprehensive needs assessment survey of all 24 local health departments in Maryland in order to provide targeted legal resources that address issues common to many jurisdictions. Since that time, the Center has worked on such projects as drafting model ordinances to reduce smoking and smoking-related injuries; given technical advice to community coalitions in advocating for ordinances; and given advice to local governments and attorneys representing local governments on issues relating to tobacco control.

In addition to these legal services, the Center hosts a Web site18 and publishes Tobacco Regulation Review, a newsletter distributed to local health departments and other relevant groups throughout the state that summarizes local, state, and national tobacco control legal issues. The Center also hosts an annual conference for state and local public health officials as well as a conference for tobacco control attorneys and policy personnel from across the country. Each year, the Center chooses a current topic on which idea-sharing and coalition building is needed.

Similar state-based centers have been established in other jurisdictions. In some states they are affiliated with a law school, in others they are independent non-profit organizations.19

iii. The Tobacco Control Legal Consortium (TCLC)

While the Maryland Tobacco Center described above functions primarily at the state level providing advice to local health departments, the Tobacco Control Legal Consortium (TCLC) provides similar services on a national level, providing assistance to state level tobacco advocates. Created in 2003, TCLC functions both as a legal resource center for the national tobacco control community, including states without their own tobacco resource centers, and as a think tank on tobacco law. It is affiliated and housed in the Tobacco Law Center at William Mitchell College of Law and funded in part by a grant from the Robert Wood Johnson Foundation and the American Cancer
Society. TCLC is staffed by three attorneys, an executive director, a half-time program manager and a half-time administrative coordinator. For large projects, the Center draws on the expertise of the attorneys in the state-based tobacco legal centers and programs.

TCLC staff responds to day-to-day requests for legal technical assistance from states that do not have state-based tobacco resource centers. TCLC also coordinates with the state-based tobacco legal centers and programs as well as other legal specialists and organizations, in providing technical assistance on large projects, development of legal briefs, and production of written materials.

TCLC staff provides legal technical assistance by: (1) responding to individual requests for consultation; (2) providing litigation support; (3) producing and distributing educational materials; (4) delivering training and presentations; (5) assisting with the creation of new state legal resource centers; and (6) developing special initiatives and projects.

2. NATIONAL BACK UP CENTER FOR LOCAL ATTORNEYS
In contrast to the academic centers, which typically provide legal information and assistance directly to local health officials (although in some cases they also work with county attorneys), a national back up center would provide legal assistance directly to local attorneys. An example of a legal back up center is the National Health Law Program (NHeLP). NHeLP is one of the original legal back up centers which was at one time supported by the Legal Services Corporation (LSC).

NHeLP currently describes itself as a “national public interest law firm that seeks to improve health care for America's working and unemployed poor, minorities, the elderly and people with disabilities.” NHeLP’s focus is primarily access to health care issues, rather than public health issues. The organization generally assists attorneys in local legal services programs, but it has branched out to serve community-based organizations, the private bar, health care providers, and individuals. Services performed by NHeLP attorneys include:

- Reviewing draft contracts;
- Preparing comments on regulations, policies and legislative proposals;
- Drafting legal opinion letters;
- Advising on individual eligibility cases;
- Assisting in developing advocacy strategies;
- Providing citations, memoranda, articles for policy development or court cases; and
- Monitoring and analyzing legislation.

While the organization’s goal is to enable local attorneys to handle cases and issues by giving them information and resources, NHeLP staff will help attorneys develop legal theories, moot them in preparation for trial, and, if necessary, serve as co-counsel or take the case themselves. They also prepare amicus briefs in support of legal aid offices for cases at the state or federal level. In terms of legislation, the organization is involved at both the state and federal level, although mostly at the federal level, where they educate congressional staffers and legislators about health care issues for the indigent. In addition, they comment on proposed regulations at the federal level from the Centers for Medicare and Medicaid Services (CMS), HRSA and the Department of Justice (Civil Rights Division). On occasion, they have commented on local regulations.

NHeLP has a listserv of approximately 500 advocates around the country, including some state and local health officials. Many of those individuals call NHeLP directly for assistance on local health matters. The organization has an extensive Web site on substantive legal issues, holds conferences for local attorneys on health law topics and publishes a newsletter (Capital Communique) with a distribution list of 13,000.

NHeLP has a current budget of $2.5 million and receives the bulk of its funding from foundations, primarily for specific projects.

3. GOVERNMENT AGENCY
Another model for building public health legal capacity at the local level is an entity operated within a government agency. Examples of government agencies where such an entity might be housed are the Centers for Disease Control and Prevention (CDC) at the national level and, on the state level, state attorney general offices or state health departments.

i. Centers for Disease Control and Prevention (CDC)
The CDC, located within the U.S. Department of Health and Human Services, is the nation’s primary organization for disease prevention and control, environmental health and health promotion, and education activities designed to improve national public health. In 2000, the CDC established the CDC Public Health Law Program. The program is located in the Office of the Chief of Public Health Practice in the CDC Office of the Director and is designed to improve the understanding and use of law as a public health tool. It works to accomplish this goal through education, consultation, conferences, funding initiatives, and facilitation of key partnerships between public health practitioners and key law-related groups, such
as elected officials and the legal and law enforcement communities. The CDC Public Health Law Program has also provided grant funding to academic institutions to support Collaborating Centers for Public Health Legal Preparedness.25

i. State Agency (Attorney General’s Office or State Health Department)
Conceivably, a mechanism to provide public health law assistance to a local health department could be part of a State’s Attorney General’s Office or Health Department. While it is beyond the scope of this article to describe how a public health law assistance center would be structured within a single state, in theory, creating a public health legal resource in an existing state agency is a viable alternative. In some states, local health departments already receive legal assistance from one or both of these two agencies. Within the structure of a state attorney general’s office, certain attorneys are tasked with providing legal assistance to the state’s health department. In some states, the assistant attorneys general who work with the health department are housed in the health department and serve the function of quasi-in-house counsel. In other states, assistant attorneys general who work with the health department are housed apart from the state health department — most commonly in the state attorney general’s headquarters. Given the existing public health expertise at the attorney general level, adding additional attorneys and resources to perform the function of providing legal advice and education to local public health officials is a promising model. Similarly, given the public health nature of its mission, the state health department is also a logical place to house a legal resource for local health departments.

