Cross-Jurisdictional Relationships in Local Public Health

Preliminary Summary of an Environmental Scan

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January 2011

This report was supported by a grant from the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation, which is engaged in efforts to strengthen America's public health system, commissioned this environmental scan to gain a better understanding of the issues involved in creating formal collaborative relationships between local health departments in different communities. More specifically, the Foundation was interested in learning what types of relationships currently exist between health departments—how are they structured, how and why were they created, and how well are they working? Also, what factors contribute to or detract from the success of these cross-jurisdictional relationships? What are the downsides, challenges, or barriers associated with the various types of relationships? And, perhaps even more fundamentally, how are these relationships defined by the stakeholders—what terms are being used to describe the relationships and are those terms universally understood?

Initially, this scan was prompted by what appears to be growing interest in the concept of public health regionalization. But, in conducting the scan, the researchers discovered that the term "regionalization" has a very strong and exclusive association with public-sector consolidations and mergers, and is not an apt umbrella term for purposes of this report, which seeks to elucidate the wide variety of formal collaborative relationships between public health departments in different communities. Therefore, for purposes of this report, the term "regionalization" refers only to the complete consolidation of services or to the merging of public health agencies across jurisdictions. And the umbrella terms "cross-jurisdictional relationships" or "cross-jurisdictional sharing" are used to refer to the wide variety of all other means by which jurisdictions can collaborate around the provision of public health services.

Interest in cross-jurisdictional sharing and regionalization appears to be growing across the nation due a variety of factors, including:

- The field's movement toward the use of objective performance standards may raise questions about the ability of some local health departments, particularly those in rural areas and those that lack sufficient resources to achieve those standards on their own.
- Some financially strapped local and state governments are expressing interest in public health regionalization, specifically, as a way to achieve economies of scale and cost containment.
- Priority attention placed on a particular programmatic area—such as emergency preparedness—has sometimes been behind cross-jurisdictional efforts to share or collaborate around the provision of public health services.

The scan involved gathering information via in-person interviews and site visits with two groups of key stakeholders.

1) Executive leadership and/or key staff at:
    - Association of State and Territorial Health (ASTHO)
    - The Centers for Disease Control and Prevention (CDC)
    - Health Resources Services Administration (HRSA)
    - National Association of Counties (NACo)
    - National Association of County and City Health Officials (NACCHO)
    - National Governors Association (NGA)
    - National Association of Local Boards of Health ((NALBOH)
    - National Conference of State Legislatures (NCSL)
    - Public Health Accreditation Board (PHAB)
    - U.S. Conference of Mayors (USCM)

2) State and local public health leaders and local policymakers in seven states considering or engaged in some form of cross-jurisdictional relationship or regionalization:
    - Colorado (which recently legislated support of regionalization activities)
    - Wyoming (which combines state and local service delivery, and was a PHAB beta test site)
    - South Carolina (which has a strong centralized state health department with multi-county regions at the local level)
    - Connecticut (which has been actively promoting regionalization of local public health jurisdictions)
    - New Hampshire (which is developing private entities to perform some public health functions regionally)
    - Nebraska (which created multi-county public health agencies about 10 years ago)
    - Illinois (which is both urban and rural has had a form of accreditation in place for some years)

Based on meetings with all of these stakeholders, this report summarizes the researchers' observations regarding barriers to cross-jurisdictional relationships in local public health as well as the conditions that are important to the development of successful relationships. Also summarized are the considerations that should be taken into account when looking at the potential for cross-jurisdictional relationships to strengthen the national public health system. Note that such efforts are highly specific to their localities and this report offers only broad generalizations; exceptions to those generalizations are easily identified. Also note that this is an initial summary based on one round of meetings. Further work, including a second round of interviews and site visits with these same constituencies, will be conducted to help refine and expand upon this initial report.

