

REGIONALIZATION

Exploration of an Alternate Organizational Model

Melissa C. Tidwell

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This paper is presented in response to a request from Barry Smith, JD, President of the Oklahoma State Board of Health, and as part of the author's preparations toward a Master's of Health Administration, through the University of Oklahoma College of Public Health . It examines the concept of a regionalized organizational structure in relation to Oklahoma's public health system. It is the author's intent to offer an unbiased presentation of current information pertaining to this subject. It is not the author's intent to present recommendation for or against regionalization, but to instead present a broad model of regionalization possibilities.

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INTRODUCTION

Public health is charged with ensuring the health of the citizens of this nation, most often performing in a quiet manner. Events in recent years moved the role of public health to the forefront. The terrorist attacks of 9/11, natural disasters, SARS and pandemic influenza place focus on the importance of a strong public health system. In a time of financial crisis, health care reform leaders identify prevention as a cost effective tool for improving the health of the nation. At no other time has public health been in a better position to take the lead role in the nation's health and safety related issues.

In its classic 1988 report, *The Future of Public Health*, the Institute of Medicine (IOM) spurred public health leaders to seek system changes. It warned that the public health system had fallen into "disarray" and that contributing to the fall was a disorganized infrastructure and poor leadership.¹ In response, research and innovative practices were instituted and from them a new definition of public health emerged. Risa Lavizzo-Mourey, Robert Wood Johnson Foundation (RWJF) President and CEO, describes the "new public health" as:

- accredited and accountable to the local communities
- performing to evidence-based standards of quality
- engaged in the political process
- reliant on evidence to determine how to improve processes²

She states that community partnerships are a must in the development of new public health practices.² These are concepts that are repeated throughout current public health literature and classrooms.

Where does Oklahoma's public health system find itself in relation to these current demands and new practice standards? With outdated system processes, historically poor legislative relations, a history of scandal, a dismal financial outlook, a fractured organization and citizens with health outcomes among the lowest in the nation, it might appear that Oklahoma's public health system is in dire straits. On the contrary, it is in a position to make evidenced-based changes toward a successful and dynamic future. Oklahoma's public health system finds itself with a new Commissioner bringing needed change and leadership; a capable State Board of Health willing to be actively involved in improving the state's health; a dedicated workforce knowledgeable in public health practice; a legislature ready to make needed statutory changes and funding allocations; Oklahoma City County and Tulsa Health Department leadership open to new partnerships; private foundations interested in promoting public health, and community collaborations proving to have influence on health practices. Oklahoma's public health system is in a position to step up as an innovative leader and champion in the public health arena; but to do so, it has to embrace change, set high standards, form partnerships and move forward

with purpose. That purpose is to protect and promote the health of the citizens of Oklahoma, to prevent disease and injury and to assure the conditions by which citizens can be healthy.³

ORGANIZATIONAL GOVERNANCE AND STRUCTURE

National Organizational Governance and Structure

Public health does not have a standard for organizational governance or structure. State agencies and local health departments vary greatly across the nation. In an attempt to categorize governance for public health delivery, NACCHO recognizes three types of authority:

- *Decentralized* - where all local health departments are under the authority of the local municipal government
- *Centralized* - where either all local health departments are under the authority of the state or there are no local entities and the state provides all local services
- *Mixed* - where some local health departments are under the authority of the state and some the local government⁴

The 2008 NACCHO *National Profile of Local Health Departments* indicates that twenty-nine states report decentralized governance, six report centralized governance and thirteen report mixed governance. Of the centralized and mixed governances, most are in the southern half of the nation.⁴ Centralized authorities are usually in rural states where local governmental entities do not have the capacity to administer local health departments. Both mixed and decentralized authority are recognized as being more responsive to local needs and the community has greater input in decision making.⁵ Mixed authorities improve intergovernmental relationships and partnering.⁶

Local health departments may serve cities, city-counties, town-townships, single counties, multi-counties, districts or regions. Nationally, sixty percent of local health departments report county jurisdictions; twenty-nine percent report city, town-township or city-county jurisdictions, and nine percent report multi-county, district or regional jurisdictions.⁴

The US Constitution charges the protection and guaranty of the health of its citizens to the states in which they live.⁷ State public health systems are governed by legal statutes or regulations. All states have a state agency that to some degree oversees the public health system. Some states have state boards of health and some do not. State agency structures have great variance.⁷

Oklahoma Organizational Governance and Structure

Oklahoma's public health system is recognized as having a mixed authority type. This is because Oklahoma City-County and Tulsa County Health Departments are independent entities and are governed by local municipalities. The Oklahoma State Department of Health (OSDH) functions as a centralized system. All other county health departments are under its authority.

Of the seventy-seven Oklahoma counties, seventy-five are under the OSDH centralized administrative structure, with seven counties having no functioning local health department. Within this system are eighty-eight operational health departments, all having county jurisdictions.⁸ The counties are divided into seventeen administrative districts.⁹ This places an added level of administration between local departments and the state agency. As of 2001, twenty states had elected to establish an intermediate administrative position between state and local health agencies.⁶

Oklahoma Legal Governance and Structure

The *Oklahoma Public Health Code* defines the powers and duties of the State Board of Health, the State Department of Health, the State Commissioner of Health as well as local public health boards, departments and their agents.