4. Membership Organizations/Associations
Membership organizations, generally, are organizations for which members pay a fee in return for certain benefits. Such benefits typically include networking opportunities, educational programs and materials, advocacy and lobbying based on the shared goals of the membership, and access to online databases, and job banks. Such organizations may target professionals, elected or appointed government officials, or entities with similar missions. In addition to membership fees to fund their core activities, these organizations may charge additional fees for supplemental services.

Existing membership organizations that reach out to players in the public health arena (which include attorneys, public health officers, and local government officials) could serve as models for delivery of public health law resources and expertise to local health departments or homes for a legal resource entity. In other words, a public health law entity could be created as a membership organization along the lines of existing membership organizations that cater to the public health community or could be incorporated into an existing public health-oriented membership organization.

i. Public Health-Oriented Membership Organizations
Examples of membership organizations targeting public health officials include the American Public Health Association (APHA), NACCHO, and ASTHO.

APHA is a non-profit membership organization comprised of public health professionals. The mission of the association is to “protect all Americans and their communities from preventable, serious health threats and...to assure community–based health promotion and disease prevention activities and preventive health services are universally accessible in the United States.”26 APHA members include health care officials, educators, environmentalists, health care providers, and policymakers. The Association works with private, governmental, and educational organizations. Members receive employment information, health care-related news, and publications, including the American Journal of Public Health (the leading peer-reviewed public health journal), and the Nation’s Health (a monthly newsletter on public health). APHA receives the majority of its revenue from conferences and membership dues. It is comprised of 24 sections representing the major public health disciplines (i.e., Alcohol, Tobacco and Other Drugs, Chiropractic, Epidemiology, etc.) and several special interest groups, including a Health Law Forum. The Health Law Forum provides interested APHA members with information about current issues in public health law.

NACCHO is a national organization that represents 1,300 local health departments across the United States.27 NACCHO “supports efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, seeking health equity and supporting effective local public health practice and systems.”28

While NACCHO does not currently have any projects that build the legal capacity of local public health departments, its 2007-2008 strategic plan highlights five strategic directions, two of which involve capacity building.29 The latter include supporting “local health department (LHD) capacity to build public health systems that perform in accordance with the operational definition of an LHD” and “enhanc[ing] the capacity of local health departments to achieve health equity through social justice and human rights.”30

In addition to NACCHO on the national level, many local public health officials belong to state-based
associations of city and county health officers (some-
times referred to as SACCHOs, or state associations
of county and city health officials). For example,
in Maryland, the state-based organization (Mary-
land Association of County Health Officers) receives
administrative support from staff at the Johns Hop-
kins Bloomberg School of Public Health. In Massa-
chusetts, local health officers frequently call the legal
counsel at the Massachusetts Association of Health
Boards for assistance. SACCHOs are generally funded
by membership fees from local health departments or
boards of health.

ASTHO is a non-profit membership organization
for the executive officer of the department of health
of U.S. states, territories, and possessions. ASTHO's
mission is to “formulate and influence sound national
public health policy and to assist state health depart-
ments in the development and implementation of
programs and policies to promote health and prevent
disease.” The Association's staff members serve as
an information resource to state health agencies and
ASTHO members and alumni on public health policy.
Guided by ASTHO's policy committees, the organiza-
tion addresses a variety of key public health issues and
publishes newsletters, survey results, resource lists,
and policy papers that assist states in the development
of public policy and in the promotion of public health
programs at the state level. According to ASTHO's
2007 strategic plan, the organization would like to
serve as the "go to" resource for state health officials
and be able to meet both member and state needs for
technical assistance.

ii. Attorney-Oriented Membership Organizations
Membership organizations supporting attorneys who
serve public health departments include PHLA and the
International Municipal Lawyers Association
(IMLA).

PHLA is a non-profit membership organization for
public health law practitioners and scholars. The goal
of the organization is to advance the use and under-
standing of law as a tool to improve public health.
Membership in PHLA is open to “those who make
the law, those who execute or administer it, those who
practice and study the law, and others who find interest
in the law as a means to improve the public's health.”
PHLA staff and board members publish newsletters,
resource lists, and best practices information for those
working in the areas of public health law and health
policy. PHLA also hosts and works collaboratively
with other organizations on conferences and telecon-
ferences. PHLA does not provide legal or technical
advice to public health practitioners or individual
public health lawyers but rather distributes relevant
educational materials regarding public health law and
policy to its members.

IMLA is a non-profit professional organization that
serves as an advocate and resource for local govern-
ment attorneys. The organization refers to itself as
“a non-profit organization dedicated to advancing
the interests and education of local government law-
yers.” The organization's focus is on Canadian and
American municipal law. Its Web site states that the
Association "champions the development of fair and
realistic legal solutions and provides its members with
information about, and solutions to, the profusion of
legal issues facing its membership today." The Asso-
ciation has more than 1,400 members. IMLA per-
forms a number of functions including: (1) studying
local government legal problems; (2) holding educa-
tional seminars, conferences and other meetings for
its members; (3) assisting local government lawyers in
carrying out their roles; (4) studying legislation, court
decisions and administrative rulings relevant to local
governments and providing materials about these
legal pronouncements with local attorneys; and (5)
advocating in courts, typically through amicus briefs,
on issues affecting local governments and local gov-
ernment law.

The organization holds annual conferences and
seminars that focus on local government law issues.
IMLA consists of four departments which reflect
its diverse membership including: (1) the Canadian
Department; (2) the Counties and Special Municipal
Districts Department; (3) the State League Counsel
and State Municipal Attorneys Association Depart-
ment; and (4) the Associate Member Department for
attorneys who work with local governments as out-
side counsel. The organization also has nine sections,
one of which is devoted to health and environment.
This section focuses on issues related to public health,
building codes and enforcement, and municipal law.

Membership benefits include networking oppor-
tunities, legal research assistance (staff assist mem-
ers in drafting ordinances and answering questions
regarding laws affecting local governments), litigation
support, legislative updates, and subscriptions to vari-
ous publications.

The Association has a staff of seven, three of whom
are attorneys. According to its Executive Director, the
Association principally provides research assistance
to county attorneys and files amicus briefs. The staff
is not as involved in legislation with the exception of
providing information to members about proposals at
the national level.