Barriers to Improving Public Health Capacity Through Cross-Jurisdictional Relationships

A gap exists between elected officials and public health leaders in understanding population health. Elected state and local policymakers do not appear to have a good working knowledge of the "Core Functions" and "Ten Essential Services" framework of population-based public health. For the most part, policymakers describe public health as an aggregate of discrete programs and services. Further, there was no clear sense that the overall improvement and protection of the public's health is a fundamental public responsibility. This lack of understanding appears to make it difficult for elected policymakers to consider cross-jurisdictional approaches as a means to improve the performance and accountability of public health. Discussions of approaches, such as regionalization, tended toward issues of governance, autonomy, and financing.

There are differences in understanding, appreciating, and operationalizing cross-jurisdictional relationships within the public health practice community. The public health practice community understands the core functions and essential services of public health, but appeared to have trouble expressing the framework in terms of the actual practice environment. This reflects the fact that, while the national public health system is moving toward a broad conceptual framework of services and functions, local public health is still arranged, practiced, and funded along discrete programmatic lines. When discussing examples of cross-jurisdictional sharing, state and local public health interviewees tended to focus on efforts to collaborate as a means to accomplish a specific purpose or address a programmatic need, such as chronic disease prevention, rather than to create a shared generic capacity that could be applied to a broad range of issues as the jurisdictions saw fit.

No common language or frame of reference exists for discussing cross-jurisdictional sharing. For the most part, no particular words or terms were used consistently to denote the various types of collaborative options that might fall under the broader construct of cross-jurisdictional sharing. When various collaborative efforts were described by interviewees, lengthy, qualitative explanations were usually given in the absence of commonly defined terms. Even in those instances where there may have been some commonality in term usage—such as with the specific "Memorandum of Understanding" and "Mutual Aid Agreement" and the more generic "shared services" and "purchase of service"—it was not clear that they were clearly understood and used with the same meaning across the board. Beyond language there wasn't a common understanding as to what was or was not considered to be cross jurisdictional sharing.

The one notable exception to this lack of a shared lexicon was the word "regionalization," which was heard and interpreted by most interviewees to mean, almost exclusively, the merger or consolidation of separate public agencies to form a single agency. This was particularly true among elected officials, though was not limited to them.

Cross-jurisdictional sharing and regionalization are occurring in a range of ways. There was anecdotal evidence of many different forms of cross-jurisdictional sharing in all states visited. It was generally initiated in response to a particular issue or specific need, as illustrated by the fact that all states demonstrated cross-jurisdictional resource sharing around emergency preparedness, with mutual aid agreements being the most common mechanism for this. Further, there were examples of multi-jurisdictional merger and consolidation approaches to local public health structure. In some states, public health agencies have the option to provide multi-jurisdictional services, while in other states, doing so was a requirement set by state policy.

Regionalization does not necessarily result in improved public health capacity or performance, but cross-jurisdictional sharing often does. Jurisdictions that experienced a merger or consolidation of two or more public health agencies did not necessarily benefit in terms of improved public health capacity or performance. In contrast, most other types of cross-jurisdictional collaboration or sharing of resources or services were seen as improving public health performance and/or capacity. Again, collaboration around emergency preparedness—such as mutual aid agreements—is a good example of this.

Conditions for Successful Cross-Jurisdictional Sharing and Regionalization

Clarity of purpose

Cross-jurisdictional sharing and/or regionalization of public health resources can help address any number of community needs and serve a variety of purposes. Elected policy makers and public health leaders—who may be approaching cross-jurisdictional sharing or regionalization for very different reasons and with very different goals in mind—must be very clear within themselves and with each other about the purpose of the endeavor. In a number of recent efforts, the intent of consolidation decisions—usually made by policymakers—was to achieve cost savings rather than to build capacity or improve performance.

Incentives, especially financial, are helpful

There usually are costs associated with cross-jurisdictional relationships and regionalization, particularly in the development and initial implementation phases. Many of the states visited that had experience with these approaches mentioned the availability of additional funding as a driver for entering into a collaborative relationship.

