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FOUNDATIONAL PUBLIC HEALTH SERVICES AND OPPORTUNITIES FOR CROSS-JURISDICTIONAL SHARING IN KANSAS

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Introduction

As Kansas moves toward the concept of the Foundational Public Health Services (FPHS) for all Kansans, there is a need to examine possible governance structures that will enable efficient and effective provision of the services that will keep the public safe and healthy. Cross-jurisdictional sharing (CJS) provides one option for health department leaders, working with boards of health, to ensure that their communities have access to these public health services. The purpose of this document is to provide information about the history of CJS for public health in Kansas and the connections between CJS and FPHS using examples from other states involved in similar work. This information can be used by health department leaders and other public health stakeholders as they plan for implementation of the FPHS in Kansas.

Background

What are the Foundational Public Health Services?

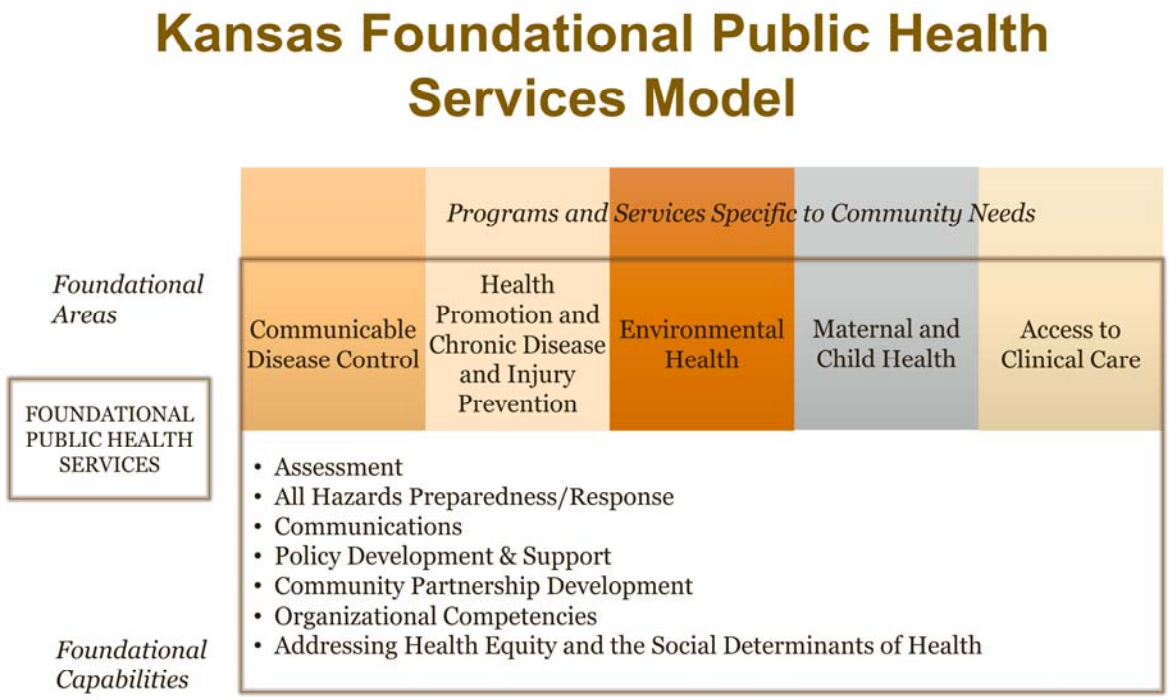
The FPHS model is a package of capabilities and services that must be provided to keep the public safe and healthy.[1]

In 2012, the Institutes of Medicine published a report entitled, *"For the Public's Health: Investing in a Healthier Future."*[2] As a response to the recommendation in this report to develop a "minimum package" of public health services, the Public Health Leadership Forum, with funding from the Robert Wood Johnson Foundation (RWJF), convened a group of stakeholders to explore ways to implement this recommendation. This work began in 2013 and was facilitated by RESOLVE, which is an independent, nonprofit organization which works to facilitate difficult public policy decisions. The result was a conceptual framework of capabilities and program areas that comprised the services that no public health department should be without.[3]