Other membership organizations that represent
members of the public health, legal, and local govern-
ment communities, include the American Bar Associa-
tion (ABA), the American Health Lawyers Association (AHLA), the National Association of Local Boards of Health (NALBOH), the National Association of Counties (NACo), the National Association of County Civil Attorneys, and the National Association of Attorneys General (NAAG).

5. NON-PROFIT/ADVOCACY ORGANIZATION
Another potential model for increasing public health law capacity at the local level is a national or state non-profit organization. These organizations are typically independent, grant-funded institutions that perform research and conduct advocacy on a particular issue. In the area of public health, there are examples of non-profit organizations at both the national and state level.

One example of a public health non-profit organization is Public Health Law & Policy (PHLP). Based in California, PHLP works with community-based organizations, local public health and planning departments, schools, elected officials, government attorneys, and private counsel to create policy solutions to public health challenges. The organization’s current projects focus on nutrition, tobacco control, school policies, communicable disease, access to care, land use, and litigation settlement management. PHLP staff provides comprehensive training, technical assistance, and legal and policy tools to advance public health goals.

PHLP is home to the National Policy & Legal Network to Prevent Childhood Obesity which provides legal and policy resources on childhood obesity prevention to national level organizations, advocates, and policy experts. PHLP and another public health non-profit organization, the Public Health Institute, collaborated to create the Technical Assistance Legal Center (TALC), a clearinghouse on tobacco policy issues in California. TALC attorneys provide legal technical assistance free of charge on tobacco policy issues for advocates, health professionals, government attorneys, and elected officials in California. TALC is similar to the University of Maryland’s Tobacco Center described earlier but is funded by the California Department of Health Services and is not associated with an academic institution. One public health official with whom we spoke commented that he found TALC’s “toolkits” very helpful in his work on tobacco control, especially legal documentation supporting model ordinances in the toolkits. He was able to take the model ordinances to his county attorney, and this helped the county attorney draft appropriate local ordinances. PHLP is funded by a number of state and private groups including the American Legacy Foundation, the California Department of Health Services, the California Endowment, Kaiser Permanente, and the Oregon Department of Justice.

6. PRO BONO LEGAL PRACTICE GROUPS
Another possible mechanism for assisting local health departments with legal issues is pro bono legal panels. Many private law firms and some non-profit groups have established pro bono panels or practice groups to provide low-income individuals, community groups, and others with free or reduced-price legal assistance. Over the last decade, law firms have increasingly formalized the structure of their pro bono programs. One recent technique is to adopt a signature pro bono project. These projects focus on particular issues, populations, or geographic regions. This allows a firm to develop an institutional knowledge on a particular issue. It is conceivable that a pro bono project could be built around public health law.

Law firms also provide “externship” opportunities for their attorneys. Through these programs, firm attorneys, for a designated period of time, work solely for a public interest firm or organization. Other firms create their own pro bono practice groups where attorneys rotate in for a period of time. Firms have also started fellowship programs to assist public interest law initiatives. Under this approach, law firms fund fellows to serve at non-profit organizations.

Pro bono panels have also been established by non-profit organizations that recruit attorneys from numerous firms, usually within a geographic area, to take cases in special areas of law, e.g., immigration, tax, constitutional law. Although we could not identify an existing pro bono panel or practice group with a public health law focus, an example of a well-developed pro bono panel focused on health law is Health Law Advocates, Inc. (HLA). HLA is a small, non-profit, public interest law firm that accepts cases from individuals residing in Massachusetts whose incomes do not exceed 300% of Federal Poverty Guidelines and who cannot afford a private attorney. HLA fulfills its mission through its Legal Network. The Legal Network is comprised of volunteer private attorneys who accept cases from HLA on a pro bono basis. Legal Network attorneys receive information about cases via email every two weeks. The emails also contain information regarding seminars and other training events. The Network accepts both experienced and new attorneys.

B. Mechanisms for Delivery of Legal Information
In addition to the structural models for building public health law capacity at the local level, there are a number of mechanisms for delivery of legal information/assistance that could be used by the structural mod-
els or could be used independently of such models. Such mechanisms might include journals, reporters, or newsletters that report on current legislative proposals, enacted legislation, and legal cases that affect local health departments and the regulation of public health at the local level. For example, something like the BNA Public Health Law Reporter does not currently exist but might be a very useful resource for local attorneys dealing with public health issues.  

There are also numerous technology-based mechanisms for delivery of legal information, including hotlines, Web sites, and interactive email. Numerous legal hotlines or telephone consultation services exist around the country. Most serve individuals and appear to target low-income individuals or individuals who may have difficulty accessing private attorneys due to lack of resources, restricted mobility, lack of transportation, or uncertainty as to how to find or approach an attorney. For example, legal hotlines exist for domestic violence victims, family law issues (e.g., divorce, custody, visitation, child support), elder law issues, landlord tenant problems, and employment law (e.g., harassment, discrimination, medical leave, etc.). Most often information is provided free of charge, but in some cases there is a small fee. Many non-profit membership associations, such as IMLA, have also established legal hotlines or telephone consultation services. These can be a very helpful and efficient resource for association members, who can call attorneys with expertise in specific areas of law for legal assistance and get a quick response.

Lawyers working national hotlines or telephone consultation services, however, must be careful to distinguish between legal information and advice. The definition of “legal advice” varies among states but generally “deals with the application of the law to specific facts, while legal information deals with general principles and descriptions of the law.” An association’s in-house attorney who responds to calls from different states may run afoul of the law in some states if s/he provides legal advice and is not licensed in that state.

Interactive email is also an efficient and simple way for public health officials and attorneys to obtain information and legal advice. As in the case of hotlines, however, there may be restrictions on attorneys in one state providing “legal advice” to individuals in another state where they are not licensed. Many public health officials and public health attorneys obtain legal and other assistance by posting questions on listservs of colleagues in related fields. This mechanism can be a useful and efficient method of obtaining legal assistance.