Willingness on both sides—public health leaders and elected policymakers

Willingness on the parts of both public health leadership and elected policymakers is essential for cross-jurisdictional sharing. Interestingly, however, successful collaboration did not appear to require a champion in either the public health or policymaker roles. Rather, what is needed is a combination of openness to consider and willingness to implement.

Attention to environment, culture, and history
Failure to address the complex web of history, culture, and relationships when developing cross-jurisdictional sharing approaches will greatly reduce their potential for success. The bottom line is that the collaboration needs to succeed within a political environment in which the different participants are responsible first to their own communities and constituencies. Competition and perceived differences can inhibit relationships and must be acknowledged and addressed.

Actual role in governance
While roles, responsibilities, and degree of oversight among various participants in a cross-jurisdictional sharing relationship may vary, it is imperative that all parties to such an endeavor feel they have sufficient voice and control. For elected policymakers, this need appears to be greatest when there are direct financial obligations, liability, and/or structural change involved. For public health officials, their need was focused around direction-setting and oversight, helping to ensure that the collaboration improves public health performance and benefits the residents of their jurisdiction.

Considerations for Moving Forward with Collaboration

Elected state and local policymakers need to be integrally involved in national public health systems development work. State and local policymakers have not been sufficiently engaged in the public health systems thinking and development work of the past 20 years and do not have a collective sense of ownership and commitment to population health. Thus, they are more likely to view national expectations regarding local public health improvement initiatives as "unfunded mandates" to be resisted rather than as opportunities to improve the health of their local communities. In order to support cross-jurisdictional efforts, policymakers need to understand the various benefits that could accrue to their communities and constituencies. This goes far beyond the need to educate and inform them about a "done deal" to the need to actually engage them in the systems development work going forward, particularly given their responsibility to be publicly accountable for government spending decisions.

Contextual understanding of the environment is essential to successful public health endeavors. Local public health operates in complex and varied environments, most often as a unit within a town, city, or county government and is just one of many functions for which local policymakers have oversight and funding responsibilities. Within these environments, public health leaders and agencies often have roles and responsibilities that fall outside of the core

functions and essential services framework. This may include responsibility for services and programs only tangentially related to improving or protecting the public's health. Further, beyond the ways in which they are organized and structured within their local governments, public health entities must operate within the realities of the communities they serve, which vary tremendously in terms of demographics and socio-economic profiles as well as history, culture, patterns of relationships, and more. Public health must attend to these factors, tailoring approaches, structures, and services as necessary in order to be successful with any changes or new endeavors, such as collaboration.

Cross-jurisdictional relationships vary greatly in their details and address a wide variety of needs, but they do not have to develop further beyond their original purpose. Several dimensions can be used to characterize cross-jurisdictional sharing relationships, including:

- relative formality and/or legal basis of the relationship;
- nature of what is being shared within the relationship, such as the simple purchase of a service by one jurisdiction from another, shared capacity functioning across the participating jurisdictions as a whole, etc.;
- duration and timing of the relationship—ongoing, episodic, time-limited, etc.;
- degree and nature of financial commitment of the respective jurisdictions; and,
- governance and oversight of the relationship, such as simple review of a working agreement between local health officials, contract management and reporting, specially created oversight mechanisms specific to the sharing, creation of whole new organizational structures, etc.

Conclusion

In closing, cross-jurisdictional sharing can and does improve local public health performance. This was acknowledged by both the elected policymakers and public health leaders interviewed. Examples of such sharing were discussed in every venue throughout the project, though the scope, breadth, and purpose of the sharing varied widely within and across participating states. Public health system performance improvements can be as straightforward as ensuring the availability of a needed service in a jurisdiction or as complex as creating new local public entities with greater capacity to serve multiple jurisdictions. As noted, the majority of the examples discussed were undertaken to address a particular need or gap. Few were initiated to develop and share ongoing, deployable public health capacities. And while there was acknowledgement from public health practitioners that cross-jurisdictional sharing would likely be necessary for many health departments if they are to consider applying for national accreditation, it was not cited as a driver in the examples offered in the state site visits.