Among other powers, the State Board of Health may:

- adopt rules and standards it deems necessary to carry out the *Public Health Code*
- accept and disburse any financial gifts, disbursements, grants, etc. given to it
- establish divisions, sections, bureaus, office and positions within the State Department of Health¹⁰

The State Department of Health is to:

- perform duties and responsibilities as directed by the Commissioner
- ensure compliance with relevant provisions of the act
- fix and collect fees related to the certification of health maintenance organizations¹⁰

Among other duties, the State Commissioner of Health:

- is responsible for the general supervision of the health of the citizens of the state
- is the executive officer and supervisor of the activities of the State Department of Health
- appoints and fixes the duties of any employees needed to run a local health department¹⁰

A county Medical Director directs the operation of all local health departments. If a full-time Medical Director is not working, the Commissioner may appoint another nonmedical employee of the local health department (Administrator) to fulfill the duties. The Administrator will work under the supervision of the Commissioner and will have all the powers of the County Superintendent of Health.¹⁰

The maintenance and operation of the local health department is a function of the county government. The *Public Health Code* allows for (with the permission of the Commissioner) the organization of county, district and cooperative departments of health. Two or more counties may form a Health District with a district local health department. A district health department is to be run just like a county health department. County boards of health may enter into agreements with other county or city boards of health, towns or school districts lying wholly or partly within the county, in order to establish cooperative departments of health. Agreements will stipulate what health services will be provided and where they will be provided. They may be all or part of the services normally provided by a county health department. Any agreement will fix the amounts of funds to be paid by the cities, towns and school districts for the services.¹⁰

Any local board of health may contract with the department of health of any neighboring county or with the State Department of Health to provide the county any or all public health services. The receiving county will pay fees for services to the county rendering the services. The fee schedule will be agreed upon by the State Board of Health and the counties affected. Payments will be equal to the cost of the services provided. Local health departments may (with the approval of the Commissioner) enter into agreements with individuals and with public and private agencies to provide health services. Local health departments may collect and/or pay fees for services rendered.¹⁰

The *Public Health Code* addresses the formation of city-county health departments in counties with a population of more than two hundred twenty-five thousand (225,000) and a city within its boundaries with a population of more than one hundred fifty thousand (150,000), according to the most recent federal census. These departments are governed by the local municipality and operate independently of the State Department of Health.¹⁰ As mentioned, Oklahoma and Tulsa counties have established independent health departments. Cleveland County may meet the statutory requirements to establish an independent department of health, after the 2010 federal census.¹¹

REGIONALIZATION

Decentralization and Its Relation to Regionalization

Any discussion of regionalization should first explore *decentralization*, a concept that has been discussed and utilized within public health and private organizations for many years. For public health purposes decentralization is defined as, “the process of redistribution of administrative authority, and sometimes resources, to local communities for planning, program management and evaluation”.¹²

There are four forms of decentralization:

- *Political* - authority is delegated to lower levels of authority
- *Administrative* - greater authority is given to managers, including financial discretion accompanied by increased accountability

- *Internal* - authority is delegated to existing tiers in the hierarchy
- *External* – authority is delegated to newly established units, some with separate legal status (external decentralization is the most radical for and the hardest to reverse)¹³

Decentralization in the public health system has shown to:

- facilitate public participation
- allow greater local and personal control over determinants of health
- spur cooperative action among coalitions of stakeholders at the local level
- result in more appropriate decisions concerning health planning within communities
- enhance community empowerment and local autonomy^{12,13}

Successful decentralization depends on the provision of adequate resources and assistance to local communities and not all services or resources have to be decentralized¹² Both private and public organizations use decentralization as a popular tool of management, resulting in innovative and efficient delivery practices. Current thinking is that it is best to place decision making as close to the source of delivery of services as possible. In a complex market such as the public health system, economists support the fact that decision making is more powerful and effective, when decisions take place in a decentralized market.¹⁴

A study on the decentralization of the public health system in Spain finds that decentralization encourages innovation and the deconstruction of the status quo. More diversity in the delivery of services occurs, resulting in better health outcomes. Foundations are developed and community involvement is increased. Financial decentralization results in more fiscal responsibility and per capita funding increased, with the introduction of funds from outside sources. Local administrators contract services and form public-private partnerships. Decentralization results in increased transparency and accountability. When mistakes are made in a hierarchical structure, they are less evident than in a local organization. A fully centralized system protects those who perform at lower levels. The Spanish system shows that, if change only occurs at the macro-system level and does not affect the working conditions, autonomy or responsibility and financial risks, it may do little to provide true health care reform. It is better to innovate on a local basis. Local innovations and changes accommodate stakeholders' interests and lead to greater reform.¹⁵

Regionalization has been described in many terms, but generally it describes a situation where two or more towns, cities or counties join together to provide public health services to a geographic area. Regionalization can occur without decentralization. A centralized public health system may regionalize its organizational structure while maintaining centralized authority. This results in delegation of increased responsibility with no authority. In such cases, the advantages of decentralization are lost. Decentralization is an important organizational tool and must be considered in conjunction with regionalization.

Reasons for Exploring the Possibility of Regionalization

Reports proposing regionalization of public health services go back more than fifty years. Recommendations for consolidating small local health departments noted small departments' lack of efficiency and coordination of services, inconsistent administration and inadequate resources to carry out primary public health functions.¹⁶ The *2008 NACCHO National Profile of Local Health Departments* support these recommendations.⁴

Multi-county, district and regional local health departments provide a more comprehensive set of services than do smaller departments. Educational levels of local health department administrators are higher in departments that serve larger areas. Smaller health departments have more difficulty attracting and retaining qualified staff and are less able to provide staff training and credentialing. Smaller health departments report more budget constraints. Local health departments serving one-hundred thousand to two-hundred and fifty thousand populations are most efficient in utilizing employees. Departments serving larger areas are more likely to have completed Community Health Assessments (CHAs) and Community Health Improvement Planning (CHIPs). They are more likely to select services to address health disparities, participate in performance improvement activities and plan to seek voluntary accreditation.⁴ Regionalization allows smaller health departments to join together and provide services for larger populations, thereby essentially functioning as a larger health department.