Web sites can also provide valuable information on the law to laypersons and lawyers. Numerous organizations including government agencies, non-profit associations, advocacy groups, and private firms host Web sites. An example of an extensive public health law Web site is the one hosted by the Public Health Law Working Group at the Institute of Government at the University of North Carolina. The Web site is a comprehensive resource of public health laws in that state. On the national level, the CDC’s Public Health Law Program has an extensive Web site that includes a database of model laws, bench books (briefings used by judges as functional practice guides), and information listed by topic on various public health legal issues. Web sites, unlike hotlines and interactive email, do not provide legal advice since they generally do not apply the law to specific factual situations, but instead provide information about the law (statutes, regulations, and case law) on relevant public health topics.

Other vehicles for delivering legal information and assistance to local health departments and their attorneys are conferences, training programs, and workshops. These educational programs can be offered on a national or state level, for regions within a state, or custom-tailed to a specific health department. The annual conference hosted by the University of North Carolina Institute of Government for both local health officials and their attorneys is an example of a state level conference. As an adjunct to the technological methods and conferences for delivering information, a public health law resource could also offer a more traditional in-person consultation service. This option is clearly much more labor intensive and thus, more costly than the technology-based approaches. It also raises the question of whether the outside resource would actually be providing legal advice and/or establishing a lawyer/client relationship with the local health department. The Maryland Tobacco Center establishes lawyer-client relationships with clients even at the preliminary discussion stage. Center staff views the formation of this relationship as essential if specific individual legal advice is discussed or rendered. If the Center agrees to represent an individual or local government on a specific issue, the client is often required to sign a retainer agreement outlining the scope of the representation and terms. Because lawyers in one state cannot practice law in another state (unless the lawyer is also a member of the bar in the other state), the Center does not provide legal advice to individuals or institutions outside of Maryland, but will instead offer them legal educational materials.
IV. Criteria for Evaluating Models of Delivery and Application to Various Models

Each of these models and mechanisms has strengths and weaknesses as a possible vehicle or method of delivering legal information/advice to local health departments. These strengths and weaknesses, in part, are based on some assumptions about the legal needs of local health departments, how they prefer to access legal information/advice, and the relationship between local health departments and their current source(s) of legal advice. In interviewing local health department officials and the attorneys who work with them, the following factors emerged as important considerations for structuring mechanisms by which to provide them with additional legal support.

A. Criteria for Evaluation

1. Expertise

The ideal mechanism for delivery of public health legal services would provide users with access to attorneys and/or paralegals with expertise in local government law and structure as well as expertise in public health law. Familiarity with public health laws at the local, state, and federal level and with how those laws interact, as well as with local, state, and federal administrative and contract law, is essential.

2. Target Audience

Ideally, any structure put in place to improve public health law capacity at the local level would target both public health officials and the attorneys who serve them. Virtually all the public health officials and public health lawyers that we interviewed emphasized the need to provide legal resources and education to both local health officials and their legal counsel and offered several reasons why it is critical to reach out to both groups. First, public health officials need to have a general understanding of the laws that pertain to the execution of their jobs in order to know when legal assistance from counsel is required. In addition, public health officials would benefit from understanding how the law can be used as a tool to improve the public’s health. Finally, basic legal education would enable public health officials to act proactively to avoid legal complications in the future. Although local health officials might seek access to public health law resources directly for advice or assistance, our interviewees suggested two reasons why any mechanism established to improve public health capacity should provide legal resources to public health legal counsel as well. First and foremost, the attorneys that assist public health officials have varying degrees of expertise in the area of public health law. In larger jurisdictions, public health attorneys may have such expertise while in smaller jurisdictions, attorneys often will have multiple areas of responsibility and, as a result, will be unable to develop expertise in public health law. Therefore, a public health law resource would be an invaluable source of legal advice and information for attorneys who, for time and other reasons, cannot develop that expertise individually. Second, because public health officials are part of state or local structures, they rightly look (in fact may be required to look — depending on local law and practice) to municipal counsel for legal advice. That relationship ensures that the advice given to the public health official fits within the scheme of applicable local and state laws but also ensures that the legal advice aligns with the other programs and priorities of the locality. Politically, public health officials might feel that it is inappropriate to seek specific legal advice from an outside source. These potential conflicts highlight the importance of reaching out and providing assistance to both groups.

3. Focus: National v. State

The key informants we interviewed for this article agreed, for the most part, that a mechanism established to assist local health departments with legal matters needs to function at the state level where most public health law is developed and implemented. Staff of a state-based resource would not only understand the unique infrastructure of local public health departments in that particular state, but also the relationship between state and local government agencies. It is unlikely that a national resource, on the other hand, would be in the position to provide public health officials with the individualized state and local legal expertise they need unless it employed experts on the law of all 50 states.

In addition, a state-based mechanism is likely to be much more accessible to its target audience than a physically distant national center. Staff of a state-based resource would be more likely to make local site visits and have face-to-face interactions with public health officials and their attorneys if they work in the same state. Because any legal resource center’s effectiveness depends on its perception as a reliable and neutral source of legal assistance, this physical proximity would foster this positive perception and encourage a trusting relationship over time.

Several key informants, however, commented on the need for a national organizing entity or network to coordinate the work of state level resource centers. A national entity would serve several functions. As with the Tobacco Control Legal Consortium, a national center could provide legal assistance to public health officials and attorneys in states that did not yet have a
state-based resource center. The national entity could also serve the critical function of coordinating strategies, information, and resource sharing between and among state resource centers.

A further consideration in evaluating a national versus state-centered resource center is the type of legal information that each is authorized to provide. State-based attorneys, licensed in the state in which they are located, can actually provide legal advice to local health departments. However, attorneys working at the national level, unless they are licensed to practice in a state, cannot give legal advice to someone in that state because they are limited to providing general legal information. This challenge is routinely faced by national membership associations with members from multiple states. Generally, association attorneys are limited to providing the following types of services:

- Offering legal opinions on matters of general concern;
- Appearing as an intervener or amicus curiae;
- Referring a member to an independent attorney;
- Drafting legislation;
- Providing legal advice to a member in connection with furthering the association's political agenda; and
- Helping a member obtain access to the courts.59

4. COORDINATION WITH EXISTING PROFESSIONAL ORGANIZATIONS
Those we interviewed also commented that an ideal entity would coordinate with existing professional organizations that represent public health officials, public health attorneys, and counties such as APHA, NACCHO (and its state affiliates), ASTHO, PHLA, and IMLA. These groups represent the different, but sometimes overlapping, constituencies that would be assisted by a public health legal resource center. Working with these groups would enhance the legitimacy of the entity and ensure that information about it was disseminated to their various target audiences. Finally, working with all these groups would help guarantee that the resource center was not “captured” by one interest group or perceived to represent one group's interests over another's.

