

Commentary

Cross-Jurisdictional Approaches to Meeting PHAB Standards and Achieving Accreditation

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With more than 2000 public health departments present in the United States, discussions are taking place about how to assure that as many of them as possible provide high-quality services and meet the requirements established for national accreditation. At the same time, resources at all levels (federal, state, and local) are decreasing. As public health departments at all levels (tribal, federal, state, multi-jurisdictional, and local) face greater challenges with fewer resources, they are looking for ways to deliver services more efficiently and effectively. Cross-jurisdictional sharing (the process of sharing resources across jurisdictional borders) has been proposed as a possible solution. This commentary will examine how cross-jurisdictional sharing (CJS) can help public health departments and their partners improve services and capabilities. We also will provide information about a new initiative to explore the use of these arrangements in public health and outline how the Public Health Accreditation Board (PHAB) has modified its accreditation process to acknowledge the influence of CJS.

This strategy helps ensure that local health departments can efficiently and effectively deliver the range of services and capabilities necessary to protect and improve the health and well-being of our communities. Some public health leaders¹ see CJS as a possible means of improving local public health performance and effectiveness. Several factors shape this perspective, including the following:

- Continuing evolution of a set of “foundational capabilities” for public health departments identified by the Institute of Medicine.²
- Establishment of national public health accreditation standards.

- Growing recognition that funding for local public health will not increase much, if at all, for the foreseeable future.
- Awareness that many of the nation’s local health departments, as currently structured and resourced, may not be able to carry out all the “foundational capabilities” nor be able to meet national accreditation standards.

At the same time, some local and state policymakers and administrators view CJS as a potential tool to address issues of increased efficiency and cost control.³ During the recent fiscal downturn, CJS arrangements were implemented for a range of public sector services. Even if fiscal conditions improve for state and local governments, it is reasonable to assume that a practice seen as more efficient or economical will be continued and possibly used in new public sector areas.

Because the authority to enter a CJS arrangement more often resides with policymakers than with health officials, those in public health considering sharing resources across jurisdictions as a means of performance improvement must be aware that policymakers and administrators value the efficiency and cost-control aspects of CJS. However, policy objectives of improved performance, increased efficiency, and cost control through these arrangements are not necessarily antithetical. Achieving these objectives requires awareness

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and articulation of the interests, issues, and goals of all parties from the outset.

To explore the effects of the application of CJS models in various settings, the Center for Sharing Public Health Services (www.phsharing.org) was created in May 2012 as a national initiative managed by the Kansas Health Institute with support from the Robert Wood Johnson Foundation. The Center’s primary role is to help public health agencies explore, inform, track, and share learning about CJS approaches to delivering public health services. The target audiences for the Center’s activities are policymakers, who often have the authority to approve such agreements and governance models, and public health officials, who often play a critical role in shaping and implementing those agreements, as well as professional organizations representing those groups.

There are several examples of successful CJS initiatives, including the West Central Public Health Partnership involving 6 counties along Colorado’s Western Slope.⁴ However, there are no clearly identified models that can be disseminated and no well-established mechanism to share the information available on this issue. The Center supports teams across the country wishing to explore innovative approaches to CJS and by translating and sharing the information available and “lessons learned.” While the Center does not promote CJS as a solution that should be embraced by all health departments, it encourages and supports exploration and disseminates information.

In January 2013, the Center announced grants totaling approximately \$2 million to 16 teams of health departments in 14 states (Figure 1). Teams of public health agencies, policymakers, their partners, and key stakeholders will work together for 2 years as 1 learning community to find shared solutions and innova-

FIGURE 1 ● The Center for Sharing Public Health Services—Funded Sites in the Shared Services Learning Community (For More Information, See [http://www.phsharing.org/sites/.](http://www.phsharing.org/sites/))



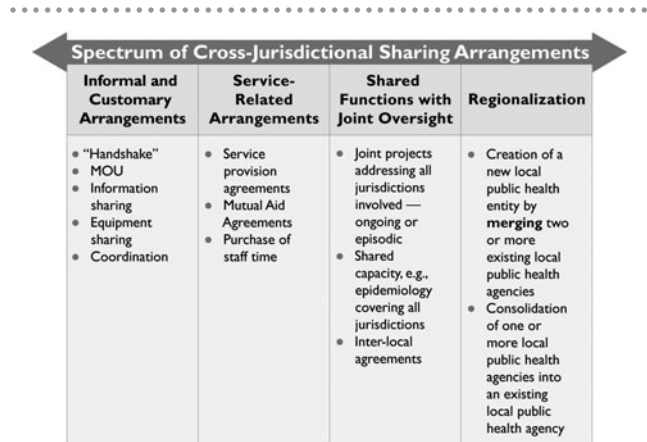
tive approaches to service delivery. Each funded team must include policymakers and public health officials, with representatives from at least 2 jurisdictions, and be committed to increasing efficiency and effectiveness in its CJS approach. The team projects range from those exploring preliminary options to others that are formalizing and strengthening existing agreements or fully consolidating multiple agencies into 1 new entity and reflect the CJS spectrum illustrated in Figure 2.

