

***I WOULDN'T WANT TO BE ANYWHERE ELSE:***

**THE KANSAS CASE STUDIES**

**A Report on Local Health Department Regionalization**

*Prepared for the*  
**National Association of County and City Health Officials**

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# ***I WOULDN'T WANT TO BE ANYWHERE ELSE: THE KANSAS CASE STUDIES***

## **I. INTRODUCTION: CLEARING UP THE CASE**

For a century and a half, Kansas has symbolized rural America.

Winds that sweep over the Kansas plain ripple across the continent. Iconic forces in American history—the expansion to the West, the clash over slavery, and the rise of the Grain Belt—pollinated the Sunflower State. More recently, the state has turned to face the decline in agriculture's influence over the nation's political, economic, and social institutions.

People here grow up steeped in self-reliance, a community perspective, hard work, and plain speaking. When you drift far from those values, you're "not in Kansas anymore."

If regionalization of local public health works in Kansas, it should work in other rural areas where an independent American spirit meshes with friendliness and sharing. This is an ideal test site.

Local health departments (LHDs) in Kansas began to establish formal, regional collaborative arrangements in 2002, in order to improve their ability to respond to public health emergencies in the wake of 9/11. The success of these initial efforts led to an expansion of regional activities—an expansion intended to facilitate greater sharing of services and to create a platform for receiving more outside funding. In addition, the expansion was seen as a way to put participating LHDs in a better position to obtain accreditation from a new national program recognizing public health departments that meet rigorous standards.

Eventually termed 'regional cooperation,' this expansion, or initiative, includes the activities described in this report. As applied in Kansas, 'regional cooperation' is the voluntary, planned, and structured sharing of services within a region, without merging existing agencies or creating new agencies. Kansas public health authorities, including

LHD heads themselves, suggested this approach and the use of this term, and NACCHO has been fully supportive. (Throughout this report, the terms ‘LHD head’ and ‘administrator’ are used interchangeably. The titles of individuals who direct LHDs in the regions vary, with the most common title being “nurse administrator.”)

Regional cooperation is one approach to regionalization of public health services. It differs from ‘regional consolidation,’ in which LHDs are swallowed up by a regional entity. Advocates for regional cooperation in Kansas see this approach as a way to build on the state’s tradition of local self-determination (“home rule”), assure that regional arrangements are voluntary, and increase access to public health services.

Accordingly, and with support from Robert Wood Johnson Foundation, the National Association of County and City Health Officials (NACCHO) launched a Regionalization Project in which two regions in Kansas—Northeast and North Central—expanded regional services beyond preparedness. The project involved three phases. The first phase included an assessment of each department’s capacity; this assessment was shared confidentially with the department, and the results were aggregated by region to identify strengths that could be shared and common gaps that could be addressed through the development of regional capacity. Participants in each region selected one gap to explore in greater detail.

In the Regionalization Project’s second phase, the participants in each region developed processes to address the identified gap. The third phase involved sharing the lessons learned from the project.

This case study report describes experiences and perspectives of the Kansas local health department (LHD) heads and some of their senior staff in the 21 mainly rural counties who participated in the NACCHO project. Part II of this report summarizes the full report and offers findings and conclusions. Following this summary, Parts III through VI offer more detailed information:

- Part III depicts the landscape of local public health in Kansas
- Part IV discusses the Northeast Kansas region, centering on the Northeast LHDs’ diverse concerns about regionalization

- Part V discusses the North Central Kansas region, centering on the North Central LHDs' diverse reasons for strongly supporting a "bottom-up" approach to regionalization
- Part VI describes the views of project participants after NACCHO support ended.

Approximately 35 confidential personal interviews have served as the primary data-gathering method for this report. (To assure confidentiality, the report does not name any interview subject.) Follow-up interviews were conducted with most sources in January 2009, at the conclusion of the NACCHO project, to elicit views forward and back. These are the views summarized in Part VI.

Besides providing the writer with nuanced information and opinions, the interviews have helped participants in the project crystallize their own attitudes toward it. As Sherlock Holmes observes in the mystery "Silver Blaze," "Nothing clears up a case so much as stating it to another person."

## **II. SUMMARY, FINDINGS, AND CONCLUSIONS: THE STEEP SUNFLOWER TRAIL**

### ***The Site***

Kansas epitomizes rural America's values, economics, and lifestyles. The state's location in the nation's geographic heart is a further reason why it's an ideal site for testing LHD regionalization in areas with low population density.