Many organizations other than public health agencies already incorporate regionalization. In the public sector, hospitals, schools districts, higher education centers, law enforcement and community co-ops are examples of organizations that have regionalized services.¹⁷ Organizations find that regionalization offers benefits from economies of scale, the ability to spread costs over larger populations and tax bases and larger pools of community partners.¹⁷

The Oklahoma public health system already takes advantage of regionalization in many areas: Turning Point Initiative; Take Charge; Environmental Health; Long Term Care; Emergency Preparedness; records consultants; district nurse managers; disease intervention specialists; state auditors, and administrators. Many more services readily lend themselves to regionalization, such as vital records, epidemiologists, training coordinators, public information officers, marketing specialists and program consultants.

As discussed previously, the new direction of public health is based on accreditation, quality improvement, performance standards, advocacy, a systems approach, collaboration and a relentless reliance on research and evidence.² There is a general consensus among public health leadership that standards of practice, performance measurement as well as accreditation requirements should be based on the *10 Essential Public Health Services* (see appendix). Many smaller local health departments do not have the capacity to provide the *Essential Services*.⁴ Regionalization is often cited as a tool to enhance local health departments' ability to provide these services, meet accreditation requirements and performance standards, gain local power for advocacy, expand partnership bases and increase collaboration and pool resources to meet the demands of research and evidence based practices. As one of the preeminent supporters of public health, the RWJF is a strong proponent for regionalization and

has supported many studies and pilot practices related to the concept. The Foundation believes that regionalizing public health agencies may enhance their effectiveness in the areas of importance related to new public health practices.¹⁸

Process to Identify Whether Regionalization Should be Initiated

Although the processes through which public health systems regionalize are varied, general consensus is that the functionality of regionalization should be based on the ability to provide the *10 Essential Public Health Services*. Since form follows function, the choice to regionalize and the processes to follow, should be based on whether regionalization will improve the ability of the involved health departments to provide the *Essential Services*. Formation of a regionalization planning team should occur.¹⁹ This team should be charged with first determining if regionalization is needed and, if so, overseeing the project. Once regionalization is in place, the team can act as a regionalization advisory group.

Assessment of the current system is the logical first step in determining if regionalization is necessary. The *National Public Health Performance Standards Program's (NHPSP's), Local Public Health System Performance Assessment* is a nationally recognized assessment tool. It answers the questions, "What are the activities and capacities of our public health system?" and "How well are we providing the *Essential Public Health Services*?"²⁰ If the current local public health system is unable to provide the essential services, the assessment should be looked at from a regional basis, to determine if regionalization can improve the capacity to meet the standards. If so, this can guide the formation of clear, measurable goals by defining the problems to be solved and the method in which solutions will be evaluated. Decisions regarding the formation, governance and structuring of the regionalized system must be made. Evidenced-based decision making must be the rule.²¹

Formation, Governance and Structuring of a Regionalized System

Formation

Formation of organizational regions begins in one of two ways, either voluntarily or involuntarily. Regionalization may be mandated from a lead agency; however, a *bottom-up* approach has been shown to be most effective.²² With this approach, involvement is voluntary and regions are allowed to self-form. Local officials and stakeholders are involved in the decision-making process. All involved parties must have a full understanding of the benefits of establishing regions.^{22,23} Financial incentives may be offered to encourage involvement; however, incentives must be rewarding enough to off-set the work of forming the region.²⁴

Four approaches to regionalization have been identified: networking; coordinating; standardizing, and centralizing.²⁵ *Networking* is usually the first aspect of regionalization. Individual entities voluntarily share information and approaches to practice. Mutual benefit occurs and there is no formal management of activities. Networking is seen in newly form regions. *Coordinating* occurs when entities work together to plan events. There is intentional management of activities. Coordination is seen in regions with well-established, independent

health departments. *Standardizing* creates uniformity across areas. Mutual adoption of tools, procedures and information dissemination may be initiated. Management of activities occurs, but control remains under local jurisdictions. Standardization is used less frequently than other approaches. *Centralization* occurs when resources are brought together and controlled by a single regional entity. Management of activities is centralized. Most regions utilize this approach. Regionalization may begin informally and evolve into a formal approach.²⁵

Governance Models

Once formalized, regions must identify a decision-making process led by a governing authority. Three main regional governance models have been identified: single-lead model; not-for-profit lead, and intermunicipal agreements.²⁶

The *single-lead model* is the most often used. It is easily understood and offers administrative simplicity. However, it is not usually popular with all involved and may not be the best choice in many situations. In this model, the state agency identifies a larger, local health department as the lead entity over a region consisting of smaller health departments. The lead department then must take on the liability and financial responsibility of the region. The non-lead, departments may feel a lack of financial control and end up being marginalized. Traditionally with the single-lead model, authority flows from the state agency to the lead agency and then to the smaller agencies. The lead agency becomes the legal entity in contracts with the state agency, receives funding and disperses within the region as it sees fit.²⁶

Benefits of a single-lead model include: (1) it is easy to implement fiscally and administratively; (2) it is a stable model of governance, and (3) it is cost-effective. Disadvantages include: (1) legal liabilities for the lead agency; (2) financial liabilities for the lead agency; (3) non-lead agency concern with equal distribution of funding, and (4) decreased local control.²⁶