5. COORDINATION WITH DESIGNATED ATTORNEY
Several individuals whom we interviewed noted that any center established to improve public health legal capacity at the local level must work closely with the state or local attorneys that are designated to provide legal services to the local health official. In order to provide consistent and coherent legal advice, and to avoid putting the local health official in an awkward position between two sets of counsel, center staff would ideally develop relationships with local and state public health counsel in order to ensure that the local health official is not given conflicting or politically damaging advice. Developing trusting relationships with local/state attorneys is also likely to lend legitimacy and goodwill to the proposed public health law center.

6. FREEDOM FROM CONFLICTS OF INTEREST
It was also important to those with whom we spoke that any entity serving as a public health legal resource center be independent from political influence. For this reason, the location of such a center in a government agency (federal, state, or local) might be suspect. This concern was given, for instance, not only with regard to locating a center in the CDC, but also about housing it at a state or county agency. The vignettes at the beginning of this paper describe the types of conflicts that can arise as a result of attorney allegiance to an entity other than the local health department. In addition to freedom from political conflicts, any entity established to take on this task should be free of legal conflicts or structured in such a way as to be free from such conflicts.

7. TRACK RECORD OF FUNDING OR ABILITY TO RAISE FUNDS
Any entity established to provide legal assistance to local public health departments will require funding to be effective. Such funding could come from federal or private grants, membership fees, institutional support, or other sources. An organization that already has a membership structure in place and/or a proven track record of grant funding would generally be in a better position to support the entity than an organization with no such structure or funding history.

8. OTHER FACTORS
In speaking to local public health officials, several additional factors emerged that should be considered when developing a model for provision of public health legal services. Because local health officials work within the structure of their local governments, they naturally carry out their duties in a political environment. Ideally, the staff of the model entity would have an understanding of the specific political environment in which local health officers are working to ensure that they provide legal advice that is both relevant and appropriate. Another issue raised by the local health officials we interviewed is the importance of timeliness. Many issues that local officials deal with are time-sensitive. An ideal entity would be able to respond to legal inquiries in a timely enough manner...
to make the advice relevant. In addition, the model entity should be able to act proactively. As we mentioned earlier, many local public health officials do not have the time or resources to act proactively to develop programs or implement procedures before problematic situations develop. A public health law entity would provide local health officials with an invaluable service if it could assist in prospective planning and policy development. Finally, and less tangible, one of our informants commented on the importance of attorney innovation and creativity in approaching public health legal questions. Because many of the situations that public health officials face are time sensitive, fluid, dangerous, and sometimes emotional, the best legal solutions are often those developed by attorneys thinking “outside the box.” While it is difficult to plan and train for this type of innovative and creative lawyering, the value of these qualities should be kept in mind as a mechanism is developed.

B. Evaluation of Models

1. Academic Center

Based on our research, the academic center — especially a state-based academic center — is a very promising model for delivery of public health law expertise to local health departments. There are several benefits to the state-based academic center model. While universities obviously attract students from outside the states in which they are located, a university’s location in a particular state often provides it with an inherent state and local focus. A law school or public health school in Maryland obviously has vastly greater contacts with state and local officials, attorneys, legislators, and state agency personnel in Maryland than it does in, for example, Georgia. Similarly, academic center staff has ready access to non-center faculty members who can provide technical and legal advice on issues not within the center’s area of expertise on a collegial and cooperative basis.

Another benefit of an academic center is its ability to leverage the work of students to assist in the function of the center. Whether students participate in the work of the center as fellows, clinical students, research assistants, or interns, the staff of the center is likely to receive assistance from a willing body of students who seek out such practical experience as part of their education. The ability to leverage the work of students often provides academic centers with the ability to act proactively by, among other things, engaging students in long-term projects such as policy development and legislative drafting. However, the effectiveness of students in an academic center varies depending on the degree of supervision given to the students by faculty and staff members. By utilizing students, academic centers also function as incubators for future professionals in the field. The training provided by centers therefore has a permanent, positive effect on the center’s field of expertise. A public health law center that is located at a law school and utilizes students, for example, would be helping to train the next generation of public health law attorneys.

Finally, because a university derives benefits from academic centers in terms of exposure, prestige, and funding, universities in return provide varying degrees of financial, administrative, structural, communications, fund-raising, and other support to academic centers.

2. National Back Up Center

An organization structured like NHeLP or other legal back up centers could be a viable mechanism for building local public health law capacity. Such an organization would include a staff of approximately 10-12 attorneys, possibly in different geographic locations across the country, with expertise in public health law as well as in statutory and regulatory construction, administrative law, and litigation. These individuals would respond to calls from county attorneys and other attorneys representing local health departments, establish a Web site on public health law issues and a listserv through which attorneys could share information and ask questions, publish a newsletter with information about public health law issues at the local level, and assist in the drafting of legally sound ordinances and, if necessary, in their defense in court. A back up center staffed by a group of 10-12 attorneys would quickly develop the expertise necessary to help local health officials develop proactive policies and programs.

While such an entity would perhaps exceed others in terms of the legal expertise it could provide, its primary target would be local attorneys not local health officials. Moreover, it would be a nationally based resource, making it difficult for the entity to have an understanding of the local political environment in which their clients work or to provide the individualized legal expertise required by local governments. Finally, such an entity, if established from scratch, would require new funding and would not have an established fundraising track record. Like NHeLP and the other legal back up centers, staff would be required to engage in regular fundraising to maintain the organization.

3. Government Agency

Establishing a public health law resource for local health departments in a government agency has both pros and cons. Perhaps the biggest advantage is that it
would be supported by government funds and would likely be assured continued operation. As between a federal and state-based agency, as discussed above, a state-based agency would be preferable. Among other concerns, federal policy may not be consistent with state or local health policy, especially on controversial public health issues, e.g., HPV vaccinations for adolescents, needle exchange programs, etc. Natural homes for such an entity would be the office of the state attorney general or the state health department. State attorney general offices and departments of health are uniquely positioned to understand the needs of public health officials in their state and to understand the political environment in which they work. On the other hand, especially in a state with a decentralized public health department structure, it is not clear that these agencies have a close enough relationship with local public health departments to provide the targeted, specialized legal assistance that we have determined is lacking at the local level. Many of the attorneys and local public health officials with whom we spoke commented that they have very little interaction with state public health officials or assistant attorneys general. One local attorney commented that “bringing in state attorneys often complicates matters for us.” Therefore, if a public health legal entity were to be housed at a state agency, then an effort would have to be made to reach out to public health officials and attorneys at the local level.

