Local Strategies for Cross-Jurisdictional Sharing

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Health Commissioner
Summit County Public Health
Why?
Rational

• Enhance efficiencies
• Gain greater joint capacity
• Strengthen existing collaborative relationships
Critical Criteria

- Governance
- Personnel
- Finances
- Public health services
- Facilities
- Legal issues
- Community and stakeholder participation
Lessons Learned

- Willingness
- Strong champion(s)
- Institutional Administrative Capacity
- Expect Hurdles (Roadblocks?)
- Establish a “why”; remember the “why”
Post Consolidations

• The City of Barberton saved $186,674 during the first year of consolidation.

• The City of Akron saved $1,318,420.

• 2008 - 2011, the three health districts paid $2,653,085 in accumulated sick and vacation leave entitlements, which significantly reduced future liability.
Public Health Service Changes

Perceptions of Overall Service Change During the First Year of Transition to an Integrated Summit County Health Department

<table>
<thead>
<tr>
<th>Survey Inquiry</th>
<th>#(% Answering Affirmatively)</th>
<th>#(% Answering Negatively)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have services been maintained at existing levels since January 1, 2011? *</td>
<td>83 (61.5%)</td>
<td>52 (38.5%)</td>
</tr>
<tr>
<td>Have services improved since January 1, 2011? **</td>
<td>42 (40%)</td>
<td>63 (60%)</td>
</tr>
<tr>
<td>Will the consolidation have positive impacts on public health services in the future? ***</td>
<td>95 (87.2%)</td>
<td>14 (12.8%)</td>
</tr>
</tbody>
</table>
## Overall Impact

### Public Health Capacities

<table>
<thead>
<tr>
<th>Audience</th>
<th>% Indicating Improved Future PH Capacities</th>
<th>Number of Usable Responses</th>
<th>Total Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCPH Supervisors</td>
<td>96.4% (27/28)</td>
<td>28</td>
<td>31</td>
</tr>
<tr>
<td>SCPH Non-Supervisory Staff</td>
<td>68.4% (54/79)</td>
<td>79</td>
<td>136</td>
</tr>
<tr>
<td>Summary Totals</td>
<td>75.7% (81/107)</td>
<td>107</td>
<td>167</td>
</tr>
</tbody>
</table>
## Overall Impact

### Perceived Pace of Progress in Pursuing Goals of Consolidation Among Differing Audiences

<table>
<thead>
<tr>
<th>Audience</th>
<th>Mean Perceived Rate of Progress (Scale: 5 = “very fast”; 1 = “no progress”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCPH Senior Managers</td>
<td>3.2 (Between “steady” and “Rapid”)</td>
</tr>
<tr>
<td>External Stakeholders</td>
<td>3 (“steady”)</td>
</tr>
<tr>
<td>SCPH Supervisory Staff</td>
<td>2.71 – 2.9 (Between “steady” and “slow”)*</td>
</tr>
<tr>
<td>Board of Health Members</td>
<td>2.23 (Between “slow” and “steady”)</td>
</tr>
<tr>
<td>SCPH Non-supervisory Staff</td>
<td>2.11 – 2.26 (Between “slow” and “steady”)*</td>
</tr>
</tbody>
</table>
Public Health Futures
Considerations for a New Framework for Local Public Health in Ohio
Since 1919, the number of functioning LHDs in Ohio decreased from 180 to 125

City-county unions (mergers)
Contract arrangements

LHDs currently engage in a great deal of collaboration and resource sharing (2012 AOHC survey results)

90% reported contractual arrangements
66% reported shared services or “pooling”
51% reported more sharing over the past four years (42% no change, 8% less)
Funding

• Ohio ranks 33rd in median per-capita LHD expenditures and 41st in state public health expenditures

• Local funding = about 75% of revenue
  ○ Varies widely by jurisdiction
  ○ Vulnerable to local political conditions

• State-generated revenue = about 6%
  Although 22% of revenue flows through the state (including federal pass-through)
Local Public Health Structure

Decisions about the jurisdictional structure of local public health in Ohio should be based upon LHDs’ abilities to efficiently and effectively provide the Minimum Package of Public Health Services.

Additional factors to consider:

a) population size served by the LHD
b) number of jurisdictions within a county, and
c) local geographic, political, and financial conditions. (see structure diagram and checklist)
Local Public Health Structure

Relationships, leadership, purpose
  History of collaboration
  Trust, personal relationships, leadership
  Clarity of purpose

Local geographic, political, and financial context
  Geographic density, dispersion, and size
  Customer service and public visibility
  Community identity and engagement
  Naturally-occurring regional boundaries

Demographics
Local funding
Local political support
Local Public Health Structure

• Most LHDs, regardless of size, may benefit from CJS. However, LHDs serving populations of <100,000 in particular may benefit from pursuing CJS or consolidation to ensure adequate capacity to provide the Minimum Package.

• LHDs in counties with multiple LHDs should consider the feasibility of voluntary consolidation.
# Cross-Jurisdictional Sharing Spectrum

<table>
<thead>
<tr>
<th>Informal and Customary Arrangements</th>
<th>Service Related Arrangement</th>
<th>Shared Functions with Joint Oversight</th>
<th>Regionalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Handshake”</td>
<td>Service provision agreements</td>
<td>Joint projects addressing all jurisdictions involved</td>
<td>New entity formed by merging existing LHDs</td>
</tr>
<tr>
<td>MOU</td>
<td>Mutual aid agreements</td>
<td>Shared capacity</td>
<td>Consolidation of 1 or more LHD into existing LHD</td>
</tr>
<tr>
<td>Information sharing</td>
<td>Purchase of staff time</td>
<td>Inter-local agreements</td>
<td></td>
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<tr>
<td>Equipment sharing</td>
<td></td>
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<tr>
<td>Coordination</td>
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