There are four types of *not-for-profit (NFP) leads*: provider consortia; associations; universities, and other. The NFP becomes the funding agent and takes on the financial and legal liabilities for the region. The NFP lead is a stable form of governance and has few disadvantages. The NFP may not be a permanent entity, so sustainability can be an issue. There may be philosophical differences between the NFP and the participating health departments. Most NFPs have access to multiple resources which can be beneficial to the region.²⁶

Incorporated *provider consortia* often grow out of collaborating partnerships. Each participating health department is a member of the consortium. The consortiums role is to manage the region's projects and provide administrative services. Funding for the region flows through the consortium. *Public health associations* may be good project partners. They may provide consultation and be able to direct funding. In some circumstances, they can direct day-to-day operations. *Universities* can be contract partners, but they often come at high prices. Depending on state statutes, *established health departments* may be able to contract to allow funding to flow through them, apart from direction of a state agency. *Coalitions or collaborations* may become an umbrella organization to a region, covering its legal and funding needs.²⁶

Inter-municipal agreements allow one municipality to perform a service on behalf of another, or for multiple municipalities. They must be allowed legally by state law. The lead municipality may charge for services. The counties receiving services may perceive a lack of control. This model works best when only two counties are involved.²⁶

Community Partnerships

Community partnerships have grown in popularity as governing authorities for health regions. Stakeholders recognize that the complex issues related to today's public health needs require knowledge and resources that must span across multiple community partners. Coalitions and collaborations are a good way to combine the knowledge, expertise and resources of a wide array of people and organizations. The partnerships' sense of ownership and sustainability of purpose have impressed on external funding sources that collaborative partnerships with shared ownership and leadership are successful.²⁷

Research shows that even externally funded partnerships that are developed based solely in response to a targeted funding opportunity are viable options for governance. In order for collaborations to flourish, decision making among the members must be shared and the region must be able to develop their own plans and ideas for service provision. It is when stringent directives are forced on the partnerships, that they lose their effectiveness. It is important for collaborations to have the ability to write grants and understand the need for a strategy for long term sustainability, even past the period of funding. Flexibility is another key to success. Defining and developing goals over time has proven to be most successful. Funding may be provided for open-end goals and may require that payment is tied to periodic evaluation of progress toward the goals.²⁷

Whether regions are formed voluntarily or are mandated, key issues must be in place. Criteria for governance models are suggested to include: (1) compatible purpose and scope; (2) flexibility; (3) authority; (4) accountability; (5) cost efficiency; (6) sustainability; (7) technical and management abilities; (8) protection of local interests; (9) political feasibility, and (10) ability to communicate. The governance authority must have a clearly defined mission, vision and goals.²⁶

If a lead agency is required, the other members of a region must have a voice in the decision-making process. Shared authority is most effective. All members must feel empowered and have ownership in the goals of the region. Funding must not be tied to stringent directives. Instead funding should be tied to broad goals and the regions must be given the freedom to reach the goals as best fits the local communities. It is when all members of the region take part in the work of reaching shared goals, that true changes occur.²⁷

Structuring

Experiences from regionalized health departments have revealed commonalities related to considerations to be taken when deciding the geographic area of a region. Although voluntary formation is identified as the best option for formation, standards and considerations should be common across a state. Mays et al determined that efficiency is diminished, once a region

serves a population greater than five-hundred thousand.¹⁶ The *2008 NACCHO National Profile of Local Health Departments* supports that efficient utilization of employees diminishes with more than five-hundred thousand population served.⁴ Local health departments serving greater than five-hundred thousand populations do well in service provision and performance areas.⁴

Local health departments serving fewer than fifty-thousand populations are at a disadvantage in most areas, including service provision, performance, workforce and efficiency.¹⁷ According to the 2008 federal census estimates, only fourteen Oklahoma counties had populations greater than fifty-thousand, including Oklahoma and Tulsa counties. Currently, fifteen Oklahoma health departments serve counties with less than ten thousand population. Eighteen counties house two or more health departments. Only two of these counties have populations greater than one-hundred thousand.¹¹ When looking at regional population, transient populations must be accounted for. Colleges, migrant workers and seasonal tourists are examples that might change a regions population from the census calculations.²⁸

Population is not the only factor to consider. Population density, geographic area and weather patterns will affect travel across regions. Similarity of population demographics and where the population currently accesses resources can be important. Recognition of self-proclaimed regions is important, such as “Little Dixie” or the panhandle. Certain regions may have similar disease patterns. The media market of regions is an important consideration and it can affect how information must be disseminated to the public.²⁹ Resource availability and needs should be examined. Perhaps the most important factor to consider is where relationships are already formed. Many counties within the Oklahoma public health system already have relationships and informally share resources. Considerations for a viable region also state that the region should: be based on sound operational principles, be able to integrate, and provide equitable services and access.²¹

BUDGET CONSIDERATIONS FOR REGIONALIZATION

Funding Considerations

Two of the most commonly accepted reasons for regionalization are that it results in improved efficiency and economies of scale. It is presumed to be a cost-efficient method of providing services. Currently, this presumption is anecdotal. There is little research-based support for the cost-effectiveness of public health regionalization; however, studies are currently in the process. Before a state pursues regionalization, a cost-benefit analysis should be completed.