At the state level, there would be a significant difference between housing a public health legal entity at the attorney general’s office and housing one at the state health department. It is not clear if public health practitioners would feel comfortable reaching out to the attorney general’s office or whether local public health attorneys would feel comfortable reaching out to the public health department for legal advice. These professional differences would have to be bridged in order to make a legal services entity relevant to all stakeholders. In addition, as noted in one of the initial vignettes to this paper, at least in some states, a state attorney may have a conflict of interest in advising both the state and local entities. Finally, government entities may face political pressure to make certain policy decisions that are inconsistent with a local government’s position. However, on a positive note, a legal entity housed in a state agency is likely to be relatively responsive in terms of timeliness given the political pressure that could come to bear if a public health issue within the state went unresolved because legal assistance from a state-funded entity was not forthcoming.

4. MEMBERSHIP ORGANIZATIONS
A membership organization fares well on many of the criteria we set forth for an effective mechanism for building public health law capacity at the local level. Such an organization could be newly created or could be established as a function of an existing membership organization with similar goals serving the public health community.

Public health-oriented membership organizations that might house a public health law resource center include APHA, ASTHO, and NACCHO. These organizations share a similar public health focus and provide similar services to their members with some important differences that are relevant for our purposes. APHA represents public health practitioners and academics regardless of their occupation. The organization’s primary focus is public health generally — without regard to where it is practiced, i.e., on the local, state, or national level. NACCHO membership includes both public health departments and boards of health at the local level. ASTHO, in contrast, is a membership organization for state health officials. In order to bridge these different constituencies, an entity established to serve the public health law needs of local health departments would ideally work with the support of all three organizations.

Further, while NACCHO and ASTHO represent local and state health officers, respectively, they are national organizations with a national focus. They look for common issues across their membership for which they can provide assistance or lobby at the national level. They do not focus on the unique individual legal issues that state and local health officers confront. Moreover, each of these organizations represents public health officials, rather than public health attorneys, and would therefore potentially bypass an important target population.

On the other hand, membership organizations like IMLA and PHLA provide current information and educational resources to attorneys in the area of public health law. Attorneys join these organizations to stay current on issues within their purview and to make professional connections with attorneys and organizations that work in the same legal area. While PHLA has not provided advice to local attorneys, IMLA engages in outreach and provides legal assistance to local attorneys dealing with public health matters. However, as a national association, it is not generally able to provide legal advice, only legal information to out-of-state attorneys. And while the organization has the advantage of targeting attorneys, it has the weakness of not reaching out to local public health officials.
A state-based membership organization (either public health or attorney oriented) is perhaps a better alternative for providing the type of legal assistance necessary for local health departments. Such organizations were, in fact, an important source of outside assistance for several of the local health officials and attorneys we interviewed. A number of them use the listservs of such organizations to seek advice on particular issues from others in similar job positions. It appears that there exists a natural collegiality among similarly situated professionals in a state and a demonstrated willingness to use these connections to seek out advice. Furthermore, we learned that most local health departments belong to various state membership organizations (most commonly their state association of local health officials) in return for membership benefits, which also indicates their willingness to allocate funds for educational opportunities. State organizations are likely to understand the local political environment in which the health officials in their state function and have the knowledge, time, and resources to provide proactive legal services. The ability of a state organization to provide legal assistance in a timely manner would depend on the organization’s structure and resources.

However, existing state-based membership organizations do not typically include both local health officials and public health attorneys and may not be attractive to professionals outside the membership of the group. Moreover, depending on the nature of the organization, it may not have the necessary expertise in public health law. If a state-based membership organization developed a legal delivery program that was targeted to both local health officials and their attorneys, then such an entity could be very effective.

5. NON-PROFIT ORGANIZATION
A non-profit organization like PHLP is a potentially good model for delivery of public health legal services. A non-profit organization devoted to public health issues is likely to have the expertise and willingness to work with state and local health officials on proactive public health projects. However, based on our criteria, a state-based organization is more likely to serve the needs of local public health officials than an organization with a national focus. A state-based organization is likely to understand the political environment in which local health officials serve and provide timely advice based on relationships developed at the state level. Existing state-based non-profits could be designated to perform this new function. In states without non-profits with similar missions, such organizations would have to be created. A state-based non-profit could be structured to deliver public health legal advice and education similar to the academic center model, although the non-profit organization would not have the benefits of being affiliated with a university, such as student assistance and office space. The benefit of an independent non-profit organization is that such an organization would be free from the political structures of local, state, and federal governmental organizations. As a non-profit institution, such an entity is also generally free of business or commercial motives. Continuity of funding is always an issue with non-profit organizations and would present an ongoing challenge for such a group.

6. PRO BONO LEGAL PRACTICE GROUPS
The benefit of pro bono legal practice groups or pro bono panels is that they are funded primarily by private law firms and staffed by volunteer attorneys. Therefore, the ubiquitous issue of funding is not a significant issue for this model. The main problems with pro bono panels as a public health legal delivery system are the lack of expertise and continuity among attorneys who work on such panels. Because pro bono panels depend on volunteers, these volunteers may or may not have expertise in public health law (although, as mentioned earlier, some law firms are trying to remedy this by focusing on a particular area of law). Volunteer commitment differs substantially from a permanent position and therefore the composition of pro bono practice groups may be constantly in flux, which makes it difficult for such a group to develop an institutional memory, expertise, or trusting relationships in the community. In addition, in the case of pro bono panels created by law firms, because law firms generally represent private interests, some of which may have legal conflicts with local health departments, law firms may confront conflict of interest issues in their representation of local health officials. In other words, because of existing conflicts, law firm-related pro bono practice groups may not be in the position to provide a full range of legal services to public health officials. Finally, in terms of the other factors we detailed as important for a public health entity — i.e., timeliness, knowledge of local political environment, and proactivity — a pro bono practice group does not fare well as a legal delivery mechanism. Lack of expertise and the relatively instability of a volunteer workforce would make it difficult for such a group to provide timely legal advice on a consistent basis, understand the local political environment vis-à-vis local public health officials, or act proactively. Therefore, although funding may be consistent, pro bono practice groups are probably not ideal mechanisms to develop public health legal capacity at the local level.
C. Recommendation for an “Ideal” Public Health Law Delivery Mechanism