The FPHS model is the suite of skills, programs and activities that should be available in every community through state or local public health agencies as basic components to keep the public safe and healthy. The FPHS are primarily population-based preventive health services that are best addressed by governmental public health and may be mandated by state or federal law. The model consists of *Foundational Capabilities* and *Foundational Areas*. The *Foundational*

Capabilities are the cross-cutting skills that need to be present everywhere to ensure equitable and high-quality public health services. They are the essential skills and capacities needed to support the *Foundational Areas*, which are the substantive areas of expertise or program-specific activities.[4] See *Figure 1* for a visual representation of the Kansas FPHS model.

Figure 1. **Kansas FPHS Model**



Source: Kansas Public Health Systems Group, 2016.

There may be additional programs and activities that are of critical significance to meet a specific community's needs. These services are not included in the FPHS model because they are not expected to be present in all communities. However, they are still important services for the communities that need them.

FPHS in Kansas

In September 2015, the Kansas Association of Local Health Departments (KALHD) adopted the following vision statement:

"KALHD's vision is a system of local health departments committed to helping all Kansans achieve optimal health by providing Foundational Public Health Services (FPHS)."[5]

KALHD's adoption of this vision statement signaled a significant shift in the future of public health in Kansas. A statewide group of public health partners, funded by the Kansas Health Foundation, oriented the focus of their work around KALHD's vision statement and the implementation of the FPHS in Kansas. The group developed four subcommittees to explore the implementation of the FPHS: 1) Policy, 2) Assessment and Performance Management, 3) Legal, and 4) Fiscal. The tasks of these subcommittees were to:

- Define the FPHS for Kansas;
- Examine the capacity of the system to implement the defined list of FPHS;
- Develop a possible legislative model suitable for Kansas;
- Describe possible governance models; and
- Present options for funding the FPHS.

There are a variety of benefits to moving toward the FPHS in Kansas. A standard set of public health services ensures that certain services are provided to all Kansans, and it streamlines communication about public health's role to policymakers and the public. However, there are also some challenges to implementing the model, including funding the services and ensuring adequate staff and resource capacity in all communities.

FPHS and their Relationship to CJS

While some health departments already offer many of the capabilities and services that have been defined in the FPHS package, others need to build additional capacity for specific capabilities or activities. In these cases, especially when the health departments are located in jurisdictions with small and declining populations, sharing capacity and resources through CJS has been identified as one possible way to increase the quality and quantity of FPHS provided.

Several other states have already taken steps to move toward the implementation of the FPHS model, and some of these states have identified CJS as a key strategy for that purpose.

Additionally, as public health moves away from providing direct clinical services and toward health interventions that are population-based, sharing services across county boundaries is more feasible since there will be less face-to-face contact with individual clients.

Finally, in a time of uncertain funding at the local, state and national levels, it is critical to ensure that quality services are provided in the most efficient manner possible. CJS can be a tool to increase efficiency.

What is Cross-Jurisdictional Sharing?

CJS in public health is defined as:

"The deliberate exercise of public authority to enable collaboration across jurisdictional boundaries to deliver public health services and solve problems that cannot be easily solved by single organizations or jurisdictions."[6]

While not limited to public health, CJS has emerged as a strategy to ensure that the services provided by local health departments are effective and efficient at keeping the public safe and healthy.