Investigation of rural public health financing shows that in many cases, funding stops at the state level. The majority of CDC money is retained at the state level, with states reporting that their administrative costs use most of the grant funding. Local health departments report that local distribution of funds is too limited to address needs comprehensively. In addition, rigidity of funding makes it hard to manage the little resources received.³⁰

If regionalization is to occur successfully, decentralization of financial authority must occur. Whether the funding stream flows from a central state agency, or is locally provided, regions must have the authority to distribute and manage funding as they see fit. In regionalized states, at least some state and federal funding is allocated to local regions, with the regions having responsibility and authority over its use. Financial decentralization can result in improved fiscal responsibility.¹⁵ Decentralized local health departments are more aggressive in seeking outside funding from donations, grants and gifts from public and private providers. They see themselves as being more fiscally accountable to the local communities.²⁸ A study of the Missouri public health system finds that local health departments that receiving more funding actually raise more money at the local level and that better financial management occurs.³¹

Financial decentralization does not mean that local municipalities must be responsible for all the financial obligations of local health departments. For example, Florida is a centralized authority system with its local health departments having substantial discretion in the use of programmatic dollars.³² In a time when state budgets are dwindling, it is beneficial for local entities to become more accountable for the financial responsibilities of the services they provide. Increased accountability and responsibility must be merged with increased authority.

Funding Formulas

Any discussion about regionalization eventually turns to funding formulas. Funding formulas are one, and the most widely used, way to allocate funding with regionalization. Formulas typically include a minimum funding base guaranteed to all recipients, and state mandated services may be associated with state funded allocations.³³ Formulas are based on many factors, including: (1) per capita rates; (2) poverty rates; (3) local resources; (4) disease rates; (5) levels of regionalization; (6) land area; (7) service levels; (8) risk factors, and (9) rates conditions targeted for prevention. Advantages of formulas are transparency and perceived fairness.³⁴ Formulas based on disease rates or conditions targeted for prevention are not recommended. Such formulas can incentivize non-improvement. Formulas can not meet all objectives and they should be specific.²⁴

Other Funding

Block funding through competitive or noncompetitive grants is another funding method. Regions apply for grant funding, from the state. The IOM recommends clustering or consolidation of grants to increase local flexibility. Local agencies receiving non-restrictive block funding are more efficient and flexible in how they use the funding to meet the needs of their community.²⁴ Regions must be trained in how to apply for grants. Grants may be associated with performance-based outcomes. Public agencies like any business respond to financial incentives.²⁴

Outside sources of funding are an option with regionalization. Regional entities may apply for foundational grants or become recipients of donor endowments. Regionalization enables areas to apply for some federal funding only accessible to larger entities. Regions may have large

businesses or organizations that will designate public health for their charitable contributions. This encourages partnership between health care stakeholders.

Performance-Based Funding

Performance-based funding is an increasingly important management tool for public health financing.³³ Performance-based funding is not a new concept to private businesses and it has been used in some public organizations. Wisconsin is a pioneer in the use of performance-based contracting for public health services. In 2002, with declining state financial resources, a commission was created to reorganize state and local public health relationships and to initiate local responsibilities for local public health services. Like many public health systems, Wisconsin's budgeting system functioned on cost-based reimbursement principles. With such a system, payment is made on what is spent. As costs increase each year, so do payments. There is no incentive for decreasing the cost of production, nonperformance brings no risk and there is little outcome accountability. By moving to a performance-based system, Wisconsin established a quasi-market model to restore the connection between price and product, making payments based on performance instead of process.³⁵ The success of this venture, was a start to what is now becoming the future of public health budgeting practice.

With performance-based funding, contracts are awarded with emphasis on results related to output, quality and outcomes, rather than being tied to programmatic processes. Being outcome based, expected objectives and timeframes are clearly defined. Measureable performance standards and quality assurance plans are incorporated into contracts and performance incentives tie payment to outcomes.³⁶ Just as payments can be increased for exceeding objectives, they can be decreased, if objectives are not met. The contracts require no new funding. They utilize current funding and distribute it in new ways.³⁵

Contracts can consolidate allocation of state and federal funds and can represent multiple programs. Based on needs assessments and local resources, contracts can be for some or all public health services. Communities are not required to perform duplicate services. For example, if a community has a private family planning provider, they may choose not to contract for family planning services. When negotiating contracts, local health departments propose objectives for each program, or across programs, based on their community needs, expertise and capacity. The state develops broad boundaries for program requirements. As long as the local objectives meet the requirements, the state does not dictate how services are provided. Objectives are based on the CDC's "SMART" criteria. They are specific, measurable, achievable, realistic and timely. They must also meet the CDC's "logic model" which requires that the product, output and outcome be defined.³⁵

Wisconsin and six other states find that performance-based funding result in:

- increased accountability
- increased training and skill development
- ability to define outcomes
- partnerships
- deletion of activities that don't show results

- decreased administrative costs
- political survival^{35,36}

Legislators and taxpayers have a hard time recognizing the value of public health. Performance-based funding requires specific and measurable outcomes which can be presented to policymakers and community members in such a way that public health value becomes tangible.

Aligning Financing with Essential Public Health Services

Financial transparency and accountability are tied to financial practices that allow valid, standardized information that is readily accessible and is routinely disseminated for review.³⁷ Private business standards have always required solid financial practices. Public organizations should be no different. Common financial practices such as uniform classifications for revenues and expenses, electronic data reporting, standardization of financial analysis practices and routine reporting of financial results must be required of public health systems. Sound business practices must be utilized and can facilitate accountability, quality improvement and evidence-based practice. Standardized financial practices allow for the use of financial data, together with performance outcomes, to simultaneously monitor results achieved as related to resource allocations.³⁷

One framework for public health financial categorizing is the *10 Essential Public Health Services*. A study using the Florida Department of Health's budget shows that 98% of funding can be categorized according to the *Essential Services* framework, as well as to the *NPHPSP Assessment*.³² Through the utilization of such frameworks for financial categorization, states can compare regional performance outcomes to resource allocations.

