

FINAL REPORT

Promising Practices in the Coordination of State and Local Public Health

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Table of Contents

Acknowledgements..... 1

Background 2

 Overview of Past Studies.....3

Methods 6

 Selecting Case Study Sites.....6

 Conducting interviews.....8

Findings 10

 Approaches for Coordination10

State-Local Public Health Liaison..... 10

SACCHO Meetings/Committees 11

Regional Collaboration..... 12

Routine Communications 12

 Funding13

 Accomplishments.....15

Navigating Difficult Decisions 15

Quality improvement and Performance Management 16

 Challenges and Lessons Learned.....18

Making the Most of Workgroups or Committees..... 18

Building Trust Through Frequent Contact 19

*Understanding Different Perspectives and Demonstrating a
 Commitment to Work Together 19*

Conclusion..... 21

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The conclusions and opinions expressed in this report are the authors' alone. No endorsement by CDC or other parties is intended or should be inferred.

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Background

The governmental public health system in the United States is comprised of federal agencies, state health agencies (SHAs), tribal and territorial health departments, and more than 2,500 local health departments (LHDs). Coordination across these different levels of government is essential in assuring the public's health. This study focuses on nine states and describes how state and local health departments have developed structures and processes to facilitate collaboration.

This study is part of the National Public Health Improvement Initiative (NPHII), which is funded and administered by the Centers for Disease Control and Prevention (CDC). This dedicated investment in public health is distributed through cooperative agreements with health departments, and aims to improve their ability to deliver public health services by providing the resources required to make organizational changes through performance management and quality improvement activities.¹ Both the Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO) received NPHII funds from CDC to provide technical assistance to public health departments through the identification and dissemination of best practices designed to improve the efficiency and effectiveness of public health systems. In turn, ASTHO and NACCHO contracted with NORC at the University of Chicago to identify promising practices in the alignment of state and local public health and to highlight findings in a series of case studies.

A total of nine state case studies were completed for this project, each of which was informed by conversations with at least four public health practitioners in the state. The first set of six case studies identifies and describes promising practices related to coordination among state and local health departments. The remaining three case studies examine how NPHII-funded activities have helped grantees to strengthen relationships between SHAs and LHDs and across LHDs.

We begin with an overview of past studies and then describe the case study methodology. We then turn to the findings from the case studies, beginning with a description of strategies implemented to improve alignment and coordination between state and local public health, as well as a discussion of how funding factors into state-local relationships. We also describe the accomplishments that have emerged from state-local collaboration. We conclude with a discussion of challenges and lessons learned related to coordination between state and local public health.

¹ Centers for Disease Control and Prevention. CDC Newsroom. (2010, September 20). *Sebelius announces \$42.5 million for public health improvement programs through the Affordable Care Act* [Press release]. Retrieved from <http://www.cdc.gov/media/pressrel/2010/r100920.htm>.

Overview of Past Studies

In the United States, typically LHDs operate the programs that provide public health services within a jurisdiction. It is also typical for SHAs to establish the policies for those programs and services, to allocate funds to LHDs, and to coordinate activities within jurisdictions.² To increase public health performance, and ultimately improve the provision of public health services, it is critical that public health agencies work closely together to ensure effective coordination. According to the ASTHO Profile of State Public Health (2011), SHAs report a high level of collaboration with LHDs. None of the SHA respondents reported having no relationship with the LHDs in the state. SHAs collaborate with LHDs by exchanging information (90%); working together on activities or projects (88%); and providing financial resources (88%). In addition, SHAs reported coordinating with locals by providing technical assistance in the following areas: data management (75%); public health law (75%); quality improvement, performance management and accreditation (73%); policy development (73%); and workforce issues (73%). States also provide training to LHDs for preparedness, disease prevention and control, and tobacco prevention and control.³

The nature of the relationship between state and local health agencies may differ depending on the governance structure in the state. A study conducted by researchers from NORC, ASTHO, and NACCHO categorizes states into the following four classifications:⁴

- **Centralized/Largely Centralized.** 75% or more of the state's population is served by local health units that are led by employees of the state and the state retains authority over many decisions relating to the budget, public health orders, and the selection of local health officials. (Fourteen states meet these criteria.)
- **Decentralized/Largely Decentralized.** 75% or more of the state's population is served by local health units that are led by employees of local governments and the local governments retain authority over many decisions relating to the budget, public health orders, and the selection of local health officials. (Twenty-seven states meet these criteria.)

² Salinsky, E. (2010, August). *Governmental public health: An overview of state and local public health agencies* (Background paper No. 77). Retrieved from: http://www.nhpf.org/library/background-papers/BP77_GovPublicHealth_08-18-2010.pdf.

³ Association of State and Territorial Health Officials. (2011, September). *ASTHO profile of state public health* (Volume 2). Retrieved from http://astho.org/uploadedFiles/Publications/Files/Survey_Research/ASTHO_State_Profiles_Single%5B1%5D%20lo%20res.pdf.