The Center for Sharing Public Health Services (http://phsharing.org/) has developed a *Roadmap to Develop Cross-Jurisdictional Sharing Initiatives* which outlines the process of developing a CJS arrangement. The three phases of CJS include:

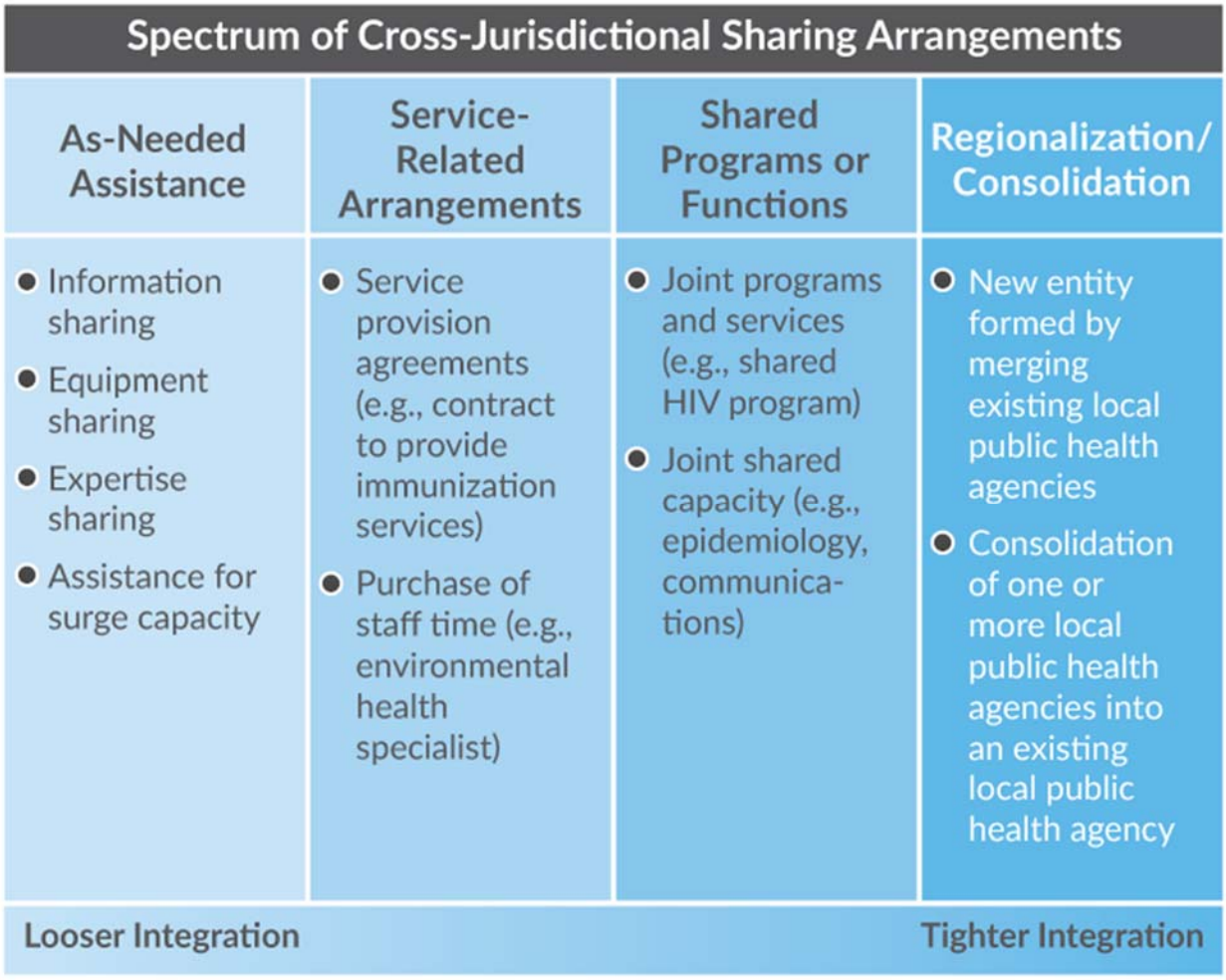
- Phase One—Explore;
- Phase Two—Prepare and Plan; and
- Phase Three—Implement and Improve.

The Center also has developed a variety of resources and guides to assist in the process of CJS development and implementation.