PRACTICE STANDARDS

One of the fears of regionalization is that it encourages fragmented services and division of care. Reality shows that regionalization encourages integration and collaboration.³⁸ Although regions must have autonomy in deciding how best to provide services and utilize finances, states must establish basic standards by which practice may be measured. Discussion on the use of the *10 Essential Public Health Services* has been presented. In addition, several other accepted practices should be the basis for standardization: implementation of population-based services; evidenced-based practice; community collaboration; systems thinking, and accreditation.

Population Based Services

The science of public health grew out of the need for a discipline which ensures the health of communities. Its foundation is on population-based practice. Through the years, public health practice has evolved to the point that it utilizes a majority of its resources for individual healthcare services.³² The previously mentioned study categorizing Florida's public health

budget found that, ideally, it is best to implement population-based programs.³² Population-based services are efficient and cost effective.³⁹ Resources that are normally used to reach one person can be used to reach groups of people. Population-based services have been described as the public health practice paradigm for the 21st century.⁴⁰ Local health departments are redefining their roles in communities and are focusing on population-based services, while collaborating with other community providers for direct delivery of services.⁴

Focusing on a large number of people for preventive care has a larger impact on the health of a community than when intervening one person at a time. Even though every person exposed to population-based services may not be at risk for disease, they gain knowledge and awareness that they may transfer to the people within their span of influence. Population-based practice focuses on a community perspective and on the capacity of the community to achieve its health goals through effective use of its assets. The new public health is returning to community mobilization efforts, such as community engagement, community collaboration and partnerships to organize communities to work together to gain community health.⁴⁰

Evidence-Based Practice

Evidence-based practice is not only a movement within public health; it is a movement within the health care community as a whole. Spurred by poor health outcomes and high health care costs, health care leaders identify evidenced-based practice as a way to decrease health costs by implementing only those practices proven to positively impact health outcomes. In 2002, the IOM recommended that policy decisions about improvement of national public health systems should be guided by scientific evidence.⁴¹

The *2006 CDC Community Guide* recommends fifty-one evidence-based, public health interventions. The programs are backed by strong scientific evidence and include those related to risk behaviors, health conditions, and the social environment.⁴² In the same year, the Oklahoma Department of Health allocated over sixty-five million dollars (\$65 million) to non-evidenced-based programs related to risk behaviors and health conditions. In comparison, approximately twenty-eight million dollars (\$28 million) was allocated to evidenced-based programs in the same areas. No dollars were allocated to programs within the social environment category. Less than half the amount of dollars did not go to evidenced-based programs than to non-evidenced-based programs.⁴² Oklahoma's citizens, nor its public health system, can afford to continue to pour precious resources into programs that are not proven to improve health outcomes.

Community Collaboration

Community involvement in health care reform is not a new concept. In fact, this nation was built on the grassroots efforts that bring social and political reform. Health determinants do not only affect certain groups. The health outcomes of those who are high risk have an impact on the whole community. Communities are invested in the health of their citizens; therefore, they must be brought to the table when health care decisions are made. The Turning Point Initiative has shown that community partnerships that are deeply involved in the work of public

health significantly strengthen, extend and enhance the public health infrastructure. The knowledge, skills, resources and contacts of individuals, businesses, agencies and organizations are priceless, in the pursuit of improved health outcomes.⁴³ When communities are involved in the business of public health, outcome goals are set in accordance with local priorities, and are based on local information, instead of being determined by a distant state agency and based on available categorical funding sources.⁴³

With regionalization, community collaborations can:

- be the voice for the community
- complete a community health needs assessment
- produce a community health plan
- develop partnerships
- administer community health grants
- govern or manage health services
- address issues from a population health perspective⁴⁴

Communities can decide how the regions should be formed, governed and structured. Citizen engagement improves accountability and government responsibility. Community involvement results in the community becoming empowered and more self-reliant.⁴⁴ When community members become involved with public health, they gain awareness and become spokespeople for the important issues.

Systems Thinking

Defining the public health system as only the governmental agencies charged to perform the duties of public health has to stop. Seeing public health as a system incorporating all stakeholders, who are involved or interested in the health of the community, is the vision that must move public health into the future. The Turning Point Initiative has moved the public health system thinking into the forefront in practice examples. It initially produced experiments in systems building in fourteen states and forty-one sites.⁴⁵ Turning Point shows that by building public health systems through community collaborations, broad resource bases can be tapped, to decrease the impact of chronic public health underfunding.⁴⁵

Regionalization is linked to the systems concept almost universally.⁴⁵ The local health department's role in the system is one of leadership and example. By joining together smaller health departments, service delivery begins to cross boundaries and larger populations are reached. Each community is aware of others and how their health and actions impact one another. Communities no longer view themselves as lone silos, but see themselves as part of the public health system.