The Center communicates these CJS activities and provides technical assistance to the 16 teams and others in the broader public health arena. Examples of the Center’s activities include the development of decision-making tools, case studies, expert consultation, e-newsletters, a data bank (with both peer-reviewed published articles and other unpublished documents), issue briefs, and videos.

PHAB has recognized the importance of acknowledging the role that CJS agreements may play in improving readiness for accreditation. Such agreements may be used by individual health departments to provide evidence that certain requirements are met through shared functions, programs, or capacity. In addition, early in the accreditation design process, PHAB determined there should be a category that allows multiple jurisdictions to apply for accreditation. PHAB created an expert panel to produce recommendations on policies and practices for applicants who meet the PHAB-approved definition for joint accreditation: “if some essential services are provided by formally sharing resources and the manner in which this occurs is clearly demonstrated.”⁵

The panel interviewed stakeholders and identified key issues, potential solutions,⁶ and recommendations for the joint accreditation application process. A PHAB subcommittee reviewed the panel’s work and made the

FIGURE 2 ● The Spectrum of Cross-Jurisdictional Sharing Arrangements, From Informal Agreements to New Public Health Entities



following policy and process recommendations, which were approved during the June 2012 PHAB meeting.

- Only health departments in the multijurisdictional category will receive accreditation, because PHAB does not accredit governance structures. All health departments in a multijurisdictional application will be eligible to receive accreditation under that application.
- Multijurisdictional applications must demonstrate a high degree of interdependence. The health departments in the application must have a strong track record of working together and not be able to fulfill their public health role in assuring the 10 essential public health services without their interdependent relationship. The degree of interdependence will be measured by the health departments' demonstration of joint work in at least half of the accreditation domain areas, documented in the majority of the measures within those domains.
- Applications with geographically contiguous jurisdictions are preferred, unless a solid explanation for a working relationship that is not geographically contiguous can be made.
- The number of health departments included in a multijurisdictional application can be limited if the number exceeds that which PHAB can reasonably include in a single review process.
- The review process for a multijurisdictional application will proceed according to the same review process as for any other local health department.
- Once a site visit team assesses a particular document for 1 health department in a multijurisdictional application, that documentation will not be assessed again for the other health departments in the application. That is, once a measure is met by shared documentation, it is met for all health departments in the multijurisdictional application. However, each health department must demonstrate how the documentation is applied and operationalized.

In summary, CJS is one possible approach with the potential to enhance the quantity and quality of public health services available at the local level, improve

efficient use of resources, and increase accreditation readiness. The results of CJS initiatives will have to be monitored and analyzed to assess the value and general applicability. Critical questions currently remain largely unanswered. For example, what are good predictors of successful sharing efforts? What is the fiscal impact of these initiatives in different settings? What are the effects of CJS approaches on the quality and quantity of services offered by public health agencies? Are arrangements to share across jurisdictions likely to increase readiness for accreditation? What are the differences in the application and results of CJS agreements in centralized versus decentralized states?

These questions are relevant to the public health practice community, as well as researchers and policymakers interested in innovative approaches to the delivery of public health services. The Center for Sharing Public Health Services and the exploratory projects that it is funding will help generate knowledge in these areas that can contribute to the development of successful models and practices.

REFERENCES

1. Centers for Disease Control and Prevention (CDC). *State, Tribal, Local and Territorial Workgroup Recommendations to the Director*. Atlanta, GA: CDC; 2012.
2. Institute of Medicine. *For the Public's Health: Investing in a Healthier Future*. Washington, DC: Institute of Medicine; 2012.
3. International City/County Management Association. *Coping With Crisis: How Are Local Governments Reinventing Themselves in the Wake of the Great Recession?* Washington, DC: International City/County Management Association; 2011.
4. The Colorado Trust. *The West Central Public Health Partnership: A Case Study in Public Health Collaboration*. http://www.coloradotrust.org/attachments/0001/8941/PFH_CaseStudy_090612-FINAL.rev.pdf. Published September 2012. Accessed July 7, 2013.
5. Public Health Accreditation Board. *Who is eligible?* <http://www.phaboard.org/accreditation-overview/who-is-eligible/>. Accessed April 12, 2013.
6. Public Health Accreditation Board. *Multi-Jurisdictional Applications Expert Panel Report*. Alexandria, VA: Public Health Accreditation Board; 2011.