⁴ Meit et al. (2012). Governance Typology: A consensus classification of state-local health department relationships. *J Public Health Manag Pract*. Forthcoming.

- **Shared/Largely Shared.** 75% or more of the state’s population is served by local health units that meet one of these criteria: where local health units are led by state employees, local government has authority over many decisions relating to the budget, public health orders, and the selection of local health officials; OR where local health units are led by local employees, the state has many of those authorities. (Four states meet these criteria.)
- **Mixed.** Within the state there is a combination of centralized, shared, and/or decentralized arrangements. No one arrangement predominates in the state. (Five states meet these criteria.)

While interactions between state and local public health units within centralized states tend to be formalized through the SHA’s organizational structure, in decentralized states we also find considerable evidence of routine interactions between state and local public health. According to the ASTHO Profile of State Public Health (2011), SHAs with decentralized governance structures reported providing more technical assistance in health law and policy development to LHDs than did centralized states.⁵ Additionally, in a web-based survey in decentralized Wisconsin, the majority of staff from the SHA and LHDs reported frequent collaboration between the state and local level—ranging from several times a month to daily.⁶ Similarly, in North Carolina, another decentralized state, a survey of LHDs found that the majority describe the extent to which they interact with the SHA as “much” or “to a great extent” (68.8%) and rated the productivity of that relationship as “moderately” or “very productive” (87.3%). The survey suggests that frequent interaction promotes more productive relationships and that collaboration promotes better public health performance.⁷

Research reveals that state and local public health representatives may view collaboration in terms of addressing the needs of specific public health programs, rather than in terms of increasing general capacity.⁸ Within these program areas, promising practices for state-local collaboration have emerged and have been documented in the following areas: behavioral health,⁹ maternal and child health,¹⁰ chronic disease prevention,^{11,12} and preparedness.^{13,14} In the area of preparedness, for example, Project Public

⁵ ASTHO, 2011, op cit.

⁶ Daley, D.M. (2009). Interdisciplinary problems and agency boundaries: Exploring effective cross-agency collaboration. *J Public Adm Res Theory* 19(3), 477-493.

⁷ Lovelace, K. (2000). External collaboration and performance: North Carolina local health departments, 1996. *Public Health Rep* 115(4), 350-357.

⁸ Libbey, P. & Miyahara, B. (2011, January.) *Cross-jurisdictional relationships in local public health: Preliminary summary of an environmental scan*. Retrieved from <http://www.rwjf.org/files/research/20110201libbeyfinal.pdf>.

⁹ Perlman, S.B. & Dougherty, R.H. (2006). *State behavioral health innovations: Disseminating promising practices* (pub. no. 945). Retrieved from http://www.commonwealthfund.org/usr_doc/Perlman_statebehavioralhltnnovations_945.pdf.

¹⁰ Fraser, M. (2009, July). *State/local collaboration in four centralized states*. Retrieved from <http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/Archive/2009/July2009/Pages/Feature2.aspx>.

¹¹ Libbey & Miyahara, 2011, op cit.

¹² Case studies in chronic disease prevention: Local health departments confront the challenge of the 21st century. (2008). Retrieved from http://www.californiaconvergence.org/sites/default/files/Case_Studies_in_Chronic_Disease_Prevention_0.pdf.

Health Ready (PPHR) provided the funding necessary to allow local and state agencies in many states to coordinate resources and activities to develop training programs and emergency response plans.¹⁵

In terms of general capacity for coordination, one county health department in California relies on state-level and regional partnerships to ensure alignment and collaboration in public health efforts. The health department participates in county, regional, and statewide organizations to align and collaborate efforts; these groups include the California Conference of Local Health Officers (CCLHO), County Health Executives Association of California (CHEAC), other LHDs, the SHA, and the Central California Obesity Prevention Project (CCROPP), among others.¹⁶ Other states lay out in statute requirements for state-local coordination. In Oregon, local health officers are organized by the Conference of Local Health Officials (CLHO), which, per statute, serves in an advisory capacity to the state.¹⁷ Similar coordinating bodies may exist in centralized states; for example, in Maine—a largely centralized state—statute describes a “representative statewide body of public health stakeholders for collaborative public health planning and coordination.”¹⁸

In addition, researchers have identified practices for encouraging the development of cross-jurisdictional relationships at the local level. Conversations with state and local public health representatives have revealed the following strategies: ensuring the presence of financial incentives, including the potential for additional funding; recognizing the current environment, including political support and existing relationships; and ensuring that roles and responsibility for oversight are acknowledged and enforced.¹⁹ Some of these practices and strategies may be useful for promoting collaboration between the state and local level.

¹³ Estrada, L.C., Fraser, M.R., Cioffi, J.P., Sesker, D., Walkner, L., et al. (2005). Partnering for preparedness: The Project Public Health Ready experience. *Public Health Rep* 120(Suppl 1): 69-75.