While some CJS projects involve the consolidation of multiple agencies, many more are based on agreements through which a specific set of functions or services is shared by health departments

that retain their overall jurisdictional autonomy, as shown on the *Spectrum of Cross-Jurisdictional Sharing Arrangements* (*Figure 2*).

Figure 2. **Spectrum of CJS Arrangements**



Source: Center for Sharing Public Health Services, 2017.

History of CJS in Kansas

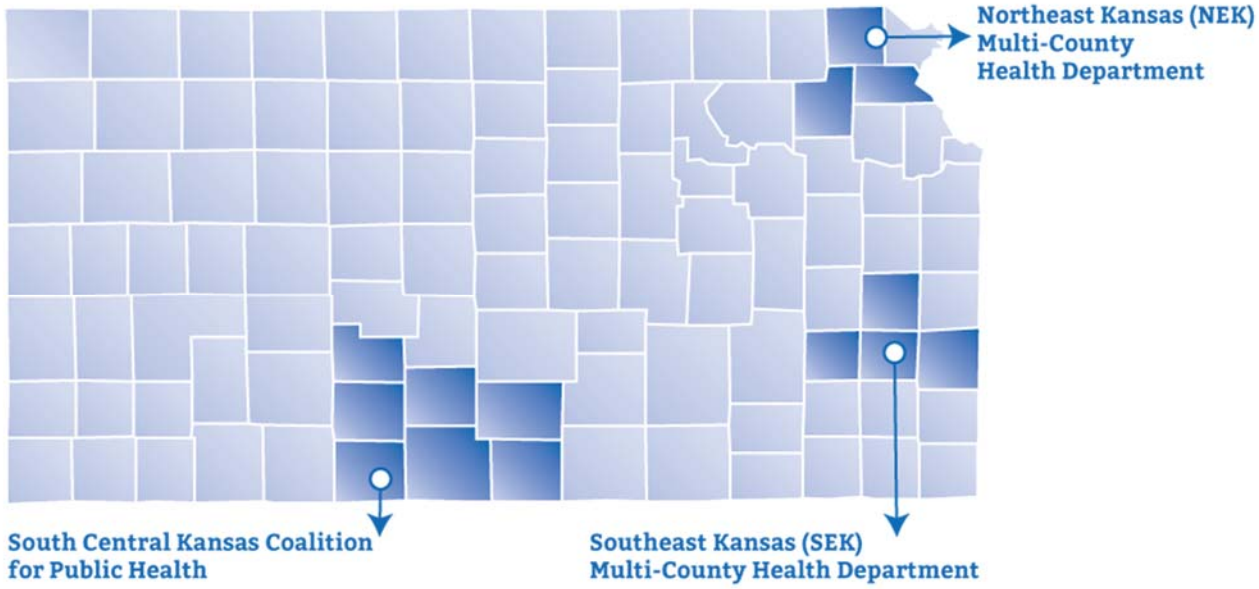
CJS has a long history in Kansas. Though there has been renewed interest in the topic in recent years due to declining financial resources and an increased focus on FPHS, there are several CJS arrangements in Kansas that have lasted 30 years or more. Understanding the development and evolution of these arrangements can help to shed light on current and future CJS activities.

In 1949, the first bi-county health department was formed between Butler and Greenwood Counties. This arrangement lasted for nearly 50 years before dissolving in the late 1990s.

The early 1970s saw the development of two multi-county health departments that still exist today. In 1971, the Southeast Kansas (SEK) Multi-County Health Department was formed between five counties: Allen, Anderson, Bourbon, Linn and Woodson. Today, four of the five counties remain part of the agreement (Linn County exited in 2006).[7] In 1972, shortly after the formation of SEK Multi-County Health Department, the agreement forming the Northeast Kansas (NEK) Multi-County Health Department was signed. Initially, this arrangement consisted of four counties: Atchison, Brown, Doniphan and Jackson. Doniphan County exited the agreement after one year, and the remaining three counties continue their relationship.[8] See *Figure 3* for the locations of the SEK and NEK Multi-County Health Departments.