Based on our research, we recommend that an entity established to increase the public health law infrastructure in local health departments have the following characteristics:

1. A state or regional base with ties to a national support organization;
2. The ability to provide services to both public health officials and public health attorneys;
3. The ability to work in cooperation with NACCHO and its state affiliates, APHA, ASTHO, PHLA, and IMLA and other groups to earn legitimacy and disseminate information to target audiences;
4. The ability to work in cooperation with the designated attorney(s) serving local public health officials;
5. Independence from political entities;
6. An understanding of the specific political environment in which local health officers work;
7. The ability to respond in a timely manner to requests for assistance;
8. The ability to act proactively; and
9. Innovation and creativity.

With these characteristics in mind, an “ideal” structure to serve local health departments would be a series of state-based centers connected through a national coordinating entity that would assist the state-based entities share information and expertise.

We recommend that the state-based center be housed within an academic institution, non-profit organization, or membership organization (such as a SAACHO) but believe the location, design of, and services provided by the center would be best determined by stakeholders within that state, taking into account the state’s existing public health law strengths, capacities, and infrastructure. Whether the entity would provide legal advice or simply legal information would also be a decision of the local stakeholders and the entity’s available resources, however, we recommend that such entities provide most, if not all, of the following services:

- Drafting ordinances and/or proposed state legislation;
- Preparing legislative “tool kits” (materials based on tested, successful strategies to support legislative advocacy efforts at the national, state and local levels);
- Strategizing/long-term problem solving (including political consequences of certain actions);
- Responding to requests for legal information or advice;
- Litigation support;
- Preparing amicus briefs;
- Holding conferences/trainings; and
- Hosting a Web site.

Such a state-based entity ideally would also offer a variety of mechanisms to reach local health officials and attorneys in the state, including publication of a journal or reporter, e-news, interactive email, a hotline or telephone consultations, and in-person consultation.

The national level coordinating body could be housed at an academic institution, a legal back up center such as NHeLP, as well as one of the existing membership organizations serving local public health officers and/or their attorneys, e.g., PHLA, ASTHO, NACCHO, APHA, or IMLA.

In terms of functions, a national center would carry out some or all of the following:

- Create model ordinances/laws on specific issues that are of interest across states;
- Develop updates and legal analyses of federal laws and regulations relating to public health;
- Serve as a forum for local health officials and public health attorneys across the country to share ideas or seek advice;
- Develop legal tool-kits focused on specific public health issues;
- Disseminate best practices;
- Evaluate state-based initiatives;
- Broker actions between state-based centers working on similar initiatives;
- Provide technical assistance teams to states;
- Provide litigation support; and
- Identify other constituencies that benefit from sound public health policies that can support the goals and agenda of the national and state based entities.

An example of an existing structure that best reflects our proposed model is the Tobacco Control Legal Consortium (TCLC) and the eight state-based tobacco control centers, one of which, the Maryland Legal Resource Center for Tobacco Regulation, Litigation & Advocacy, is described in detail above. This combination of local-state based centers and a national coordinating body has been very successful in promoting tobacco control policy and legislation over the last five years. This successful hybrid structure generally meets the criteria we set forth as essential for a public
health legal entity and is a practical model to study going forward.

V. Conclusion
Our research indicates that local public health officials often do not receive the necessary assistance to address the various legal questions that confront them. This shortfall makes it difficult for public health officials to both implement current programs and to use the law proactively as a tool to improve the public's health. In addition, many of the attorneys who provide legal support to public health departments are spread too thin to have a deep understanding of public health law or the time to stay current on current public health legal issues. Interviews with a number of local public health officers and their attorneys from a diverse range of public health departments (geographically and structurally) indicated an interest in and a need for additional legal resources. In some cases, they are unable to obtain access to legal assistance when they need it; in others, they are unable to obtain the legal expertise that they need.

Such legal resources could be provided through a variety of mechanisms. We identified several characteristics of an “ideal” mechanism, including availability of public health law expertise; ability to target and work with both local health officials and their attorneys; familiarity with state and local public health law infrastructure as well as relevant laws, ordinances, and regulations; ability to provide legal advice; and freedom from conflicts of interest. Such an entity would provide legal resources, advice, and information to its target audiences via in-person consults, conferences, telephone response, email, listservs, newsletters, and Web sites. Based on these characteristics we recommend a series of state-based centers connected through a national coordinating entity that would assist the state-based entities share information and expertise.

Acknowledgement
This paper was commissioned by the Public Health Law Association (PHLA) to examine the experience of local health departments in obtaining legal advice and to assess different models for “organizing and financing legal services, examine efforts to enhance these services and suggest strategies for making better use of available resources.”

This paper focuses on health departments at the local (city, county, municipal) level rather than on state health departments, although the analysis and recommendations in this paper would apply to states where local health departments are units of the state health agency, or where the state health agency regulates and provides public health services at the local level.

An earlier draft of this report was presented at a summit organized by PHLA on November 4, 2007, in Washington, D.C. Key stakeholders in both the public health and public health law arenas attended the summit and were asked to provide feedback on the report. The comments and recommendations made by summit participants have been included in this paper.

We would like to express our special thanks to Martin P. Wassemer, M.D., J.D., and Daniel O’Brien, J.D., who, as members of the Board of Directors of the Public Health Law Association (PHLA), asked us to prepare this paper as part of PHLA’s Summit on “Building Capacities and Communication Linkages in Public Health Law” and for their invaluable comments and contributions to this paper. We would also like to thank Ross D. Silverman, J.D., M.P.H., and Jason A. Smith, M.T.S., J.D., who also presented papers at the summit, and Patricia Davidson, the Summit’s Project Manager, for providing comments and insights, many of which we incorporated into our paper. Finally, we would like to thank our student research assistants, Rebecca Jesada and Vanessa Schultz, for their tireless assistance.