Accreditation

Accreditation should not be an option for local health departments. Public health has gone too long without accountability or standardization. Accredited local health departments cite that the benefits of accreditation outweigh the costs. Benefits cited include:

- improved collaboration
- increased attention from universities, including free labor from interns
- enhanced credibility with policy makers
- receipt of new grant funding
- increased recognition
- new motivation and engagement among staff
- improved understanding of local health department functions
- improved relations with governing bodies
- increased pride⁴⁶

Accreditation requires that performance standards be set and be monitored through the implementation of performance improvement practices. When high standards are placed on an organization, quality follows. Many states have implemented accreditation programs and often tie accreditation to funding allocation. The Turning Point Initiative developed a model for assessing public health laws, stating that accreditation should be a statutory requirement for public health departments.⁴⁷

Regionalization is almost always mentioned in discussions of accreditation. Accreditation is based on the *10 Essential Public Health Services*. On their own, smaller local health departments are unable to meet the requirements for accreditation. Health departments themselves do not need to have all the resources necessary to meet accreditation requirements. Requirements may be met if local health departments have access to resources. Through regionalization and community collaboration, pooled resources allow for accreditation as a region. In its model for assessing public health laws, Turning Point also states that public health districts and collaboration should be statutory requirements.⁴⁷

EXAMPLES OF REGIONALIZATION IN OTHER STATES

Chicago⁴⁸

The Northern Illinois Public Health Consortium is an example of a successful public health region that began as an informal collaboration. The Consortium consists of several local health departments in the Chicago metropolitan area. The members originally joined together because they all had similar public health goals and interests; they had similar progressive views of public health practice, including using national standards for public health practice and they had a mutual dissatisfaction with the state health department and poor funding allocation.

The Illinois Department of Health divided the state into regions, for administrative purposes only. The Consortium partners wanted to see functional regionalization occur and began meeting to try to make changes. Eventually, the group formed a non-profit organization, hired a lobbyist and incorporated. They hired employees, a director and established dues. Governance is distributed among the group and the local health departments remain independent.

Eventually, the Consortium has developed a good relationship with the state department. They have collaborated to develop a funding allocation plan. Through the plan, the state department specifies the overall framework and guidelines for meeting grant requirements and the local health departments are responsible for delivering the services as they see fit. This leads to improved synergy and capacity. In addition to tackling funding issues, the Consortium has dealt with disease surveillance and reporting, laboratory capacity, medical care availability and public health reform.

Outcomes of the regionalization are: (1) standardization throughout the region, using national standardization frameworks; (2) learning through shared lessons and networking; (3) relationship building; (4) greater ability to challenge the status quo; (5) development of effective practices that affect broader health issues, and (6) a focus on strategic planning. The Consortium is an example of how regionalization can be successful, while maintaining the distinctiveness of the individual local health departments.

North Dakota⁴⁹

Due to resource constraints, North Dakota regionalized its primary health care system through cooperative networks. North Dakota is a very rural state. Through the collaborative networks, local communities are able to work together to meet their health care needs. The rural communities have a sense of strong trust and interdependence. This is a social capital that allows them to work together in innovative ways that might not happen if they were working through state agencies or with urban partners.

Outcomes of the regionalization include increased efficiency and better health outcomes. Enhanced communication is a key to continued improvements in the system. A strong sense of mission and collaboration are also factors in its success. Through regionalization, North Dakota achieves far better health outcomes compared to high-cost systems elsewhere.

Kansas⁵⁰

Kansas implemented a decentralized, regionalized public health system. It is described as *functional regionalization*, an approach which allows counties to cooperate to provide essential public health services. Local county health departments remain separate, but are members of the region. They work together to provide certain public health service functions. Regionalization was initiated in order to increase efficiencies, allow for accreditation and standardization and provide increased access to public health services.

Kansas actively campaigned for community acceptance of regionalization. To promote the idea of regionalization, individual health departments use the same branding, messaging and approach, personalized for each county. They use the term, "Regional Cooperation". The vision was first presented to the county commissioners by showing that regionalization is a way to ensure that the health of the community is protected and that essential services are provided to all citizens.

The state health department provides assistance with assessment, planning, legal issues, financial and economic issues and communication. Regionalization has enhanced preparation for accreditation and shows that communities are willing to work together for the betterment of their citizens.

Massachusetts⁵¹

The goal of the Massachusetts regionalization project is to strengthen its public health system by creating a state-funded regional structure for equitable delivery of public health services. Regionalization was initiated because local health departments were struggling under decreased funding, increased responsibilities and insufficient staffing.

Massachusetts developed a regionalization working group, led by Boston University College of Public Health. The working group: (1) developed regional planning; (2) established guiding principles for the development of regions; (3) identified critical elements required for services, based on the *10 Essential Services*; (4) conducted research; (5) drafted reports with recommendations for moving forward; (6) identified legal, funding and other concerns; (7) sponsored legislation, (8) framed models; (9) created an incremental plan, and (10) secured grant financing.

Massachusetts' local health departments developed regions of various organizational and governance structures. Minimum standards for the population served by a region, is fifty-thousand. From regionalization, Massachusetts sees economies of scale, increased public health funding, greater capacity to apply for grants and a better prepared public health workforce.

Nebraska⁵²

Turning Point was the impetus for change in the Nebraska public health system. In 2001, legislation was passed that led to the creation of sixteen regional health departments. Departments serve a population greater than fifty-thousand, or consist of at least three counties with a population of at least thirty-thousand. Nebraska found that the state could no longer support ninety-three local health departments and identified regionalization as an alternative way to deliver services.

Nebraska's local health departments are allowed to have autonomy and choice in selection of county partners. The regionalization takes advantage of economies of scale, improved ability to plan and respond to emergencies, improved disease detection and tracking and improved coordination of services. Public health capacity in Nebraska has expanded and the state department role is more focused on providing technical assistance, monitoring and training.