The above agreements are tightly integrated models—in each of the above cases, a new public health agency was formed to provide public health services to all the participating counties. In the mid-1990s, a group of seven health departments in south central Kansas developed a different kind of partnership. Based on a desire to maintain local control and autonomy, these counties developed an interlocal agreement for public health in which each county retains its own public health agency, but shares some functions through an eighth agency, the quasi-governmental South Central Kansas Coalition for Public Health. In this model, three of the counties each have responsibility for one of the primary programs provided by the agency and serve in an administrative capacity by applying for and receiving grants on behalf of the region. The regional funds are then shared with each of the other health departments and services are provided at each agency.[9] See *Figure 3* (page 7) for the location of the South Central Kansas Coalition for Public Health.

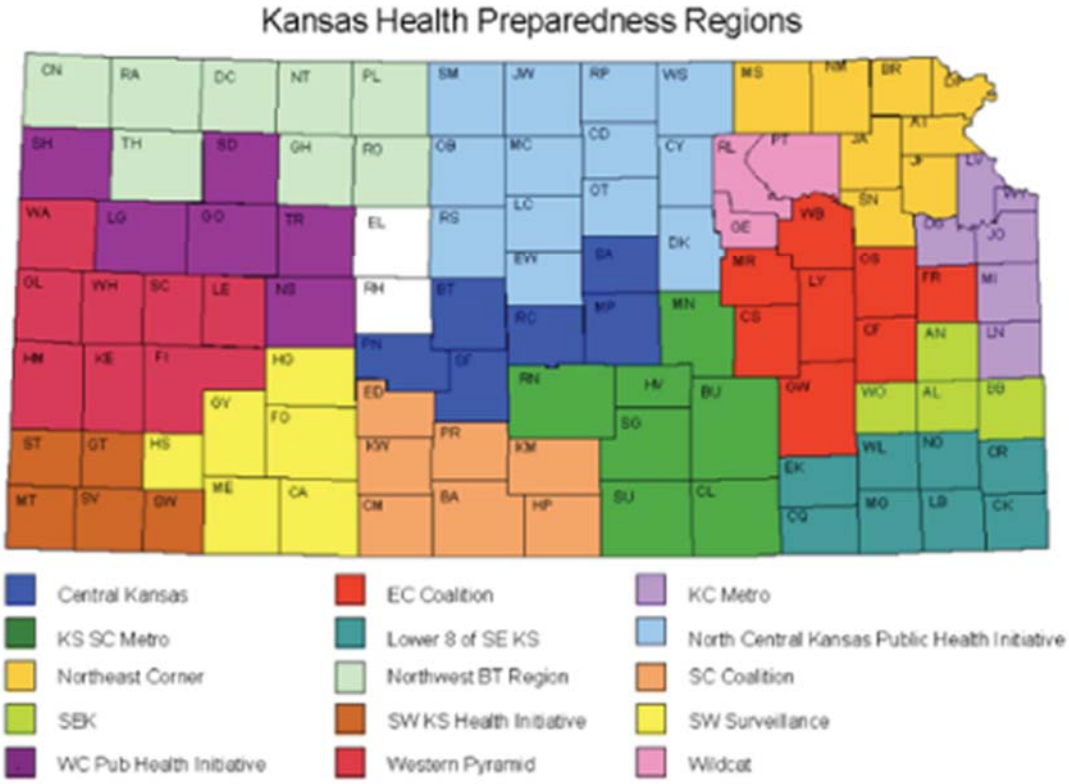
Figure 3. **CJS Case Studies in Kansas**



Source: Kansas Health Institute, 2015.