¹⁴ Wholey, D.R., Gregg, W., & Moscovice, I. (2009). Public health systems: A social networks perspective. *Health Serv Res* 44(5 Pt 2): 1842-62.

¹⁵ Estrada et al., 2005, op cit.

¹⁶ Case studies, 2008, op cit.

¹⁷ *Oregon Revised Statutes and the Conference of Local Health Officials*. (2007). Public Health, Oregon Health Authority. Retrieved from: http://public.health.oregon.gov/ProviderPartnerResources/LocalHealthDepartmentResources/Documents/CLHO_documents/ORS_CLHO.pdf.

¹⁸ Health and Welfare, State and Local Health Agencies, Public Health Infrastructure §412. Coordination of public health infrastructure components (2011). Retrieved from <http://www.mainelegislature.org/legis/statutes/22/title22sec412.html>.

¹⁹ Libbey & Miyahara, 2011, op cit.

Methods

This report draws on findings presented within the nine case study reports, which were based on interviews with key informants at state and local health departments. Below we describe our study methods.

Selecting Case Study Sites

Nine health departments were selected as case study sites. One group of six health departments was selected to highlight and describe promising practices related to aligning state and local public health. The second set of three health departments was chosen specifically to describe their systems development and reengineering efforts through NPHII. NORC, ASTHO, and NACCHO worked together to identify health departments that had demonstrated leadership in efforts to coordinate between state and local public health to serve as case study sites. While it was deemed important to include health departments with diverse governance structures, most of the health departments selected as case study sites are decentralized. The rationale for focusing more on decentralized states was based on recognition that coordination between state and local public health units in centralized states is a natural part of the health department organizational structure. By contrast, the independent nature of local health departments in decentralized states offered the opportunity for a more in-depth examination of state and local relationships where they are not structurally defined.

Each of the health departments selected as case study sites received Year 1 and Year 2 funding from NPHII. To ensure coordination with CDC, ASTHO communicated the project's intent and methods to each of the NPHII Senior Public Health Advisors assigned to the state health agencies selected as case study sites.

Table 1 provides a brief overview of the nine case study states.

Table 1. Description of Case Study States

<p>Arizona Decentralized</p>	<p>The Arizona Department of Health Services designates some funds for service provision to the local public health system, comprised of 15 county health departments. Counties are responsible for determining the local public health budget for their county health department, may issue public health orders, and may establish taxes and fees for public health. Local government appoints and approves local health officers.</p>
<p>California Decentralized</p>	<p>The public health system in California consists of the California Department of Public Health and 61 local health departments. These local health departments set their own budgets, establish taxes and fees for public health, and issue public health orders without state approval. Local health officers are appointed and approved by local government.</p>
<p>Florida Shared</p>	<p>The Florida Department of Health operates 67 county health departments that implement programs locally through cooperative agreements with the state. County health department staff are employees of the state, and local health officers are appointed by the state but approved by local officials. Local governments have the authority to establish taxes for public health, establish fees for public health services, and issue public health ordinances. Revenue from taxes and fees goes to the state-operated LHDs, and the Board of County Commissioners may determine how those funds are designated within each local health department.</p>
<p>Massachusetts Decentralized</p>	<p>The Massachusetts Department of Public Health, with its five Regional Health Offices, and 351 LHDs comprise the state's public health system. State statute requires that each Massachusetts city and town establish an independent LHD, which is responsible for enforcing sanitary and environmental public health codes, issuing public health ordinances, determining their local budget, establishing taxes and fees for public health, and carrying out state-mandated public health programs. Local health officers are appointed and approved by local government.</p>
<p>Ohio Decentralized</p>	<p>The public health system in Ohio is comprised of the Ohio Department of Health and 125 local health departments. Local government appoints the district health commissioner and makes budgetary decisions at the local level, which includes establishing taxes. Authority to issue public health orders also resides at the local level.</p>
<p>Oklahoma Mixed</p>	<p>The Oklahoma State Department of Health coordinates 68 centralized county public health units, which serve approximately 63% of the state's population. Staff of these local health units are state employees, and the local health officer is appointed and approved by the state. Each county health department generates funds through local millage or taxes and has some oversight for those funds. However, the state provides and controls a significant portion of the health departments' budgets, and also decides, to a great extent, which programs are to be carried out at the local level.</p> <p>In addition, there are two decentralized county/city health departments, staffed by employees of the local government. Budgetary authority resides with local government, which establishes taxes for public health, establishes fees for services without state approval, and issues public health orders. Local government appoints and approves the local health officers in these two health departments.</p> <p>There are also seven small, rural counties in Oklahoma whose residents are not served by either state or locally operated public health agencies because the state will only recognize a centralized health department within a county that has established a millage for providing public health services. Residents of these counties may receive limited public health services in adjoining counties, provided by county health departments and/or by the state central office.</p>