DISCUSSION OF INFORMATION

Oklahoma's public health system must make changes in order to function effectively in the twenty-first century and beyond. Health outcomes will not improve if the status quo prevails. Fortunately, many factors are in favor of change in Oklahoma's public health system. Regionalization is a tool that has been shown to have favorable outcomes related to many areas. Oklahoma's *Public Health Code* supports regionalization and mandates decentralization, although the current system has drifted far from its original intent.

Regionalization without decentralization of administrative and fiscal authority loses its effectiveness. State Health Department leadership has voiced concern that county health department administrators are not able to handle administrative and fiscal authority. If this is true, then current administrators should not hold the positions. People often rise to the standards set for them. If they are given the opportunity and training, many administrators may be able to excel with increased authority. Research shows that decentralization results in increased efficiency, improved accountability and fiscal responsibility.

Current and past information supports regionalization. Health departments that serve larger populations perform better in most areas. The vast majority of the current system's local health departments serve populations of less than fifty-thousand. This has been shown to be inefficient, both fiscally and functionally. Much of Oklahoma's current public health system is regionalized and many local health departments already have relationships through which resources are shared. Regions may readily develop, if given the opportunity.

There are many accepted, national frameworks for standardization, related to local public health capacity assessment and to local community health needs. They should be used as the basis for any regionalization decision processes, development and implementation. Formation of regions should follow function. Development of regions should be autonomous, based on the needs of involved communities, enhance the capacity to provide the *10 Essential Public Health Services* and prepare regions for accreditation.

Financial accountability and transparency must be developed. Sound business practices can and must be implemented throughout the public health system. Fiscal decentralization must occur and budgetary categories should be standardized and aligned with the *Essential Services*. Performance-based funding is an important management tool and should be explored for funding allocation. The current system is restrictive and inefficient. Administrative costs consume far too much funding and too many dollars remain at the state level.

There are several nationally recognized practice standards that should be norms for Oklahoma's public health system. Practices should be evidence-based and focus on populations and outcomes. If possible, direct care services should be delegated to community partners. The public health system must include all public health stakeholders. Community collaborations should be sought. Local foundations, universities, Oklahoma City-County and Tulsa County health departments, hospitals, non-profits, private providers, businesses and interested individuals should all be considered part of the public health system. The Oklahoma State

Department of Health can no longer function as a silo for public health services. Accreditation should be a requirement for all local health departments. With accreditation come many useful practices, such as performance improvement, community assessments, health plan development and performance and outcomes evaluation.

Public health in Oklahoma must be ready for change. Those who care about the health of the state's citizens and have a strong conviction for the future of public health will move forward, despite the discomfort and hard work that radical change may bring. Those who are not willing to move forward must not be allowed to impede progress. The status quo does not show itself to be effective. New and high standards must be set, accountability and transparency must become the norms and relationships must be built based on common goals. The opportunity for change is now.

POSSIBLE MODEL FOR REGIONALIZATION IN OKLAHOMA

Assuming the decision for regionalization is made, it may be piloted with voluntary participation. Counties will be allowed autonomy in decisions regarding structure and governance. Regions will be required to serve a population of at least fifty-thousand. Ideally, regions will consist of at least one local health department, a community coalition and/or collaboration and other public health stakeholders. Local Turning Point Initiatives are natural partners for regions and will be an integral part of the regionalization process. A non-profit or a lead agency may be developed as the governing authority and the agent for funding allocation. All members of the region will have equal decision-making authority. Funding allocation and service provision will be equitable and based on the needs of the involved communities. National standard evaluation tools will be utilized, in order to identify regional capacity to meet the *10 Essential Public Health Services* and to identify the regional health needs. Regional health plans will be developed and will involve community members' input. All regions will become accredited. Regions will gain uniformity through national public health standardization frameworks.

Regions will contract with the state for service provision. Fiscal allocations will be decentralized and will be through performance-based funding. Required services will be state funded. Regions may collect fees for services which will be available as regional revenues. Programs will identify broad outcome-based requirements for funding. Regions will have the opportunity to negotiate contracts for only the services they deem necessary, based on community needs. Performance objectives will be evidence-based and will focus on populations. Individual, direct services will be provided by regions, if there are no other available sources for the services. Regions will have the opportunity to apply for and receive funding from outside organizations and grants. Ongoing evaluation of performance outcomes will occur.

Among the roles of the local health department will be one of leadership and example in the provision of public health services. It will be a partner in and will encourage community collaborations. It will be active in the development and implementation of health policies and reform. It will actively seek evidenced based-practices that positively influence the social, behavioral and biological determinants of health.

The roles of the State Department of Health will include data collection and monitoring; identification of broad state health objectives; guarantee that a minimum set of essential health services will be provided to all citizens; support of local services financially and technically; assurance that policies and statutes support local health services; provide services deemed to be most efficiently centralized, and provide workforce education and development.

APPENDIX

ESSENTIAL PUBLIC HEALTH SERVICES

1. **Monitor** health status to identify community health problems.
2. **Diagnose and investigate** health problems and health hazards in the community.
3. **Inform, educate and empower** people about health issues.
4. **Mobilize** community partnerships to identify and solve problems.
5. **Develop policies and plans** that support individual and community health efforts.
6. **Enforce** laws and regulations that protect health and ensure safety.
7. **Link** people to needed personal health services and assure the provision of health when otherwise unavailable.
8. **Assure** a competent public and personal health care workforce.
9. **Evaluate** effectiveness, accessibility and quality of personal and population-based health services.
10. **Research** for new insights and innovative solutions to health problems.

*Core Public Health Functions Steering Committee
1994*

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