In 2001, in response to terrorist attacks and the possible threat of biological and other forms of terrorism, the federal government developed Public Health Emergency Preparedness grants to increase state and local capacity to respond to a variety of public health threats. In Kansas, portions of these funds were distributed to 15 self-organized regions each consisting of between three and fifteen counties (*Figure 4,* page 8). These regions are still operational, and currently only two counties do not participate. The regions have regular meetings with their preparedness partners to plan and accomplish regional work. These Public Health Emergency Preparedness regions are an example of CJS being used to increase capacity for emergency response in Kansas.

Figure 4. **Public Health Emergency Preparedness Regions**



Source: Kansas Department of Health and Environment Bureau of Community Health Systems, 2014.

Though the above examples are not specific to the relationship between CJS and the FPHS, the lessons learned from these existing arrangements in Kansas can be informative when looking toward the future of resource sharing in public health.

Experiences in Other States

Ohio

Ohio's local public health system is structured similarly to that of Kansas with decentralized governance of public health and a strong emphasis on home rule.[10] Like Kansas, Ohio also has a large number of health departments that serve small county and township jurisdictions. As of 2013, there were 124 local health departments serving 88 counties in Ohio, and more than half of the local health departments served fewer than 50,000 people.[11] [12]

The Association of Ohio Health Commissioners (AOHC) in 2011 established the Public Health Futures Project, which focused on identifying approaches to increase the effectiveness and efficiency of local health departments.[13] Initially, CJS and/or regionalization were the primary focus of the project. Eventually, it became clear that enhancing quality and assuring value should be the primary goals, and that sharing was a means to an end, not an end it itself.[14]

The AOHC *Public Health Futures Report,* published in 2012, identifies a "minimum package" of services that must be provided as basic public health protection in all communities. This minimum package is modeled after the FPHS.[15] [16] The Ohio minimum package was modified, however, to include the mention of CJS as a strategy for providing both the *Foundational Capabilities* and *Foundational Areas* (called core public health services).[17] A number of recommendations were made in the *Ohio Public Health Futures* report. Ultimately, 11 of these recommendations were made to the state legislature.[18] Of them, three recommendations mention exploring, encouraging and enabling CJS in Ohio:

- The multi-district public health levy allows multi-county tax levy authority for public health services.
- The state health department is encouraged to share model contracts, memorandums of understanding, financial and other technical assistance that are easily adaptable by local boards.
- Contiguous and non-contiguous city and county health districts are allowed to contract, consolidate or merge together within a "reasonable" geographic distance.

As a result of the recommendations and committee work, a bill was passed in 2014 that included the above recommendations, as well as:

- Block grant funding and regionalization of grants through the state department of health;
- A requirement that all local health departments meet Public Health Accreditation Board (PHAB) accreditation standards by 2018 as a condition for receiving funding from the state department of health;

- Authorization for the state department of health to reassign the provision of mandatory services from any local health department that cannot demonstrate it has the capacity to deliver the minimum package; and
- A requirement for the commissioners of health districts to collaborate with community organizations to conduct comprehensive community health needs assessments.

The requirements in the legislation not only encourage and enable CJS, they also include incentives for sharing and penalties for not meeting certain performance requirements. This approach has catalyzed the discussion around the role of CJS in Ohio.

Some of the resulting guidance surrounding CJS provides specifics on the recommendations for considering sharing services. The *Public Health Futures* report includes a graphic called the *Local Public Health Structure Analysis,* which outlines specific questions that health department leaders should answer when considering CJS.[19] Health districts that are not able to efficiently provide the minimum package are encouraged to consider consolidation or other forms of CJS. The ability to provide the minimum package is assessed based on the following three criteria:

1) Adequate funding to support the staff necessary for core services;
2) Adequate funding to support the staff necessary for the *Foundational Capabilities;* and
3) The ability to complete PHAB accreditation prerequisites and apply for accreditation.

Consolidation is encouraged when these requirements are not met and when the county has more than one health department (such as a city and a county health department) or serves a population of fewer than 100,000 people.