Oregon Decentralized	Oregon’s public health system consists of the Oregon Health Authority’s Public Health Division at the state level and 34 county health departments locally. These LHDs set their own budgets, establish taxes and fees for public health, and issue public health orders. Local government is responsible for appointing and approving LHDs’ local health officers.
Washington Decentralized	The Washington State Department of Health (DOH) works with 35 local health jurisdictions (LHJs) that serve Washington’s 39 counties. The local health officer is appointed and approved by local government. LHJs maintain budgetary authority, establish fees for public health services, and issue public health orders.
Wisconsin Decentralized	The Division of Public Health in the Wisconsin Department of Health Services operates five regional offices that coordinate with the 92 LHDs in the state. Local government appoints and approves the local health officer. Each LHD establishes its own budget and has the authority to issue public health orders. In addition, local governments may establish taxes and fees for public health.

Conducting interviews

Four interviews were conducted with public health representatives from each of the nine case study sites. One interview was held with staff at the SHA, two interviews were held with staff at two different LHDs within the state, and one interview was held with a representative of the state association of county and city health officials (SACCHO). (For the one state that does not have a SACCHO, three interviews were held with staff at three different LHDs.) The interviews for the first set of six case study sites were conducted between June and October 2011. Twenty-four telephone interviews were conducted with a total of 26 individuals. The interviews for the second set of case study sites were conducted between November 2011 and February 2012; 16 telephone interviews were conducted with 16 individuals.

For the first set of case studies, the initial advance letters were sent to each SHA’s senior deputy. The advance letter requested that the senior deputy direct us to the individual who serves as the state’s local health department liaison. If there was no individual serving in the liaison role, we asked that the senior deputy refer us to whomever they deemed most appropriate. During the first interview, we requested recommendations for contacts at LHDs within the state as well as for the state’s SACCHO. A similar process was used for the second set of case studies; however, the initial advance letters were sent to the NPHII principal investigators.

A semi-structured interview protocol was developed in consultation with ASTHO and NACCHO.²⁰ While the protocols differed depending on the type of interviewee (i.e., SHA, LHD, or SACCHO representative), the discussions covered the following topics:

- Overall impressions of the relationship between state and local health departments;
- Communications between state and local health departments (including assistance states provide to LHDs, role(s) of the SACCHO, opportunities for local input on state policies, and collaboration among LHDs);
- Performance management efforts; and
- Funding.

Members of the research team conducted one-hour interviews via telephone. These interviews were recorded and transcribed. Interviewees received copies of case study drafts and were invited to revise and correct any inaccuracies.

²⁰ The protocols were submitted to the NORC Institutional Review Board and were found to be exempt. All interviewees provided their consent to participate in the interview, to be recorded, and to be quoted in the reports.

Findings

The interviews in the nine case study states focused on strategies that were deployed to foster communication and collaboration among state and local health departments. Because the allocation of funds plays a central role in the relationship between state and local health departments, we also provide an overview of funding mechanisms in the case study sites. Next, we describe the accomplishments that have emerged from efforts to encourage positive state-local relationships—in particular, by allowing state and local representatives to negotiate about potentially contentious issues and by supporting activities related to performance management and quality improvement. The interviews also revealed some challenges and lessons learned for overcoming obstacles in building productive state-local relationships.

Approaches for Coordination

Health departments pursued various approaches to foster collaboration between the SHA and LHDs. In some cases the SHA designates a particular staff person or office to serve as a liaison. In many instances, the SACCHO facilitates the sharing of ideas between the SHA and all of the LHDs in the state. Occasionally, there is a regional element to this collaboration; for example, the SHA may operate regional offices to coordinate with the LHDs in different geographic areas. In all cases, mechanisms for routine communication—either via email or telephone—are an important component of coordination efforts.

State-Local Public Health Liaison

Among the seven decentralized states examined in the case studies, the state health agencies in four states have designated one individual or established an office charged with fostering coordination with LHDs. (As described below, other states do not have one liaison in the central office; instead the SHA coordinates with LHDs through several regional offices.) While the responsibilities of this liaison or office vary from state to state, in general, key roles include:

- Communicating with the LHDs about such topics as contractual requirements, policy changes, and funding information;
- Serving as an initial point of contact to whom LHDs can direct questions and requests for technical assistance, which the liaison will then pass along to the appropriate SHA staff member; and
- Maintaining relationships with the SACCHO and, in one state, providing logistical support for SACCHO meetings.

In several states, interviewees noted that having a single point person for questions was beneficial; they appreciated having one familiar individual to help them navigate the SHA. In the absence of a clear line of communication, some LHDs expressed frustration if they were unsure to whom to direct inquiries. From the state's perspective, it may also be beneficial to channel all/most communication through one office to ensure that the SHA is conveying consistent messages.