References
3. Id.
5. The models are described in the 2005 National Profile of Local Health Departments (id.) and the Turning Point Project’s 2002 State Public Health Law Assessment Report (L. O. Gostin and J. G. Hodge, Jr., Turning Point Public Health Statute Modernization National Excellence Collaborative, State Public Health Law Assessment Report, 2002, available at <http://www.turningpointprogram.org/Pages/pdfs/statute_mod/phsm_state_ph_law_assessment_report.pdf> (last visited July 1, 2008)). In its 2005 National Profile of Local Health Departments, NACCHO surveyed 2,664 local health departments across the country. Of the 2,300 local health departments that returned the Web-based questionnaire, 79% self-identified as units of local government (decentralized) and 21% as units of the state health department (centralized). See Leep (id.), at 4. The NACCHO study named four categories (centralized, decentralized, mixed, and shared) but used only three categories in the study for purposes of simplification: all local health departments are units of the state health agency, all local health departments are units of local government, and mixed.
8. Arkansas, Delaware, Hawaii, Louisiana Mississippi, New Mexico, Rhode Island, and South Dakota do not have local boards of health. See Leep, supra note 4, at 13.
10. Id., at 11.
11. See Institute of Medicine of the National Academies, supra note 7, at 109-110.
13. See Lopez and Frieden, supra note 2, at 201.
14. Federalism in this context means the theory of government by which powers are divided between a national government and state governments, each with their own areas of substantive jurisdiction. Federal and state preemption is the legal principle that a federal law supersedes or trumps any inconsistent state law or regulation. Similarly, state law may trump or “preempt” local or city law on certain issues.
15. See Lopez and Frieden, supra note 2, at 211.
17. HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, which included “administrative simplification” provisions that required Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions and standards to protect the privacy of those transactions.
19. These Centers include the Technical Assistance Legal Center (California), the Tobacco Control Resource Center (Northeastern University, Massachusetts), the Tobacco Law Center (William Mitchell College of Law, Minnesota), Smokefree Environments Law Project (Michigan), the Tobacco Control Policy Legal Resource Center (New Jersey), the Secondhand Smoke Technical Assistance Resource Center (Colorado), and the Tobacco Public Policy Center (Capital University Law School, Ohio).
20. Id.
21. Telephone interview with Steve Hitov, Managing Attorney, National Health Law Program, June 12, 2007. NHeLP actually predated the LSC and was started at the University of California, Los Angeles (UCLA) School of Public Health. The LSC, established by Congress in 1948, was an outgrowth of the legal services programs for the poor that had been administered by the Office of Economic Opportunity (OEO) in the late 1960s and early 1970s. At the height of LSC funding, there were approximately 13 legal back up centers, a number of which had academic roots. These centers primarily assisted local legal aid attorneys. When Congress dramatically amended the functions of the LSC as part of an appropriations act in 1996 — placing limits on the types of permissible actions they could undertake (e.g., no class action suits, no assistance for illegal aliens or some classes of legal aliens, no attempts to influence legislation, no litigation regarding welfare reform) — and extended those prohibitions to legal aid programs’ use of other sources of funds, NHeLP and other back up centers refused to accept LSC funds and established themselves as independent organizations, committed to assisting local attorneys working with the indigent on issues ranging from health care to housing to welfare.
23. Id.
25. CDC Grant Announcement Synopsis, “Collaborating Centers for Public Health Legal Preparedness,” Grants.gov Web site, available at <http://www.grants.gov/search/search.do?oppId=140444&mode=VIEW> (last visited June 23, 2008). These three to five year grants are awarded to an institution that pledges to improve the contribution law makes to the health of the public and to the performance of the public health system through development and dissemination of information, training, and learning materials on public health legal preparedness for public health practitioners, policy makers, emergency management officials, the legal community, and others key to public health and public health legal preparedness.

According to the grant announcement, the CDC’s highest priority for these centers is “public health legal preparedness, including improving legal preparedness for terrorism, outbreaks of infectious disease, natural disasters, and other public health threats and emergencies.” Id. To date, the CDC has made three successive grants to the Center for Law and the Public’s Health at the Johns Hopkins Bloomberg School of Public Health (the most recent being a five-year grant that began in October 2007) and one grant to the Institute for Bioethics, Health Policy and Law at the University of Louisville.
30. Id.
31. Id.
32. These organizations are affiliated with, but not financially supported by, NACCHO.
34. Id.
36. Id.
40. Id.
43. Public Health Institute, “Who is PHI?” available at <http://www.phi.org/about.html> (last visited June 23, 2008). The Public Health Institute is an independent, non-profit public health organization that promotes research and innovations to improve the efficacy of public health nationally and internationally.
44. Tobacco Assistance Legal Center, available at <http://www.philaw.org/talec> (last visited June 23, 2008); see also supra note 19.
46. Id., at 72-73.
47. Id.
48. Id.
49. Id.

Furthermore, HLA only accepts cases that fall within its current priorities which include: (1) the Children’s Mental Health Access Project; (2) the Divorce Judgment and Health Insurance Project; (3) ensuring access to dental care; (4) fighting for essential hospital services; (5) maximizing access to private health insurers; (6) the Massachusetts Mental Health Parity Project; (7) preserving the safety-net for Massachusetts’ most vulnerable residents; (8) supporting access to prescription drugs; (9) the Worcester Mental Health Task Force; (10) working to improve prison health care; and (11) Massachusetts health care reform. Id.

BNA is a publisher of information and analysis products for professionals in law, tax, business, and government. The company’s 350 print and electronic products address legal, legislative, regulatory, and economic developments affecting business. These reports are available based on paid subscriptions. BNA currently publishes 15 health related reports.


Another possibility is a “blog” or online question/answer format. The Baltimore City Health Department hosts an online forum through which city residents can obtain answers to questions relating to environmental health and hygiene regulation. “Ask Inspector O” is a popular, informal service staffed by a city attorney housed in the city health department. See City Health Department, “Ask Inspector O,” available at <http://inspectoro.blogspot.com/> (last visited June 23, 2008).


See supra note 16.

See Jacobs, supra note 55.

NHeLP, for example, has offices in Washington, D.C., Los Angeles, and Chapel Hill, North Carolina.