Other CJS strategies (such as service provision agreements) are encouraged when the county either has just one health department or the population size is more than 100,000 people. See *Appendix A* for a graphical representation of the *Local Public Health Structure Analysis.* As this work has progressed, Ohio stakeholders have found that the 100,000 population cutoff was not an effective target, and emphasis has since shifted toward the ability to provide the FPHS, regardless of size or location.

Oregon

Oregon, like Ohio and Kansas, has a decentralized public health system. According to the *2013 National Profile of Local Health Departments* published by the National Association of County and City Health Officials (NACCHO), more than half of Oregon's local health departments served populations of fewer than 50,000 people.[20]

Oregon's *Task Force on the Future of Public Health Services* was created in 2013 with the directive of providing recommendations for the future of public health. Their initial focus was also to study regionalization and consolidation of public health services in Oregon in order to make recommendations for legislation.[21]

As in Ohio, as the work progressed, the task force identified efficiency and effectiveness as primary purposes behind the request to examine regionalization and consolidation. They focused on a model that would improve efficiency and effectiveness of the public health system. Through this lens, Oregon's task force identified a minimum package of public health services that is based on the FPHS, and recommended legislation to support its funding and implementation.

In its report, *Modernizing Oregon's Public Health System*, the task force outlines an implementation strategy that gives health departments one of three options for moving forward:

1. As a single county,
2. As a single county with shared functions, or
3. As a multi-county district.

The second two options would require various CJS strategies for implementing the FPHS. The implementation recommendations that were offered are aimed at achieving sustainable and measurable improvements in population health services delivered through governmental public health.[22]

A recently conducted survey of local health departments in Oregon asked respondents to indicate potential future shared services. The most commonly cited opportunities include:

- Assessment and epidemiology,
- Prescription drug overdose prevention,
- Environmental health, and
- Emergency preparedness.

Additional recommendations include building upon existing relationships and sharing arrangements to build a foundation for future sharing.

Opportunities in Kansas

The work of moving toward the FPHS model is ongoing; however, there has been renewed interest and attention to the issue of resource sharing in public health, particularly in rural Kansas.