The local health liaison can also play a role in conveying LHDs' perspectives to state staff. For example, a local health official in Arizona explained that local health liaison was able to present the LHDs' perspectives to colleagues at the SHA and advocate on their behalf in state decision making. This willingness to support local needs has fostered a sense of trust among the LHDs.

SACCHO Meetings/Committees

The SACCHO may serve as an important bridge between the SHA and the LHDs. Representatives from the SHA often participate in SACCHO meetings to provide information about state-level public health activities and to answer questions. Of the nine states studied in this report, only Oklahoma does not have its own SACCHO, because most jurisdictions in the state are served by centralized local health units. However, in order to ensure close communication with the two independent health departments in Tulsa and Oklahoma City, the state Board of Health hosts Tri-Board meetings with the independent city-county Boards in order to explore joint initiatives, such as the Oklahoma Health Improvement Plan.

To facilitate discussions between the LHDs and the SHA, subgroups of the SACCHOs are often convened. In some states, standing committees have been formed that are comprised of a small number of representatives from the LHDs and SHA. As one example, the president of the SACCHO in Arizona also chairs the Collaborative Team, which is composed of five local health officials that meet periodically with SHA staff. In other instances, this type of state-local committee is formed to address a particular topic. For example, in Florida, the SHA often uses the SACCHO's board of directors to act as a "sounding board" to provide the SHA with feedback and advice, or to ensure that they have local health officer support on certain issues. At times, the SHA may request assistance from the SACCHO board of directors to pull together a committee to help address a particular topic, such as the Fiscal Management Advisory Council (FMAC) described below.

Regional Collaboration

Some states that have a large number of LHDs have implemented a regional approach to coordinating among LHDs and between those LHDs and the state. The Wisconsin SHA has five regional offices through which they direct communications and provide technical assistance to the LHDs. The SACCHO has a parallel structure with five regional associations of LHDs, each of which meets regularly and communicates with the regional office of the SHA. A representative from each regional association serves on the board of directors for the state-wide association. That representative gathers information locally and shares those perspectives with the state association, which in turn communicates with the SHA.

In Florida a different model of regional coordination has emerged. Throughout the state, there are several consortia of neighboring LHDs. For example, eight county health departments began to meet as the West-Central area consortium. Formed with the encouragement of the state, these LHDs continue to meet regularly to coordinate their communication efforts with the state, share legal services, and disseminate best practices—particularly with new health officers.

As a third approach, LHDs in Massachusetts are exploring different models to develop regional districts. (See “Spotlight on National Public Health Improvement Initiative Grantees” for more information.)

Routine Communications

In addition to using a committee structure to allow SHA representatives to speak with a subset of the LHDs, SHA staff may host regular meetings—often by telephone or web/video conference—that are open to all LHDs in the state. For example, in Florida there are weekly conference calls with all the county health departments. These provide an opportunity for the state to brief health officers on legislative updates, budget allocations, and other relevant information; and to answer questions from the LHDs. Ohio supplements its weekly web conferences with two in-person meetings a year, which are held in conjunction with the meetings of the public health associations to help foster coordination among different public health efforts in the state.

In addition to these calls and meetings, states send emails or use websites to maintain regular communication with LHDs. Some routine communication may originate from the local level, as well. For example, in Ohio, the SACCHO produces a weekly newsletter that summarizes the information presented in the weekly calls with the SHA and also highlights pertinent public health topics, including grant opportunities and legislative updates. Because representatives from the SHA also read this newsletter it serves as a mechanism for two-way communication between the state and the locals.

Funding

As strategies for coordination differ among the case study states, so do mechanisms for financing public health. We briefly describe the themes that emerged in the case study interviews relating to funding.

Representatives from both state and local health departments articulated their heavy reliance on federal funds through grant opportunities to support public health activities within their jurisdictions. Often federal funds are passed to LHDs through the SHA. According to the ASTHO Profile of State Public Health, approximately 60% of SHA funds that come from the federal government are used to support LHDs.²¹

These federal funds that are passed through the SHAs are typically allocated to LHDs along programmatic lines using funding formulas that often take into account population or need. State general funds may also be distributed to LHDs using similar formulas; however, one state explained that there are no general funds available from the SHA to support local public health. Table 2 summarizes how much funding LHDs received from the state in each of the case study sites.

Table 2. Percentage of funding provided by SHAs to LHDs

Estimated Percentage of LHDs' Budgets Provided by SHA [#]		
0 – 25 %	26 – 50 %	51 – 75 %
Arizona (Decentralized) Massachusetts (Decentralized) Ohio (Decentralized) Washington (Decentralized)	Florida (Shared) Oregon (Decentralized) Wisconsin (Decentralized)	California (Decentralized) Oklahoma (Mixed)*

[#] This information was collected as part of a 2009 survey of SHAs. Respondents were asked the following question: “On average, what proportion of local health unit budgets is provided by the state public health agency (including federal flow through)?” and were instructed to select the range that corresponded with their best estimate.