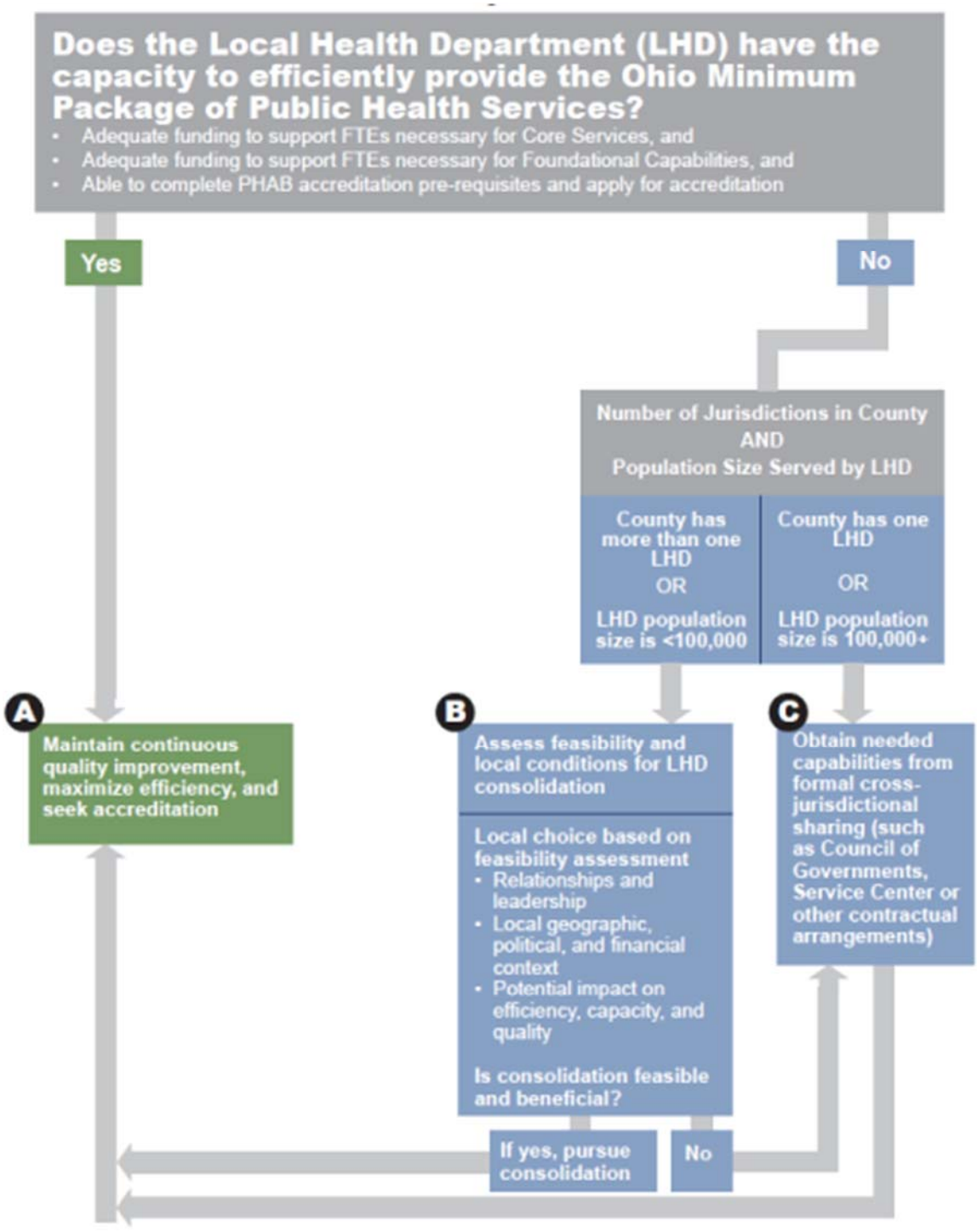
The examples offered in this report are instances where FPHS development and an emphasis on CJS strategies were complementary to each other. In contrast to the processes in Ohio and Oregon that began with CJS as the primary emphasis, the work of adopting a FPHS model in Kansas has placed increased attention on CJS as a potential strategy to increase the efficiency and effectiveness of the model.

The examples of the integration of FPHS and CJS in states with similarly structured public health systems offer food for thought as Kansas develops an implementation strategy for FPHS. However, due to the different context in which the decisions are being made, there are some important distinctions that should be made between these states' approaches and the Kansas model.

First, although Ohio has the most robust guidance around CJS and FPHS, the requirement to apply for accreditation by 2018 and to become accredited by 2020 has been a primary driving factor in the movement toward consolidation and other CJS efforts. In Kansas, this requirement

does not exist. The implementation of the FPHS model has been described as an achievable milestone on the journey to accreditation readiness, but there is no current intent to require all health departments to become accredited. Second, Ohio's guidance recommends that jurisdictions consider sharing if the population is less than 100,000. If adopted in Kansas, all but very few health departments would meet this criterion. In Kansas, more than 90 percent of health departments serve populations of fewer than 50,000, which is a large percentage when compared to the other states discussed in this report, in which approximately 50 percent of health departments serve populations below 50,000.[23] If Kansas puts forth guidelines similar to Ohio's guidelines for consideration of CJS based on population served, the threshold would need to be reconsidered in the local context. The high percentage of small health departments in Kansas presents additional challenges, both for efficient implementation of the FPHS as well as for identifying a unique model for CJS that maintains local autonomy and effective service for Kansas residents.

Appendix A. Ohio Local Public Health Structure Analysis



Source: Association of Ohio Health Commissioners, 2012.

Endnotes

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