* In Oklahoma, both the 68 centralized county public health units and the 2 decentralized county/city health departments receive between 51 and 75 percent of their budget from the Oklahoma State Department of Health.

The states we spoke with mentioned an array of locally operated public health programs and services that receive a combination of state and federal funds, including: maternal and child health; chronic disease prevention; communicable diseases; STD treatment; HIV; immunizations; epidemiology; water testing; vital statistics; and emergency preparedness; among others. To provide these services, LHDs in decentralized states work under contract with their SHA—representatives from six of the decentralized states we spoke with mentioned that LHDs contract with their SHA to provide public health services and

²¹ ASTHO, 2011, op cit.

programs. Two of these six states also explained that the SHA delegates authority for some public health services to LHDs. Rather than creating a contract for restaurant inspections, for example, the state delegates that authority to locals and local health agencies are permitted to charge fees or use revenue from taxes, as required, to cover the cost of providing that service. (In all the decentralized case study states, LHDs supplement these federal and state funds with local revenue.)

In addition to formula-based funding and contracts, some SHAs award funds through competitive grant opportunities. These competitive grants are often open to non-governmental entities, such as nonprofit organizations, community-based organizations, community action commissions, hospital groups, or other entities. Four of the decentralized case study states mentioned that they may compete with non-governmental organizations for funds. One of them explained that their state procurement office requires RFPs for some funding opportunities because not all funds can be directly granted to governmental entities. The same four decentralized states also said that LHDs in their state may compete with one another for funding. The health departments explained that while competitive grant opportunities may create competition among LHDs, they may also provide a window for cross-jurisdictional collaboration. LHDs may be able to submit joint applications to the state for funds, which allows them to share limited resources with one another.

In Oklahoma, the only mixed-governance state included in this study, the SHA contracts with the two independent health departments in much the same way as described above. The remaining LHDs operate under a centralized governance system; thus, the state health agency determines which services are provided by local public health units and the degree to which they are provided.

Because funding discussions have the potential to be contentious, some health departments discussed mechanisms that are in place to facilitate conversations between the state and local level. Several states described cooperative approaches by which the state seeks input on funding decisions from locals through subcommittees. Additional details about strategies states employ to negotiate about these financing issues are included in the next section.

Most of the states we spoke with expressed concerns about decreasing funds for public health. Many states have tighter budgets, which has led, in many cases, to reduced public health funds for LHDs. In light of reduced funds for public health, SHAs may decide to take more directive leadership on funding decisions. This was the case in one decentralized state, which no longer seeks consensus among locals for funding decisions due to budget cuts. In other states that were facing budget constraints, state representatives felt it was more important than ever to include LHDs in transparent discussions about the

allocation of limited funds. In one decentralized state, a local health commissioner explained that while the state's contribution to local funding for public health is not substantial, and has continued to decline, their continued contribution serves as a symbol of the state's commitment to work in coordination with the locals as partners.

Accomplishments

Building on efforts to increase communication and coordination among governmental public health agencies, state and local health departments have successfully negotiated challenging issues, including some related to public health budgets. They have also been able to collaboratively advance quality improvement and performance management initiatives. This section begins with specific areas where state and local health departments have successfully collaborated, and concludes by highlighting some of the collaborative activities directly related to the NPHII funding.

Navigating Difficult Decisions

Given current budget constraints, structured mechanisms for communication between state and local health departments are particularly important for discussions about the allocation of funds. The case study sites presented several examples of how states incorporate local feedback into financial decision making. In Arizona, Ohio, and Wisconsin, committees of LHDs provided input on the distribution of federal preparedness dollars to local health departments. For example, in Arizona, as a result of negotiations among state and local representatives, the state redesigned its preparedness funding formula to establish a base dollar amount for each county, with remaining funds distributed to each county based on population. As another example of local input on the distribution of public health funds, in Florida the Fiscal Management Advisory Council (FMAC), which includes both state and local public health representatives, prepared recommendations to the SHA for alternatives to a proposed 20%, across-the-board reduction in state funding for local public health.

Using structured processes to negotiate about potentially contentious issues extends beyond funding formulas. In Florida, a committee comprised of staff from the SHA, representatives of eight county health departments, and other stakeholders developed a report with recommendations for increasing the efficiency of the public health system. One of those recommendations was to pilot efforts to consolidate human resources, accounting, and other functions in a limited number of counties before implementing the consolidation plan more broadly. As part of the pilot project, the committee proposed that a series of process measures—for example, the number of days for processing paperwork—be tracked in order to

understand the impact of consolidation in these counties, to see if they save money, and to track any unintended consequences.

As another example, when the Arizona SHA decided to shift the focus of the state’s tobacco program from direct services to more policy-oriented activities (e.g., a social media campaign, and policies related to smoke-free housing and other issues), it realized the importance of involving the LHDs in the process. The SHA worked with local health officers to review the evidence behind the decision, vet the available options, and arrive at a mutually agreeable decision that benefitted the public health system as a whole.

Quality improvement and Performance Management

Efforts to strengthen state-local relationships have often gone hand-in-hand with activities to foster performance management and quality improvement (QI). The following examples illustrate how state and local health departments have worked together to improve the quality of services and operations.

- The Ohio Voluntary Accreditation Team, which is comprised of state and local representatives, was tasked with developing Ohio’s public health improvement standards. The committee recommended—and the SHA approved—that the state adopt the Public Health Accreditation Board’s (PHAB) standards as Ohio’s set of public health improvement standards. In addition, the SHA is now reporting on the same public health standards that LHDs are required to report on. According to one LHD representative, this commitment of the state and the collective accountability of all public health entities will facilitate state-local cooperation.
- Developed jointly by the LHDs and the SHA, the Standards for Public Health in Washington measure and evaluate public health performance at the state and local levels, with the goal of continuous quality improvement. Every three years, a review team consisting of state and local public health representatives conducts a visit to each health department—including the SHA—in order to assess health departments relative to the standards for public health, and to coordinate quality improvement efforts throughout the state.
- With input from LHD representatives, the Oklahoma SHA developed an online performance management system that allows county administrators to enter data and track progress on performance measures. The SHA is also reaching out to community partners through the national Turning Point Initiative in order to strengthen and improve public health decision-making and partnerships. Health assessments and health improvement plans are conducted at county health departments with Turning Point representatives.

As part of these initiatives to encourage engagement in QI activities, the state or SACCHO often compiles promising practices and makes them available online so that LHDs can learn from each other. For additional examples of how state and local health departments have collaborated in order to support performance management, see “Spotlight on National Public Health Improvement Initiative Grantees.”

Spotlight on National Public Health Improvement Initiative Grantees

Three of the case studies featured the work that state and local health departments engaged in using NPHII funding from the CDC. We briefly describe each of those initiatives below.

Massachusetts. With the goal of improving the scope and quality of local public health services and strengthening local public health infrastructure, the Massachusetts Department of Public Health launched an incentive grant program to support LHDs and other local entities in planning and implementing regional public health districts. Eleven districts—representing a total of 113 cities and towns and nearly 2 million residents—received planning grants. This funding allowed them to assess the feasibility of and develop plans for forming health districts that share services and staff in one of three models: consolidated districts, shared services, or contracting for certain services. After developing their plans, five of those districts received implementation grants. To support the LHDs throughout this process, the SHA hired two consultants to work with the grantees and provided technical assistance in such areas as developing needs assessments, conducting evaluations, and creating legal documents like MOUs.

Oregon. As part of its NPHII funding, the Oregon Health Authority's Public Health Division funded 13 of Oregon's LHDs that were identified as potential early adopters of accreditation to build capacity for and work towards accreditation. The SHA also provided resources to the SACCHO to hire the Local Accreditation Manager, who provides accreditation-preparation guidance and assistance to the LHDs not directly funded by the grant. The state also has provided opportunities for LHDs to collaborate with one another through bimonthly technical assistance calls and a peer-learning website to which LHDs can submit materials to be shared with other health departments engaging in accreditation-related efforts.

California. Three of California's public health departments—California Department of Public Health, Los Angeles County Department of Public Health, and County of San Diego Health and Human Services Agency's Public Health Services—received funding through NPHII. These resources are being used to help prepare for accreditation at those three health departments as well as others throughout the state. NPHII-supported activities include: hosting the Performance Management, Quality Improvement and Public Health Accreditation Summit; providing technical assistance and online training webinars; and developing the California Performance Improvement Management Network website, a central repository for documents and templates related to quality improvement, performance management, and accreditation. In addition, the NPHII program is helping the state to communicate to LHDs about public health meaningful use requirements of the Electronic Health Record (EHR) Incentive Program.

Challenges and Lessons Learned

The discussions with staff from state and local health departments yielded several strategies for strengthening relationships among the agencies they represent.

Making the Most of Workgroups or Committees

As mentioned above, many of the case study sites used workgroups or committees with state and local representatives as a tool to support collaborative decision making. The interviewees shared several pieces of advice for maximizing the effectiveness of this type of workgroup:

- It is important that the membership of the workgroup reflect the diversity of public health in the state—by including LHDs of varying size or representing different geographic regions within the state—because the same policy may affect a small, rural LHD very differently than a large, urban one. However, it may be the case that some LHDs are less able to actively engage in these types of initiatives. For example, LHDs with limited numbers of full-time staff may opt not to participate in state-wide initiatives or associations in favor of focusing limited staff time on service provision within their jurisdictions, thus foregoing representation at the state or national level.
- Having an LHD representative and an SHA staff member co-chair the workgroup is a useful strategy for building collaboration at the state and local level.
- Prior to meeting with the full workgroup, the chair may consider having one-on-one conversations with participants who are likely to oppose a particular recommendation. This preliminary discussion allows those participants to air their opinions in a private setting. It may then be possible to reach a compromise position prior to discussing the matter with the group as a whole.
- Engaging an outside facilitator can increase the likelihood that discussions will be productive. Facilitators can help develop meeting agendas, identify issues that need clarification, and resolve conflicts.

In addition to using the techniques described above to make the meetings of the workgroup most effective, it is also important to consider how to engage the LHDs that do not participate in the workgroups. For example, all local health officials in Florida can listen in on FMAC calls with the SHA. Although non-members cannot talk during these calls, they can send emails to FMAC members during the course of the call and ask the members to convey their questions or opinions.

Building Trust Through Frequent Contact

Opportunities for state and local public health staff to interact are important for developing strong relationships. Routine phone calls, in-person meetings, and visits to LHDs by SHA staff allow health departments to better understand each others' concerns. Unfortunately, travel restrictions that have been implemented as a result of the current economic downturn have reduced the capacity for some health department employees to travel. Interviewees noted that it will be important to compensate for those missed opportunities. For example, some discussed using more frequent video conferencing to try to maintain more personal interaction in the absence of face-to-face meetings.

States may also want to make the most of existing options for in-person meetings. For example, in Wisconsin all LHDs undergo a statutorily required review by state staff. While such an activity has the potential to be contentious, the SHA has strived to make these interactions with local representatives less stressful and less adversarial. Indeed, these reviews have the potential to strengthen the relationship between the state and the LHDs because they provide the opportunity for LHDs to showcase public health efforts—and for the state to learn about local activities—while simultaneously allowing the state to provide assistance and guidance for the highest possible level of achievement.

Another interviewee also agreed that increased interaction between the LHDs and the SHA may be beneficial. That individual noted that “forced cooperation” may improve communication from both sides of the public health system. As an example, for the Public Health Emergency Preparedness (PHEP) grant, the SHA must work in cooperation with LHDs; such a model could be utilized in other public health program areas.

Understanding Different Perspectives and Demonstrating a Commitment to Work Together

Several interviewees stressed the importance of SHAs recognizing the contributions that LHDs make to the public health system and vice versa. LHDs may be wary of the SHA if they feel that the state views them as “subcontractors” or creates a “parent-child relationship.” State-local relationships are more positive if the LHDs believe that the state views them as collaborators in the public health system and appreciates that many public health interventions happen at the local level. The leadership at the SHA is often instrumental in shaping the way LHDs perceive the SHA's attitude towards them.

One of the most powerful ways that an SHA can demonstrate commitment to working with LHDs is the way the SHA responds to cuts in its budget. LHDs are very appreciative if they perceive that the SHA makes reductions in its operating budget instead of, or in addition to, passing along cuts to the LHDs. This willingness to share in the sacrifice can help build trust among local health officers.

Just as it is critical for the SHA to acknowledge the important role that LHDs play in the public health system, LHDs must also realize the key contributions of the SHA. When funding is tight, local health departments—who are on the front line of service delivery—may express frustration about funds that are maintained on the state level. In those instances, it may be helpful for LHDs to recall the role that the SHA plays in supporting the state-wide public health system in terms of technology, laboratory services, and regulatory functions, among others.

In several interviews the SHA staff had previously worked in a LHD (or vice versa). Individuals who had worked at both state and local levels were perceived as having a greater understanding of the challenges at both levels. Seeking individuals with experience at other levels of government when making hiring decisions may be another strategy for building strong state-local health department relationships. In six of the case studies, interviewees mentioned the value of collaborating with individuals who have had experience at both the state and local level.

As another strategy for encouraging positive state-local interactions, one SACCHO representative recommends that LHDs acknowledge SHA activities that strengthen the state-local relationship, as this may provide “positive reinforcement” for behavior that LHDs would like to see replicated.

Conclusion

It is important for state and local health departments to work collaboratively in order to assure the public's health. In light of cuts in public health spending, it is particularly critical for SHAs and LHDs to be attentive to the contributions that the other makes to the public health system. Frequent communication and transparent processes for deciding how to operate under constrained budgets is helpful in navigating these challenging times. Many of the case study states initiated strategies to enhance communication around funding and policy decisions, including workgroups to allow a small group of representatives from the SHA and LHDs to address potentially contentious topics related to funding and shifting public health priorities; joint leadership calls and meetings; and the development of regional coordination efforts.

Through the current set of case studies we were also able to identify opportunities for SHAs and LHDs to engage together in performance management and QI initiatives. The NPHII program and PHAB accreditation have helped promote activities to strengthen state and local public health systems that will help move agencies towards accreditation, while further developing productive state-local relationships.