On balance, the 21 participating county departments entered the 2008 NACCHO regionalization project in strong positions. Most have grown substantially in size over the past several decades. They benefit from extremely stable leadership and enjoy comfortable relationships with county commissioners. Both the eight-county Northeast and 13-county North Central regions successfully navigated regionalization of bioterrorism (BT) coordination after 2001.

What the departments most lack is sufficient funding to provide enough population-based disease prevention and environmental

health services. Kansas ranks absolutely last in federal funding for public health, and the state government's funding of, and enthusiasm for, local public health in rural areas also is low.

Because home health—and, although used less, hospice—services are reimbursable, and because most of the 21 LHDs had their origins in nursing services, the departments focus on nursing. (By contrast, LHDs in Massachusetts, the other NACCHO project site, focus on environmental health services.) The departments are led by nurses and oriented to the traditional nursing role of providing excellent personal health services.

As a result, residents of the Northeast and North Central regions do not fully receive some essential public health services listed in NACCHO's authoritative Operational Definition of a Functional LHD. The focus on nursing has implications for regionalization, too. Personnel or clients would have to travel long distances—inefficiently spending lots of “windshield time” and money on gasoline—to obtain services that today are provided in people's homes by nurses from their own communities. As is detailed in the “Regionalization Drivers and Barriers” section below, activities other than direct-care nursing are more likely to benefit from regionalization.

The LHD administrators enjoy practicing public health. Their main complaint is the ‘paperwork’ burden (a broad term that includes completing online insurance claims and state reporting forms). They would be very pleased if regionalization would reduce this burden.

### ***The Rural Method***

Interviews and observations that contributed to this report reveal something that most national leaders in health policy and public health may not fully appreciate: Local public health is simply different in rural areas like Northeast and North Central Kansas.

The rural method of practicing local public health displays three characteristics:

- *It's very personal.* Practitioners personally know their clients' families and broadly adjust the delivery of services,

especially health education services, to people's circumstances.

- *Methods of gathering information are informal.* Practitioners make themselves highly visible in the community and ask around to learn which diseases or health conditions are becoming more prevalent, and which groups appear most at risk. But, these surveillance efforts are undocumented and so might not meet forthcoming national accreditation standards.
- *Programs are less structured.* In small offices like those of rural Kansas LHDs, written forms tend to be less important, procedures are relatively informal, and employees have somewhat broader discretion about which services they can provide to an individual client.

## **Regionalization Drivers and Barriers**

The advance of national efforts to accredit LHDs is the greatest driver of regionalization in Northeast and North Central Kansas.

Administrators believe they must pool resources if they are to provide all services included in the Operational Definition, the basis of new accreditation standards.

Ten additional, somewhat overlapping motivations to regionalize include the need to:

- *economize*, by sharing equipment, supplies, and pharmaceuticals
- *share information and knowledge*, in order to meet state reporting requirements and simplify record-keeping, human resources functions, and guideline development, perhaps through regional templates
- *expand preventive and environmental services*, especially health education—services that area residents deserve and are not now receiving in full
- *meet increasing staff shortages*, and cover for sick and vacationing employees and temporary vacancies
- *obtain greater expertise*, by voluntarily assigning each LHD head to specialize in a specific type of service or health education topic

- *generate data that will appeal to funders and be more useful*, through the added validity that a larger population base would assure
- *enable a community health assessment*, which would allow LHDs to be more responsive to community interests and more strategic in their programming
- *improve accountability and quality improvement*, by disseminating best practices, providing comparisons in performance among counties, and showing whether specific programs are effective and worth their cost
- *mobilize LHD “voice-power,”* to achieve greater leverage in dealing with county governments, regional planning authorities, and the legislative and executive branches of state government, and
- *facilitate personal career development* for LHD administrators and other personnel.

The LHD heads have identified diverse public health services that are amenable to regionalization. These include services that are not yet provided in the two regions, such as the services of a professional epidemiologist or tobacco control specialist, or are provided only in some counties, such as family planning. They further include services that could be enhanced and made more efficient, such as grant development, emergency preparedness coordination, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) services, financial management, other aspects of business management, and the professional services of a full-time regional social worker, dietitian, or child health specialist.

A major new driver is the recession, which grew in severity during the course of the project in the latter part of 2008, finally emerging as the major determinant of nearly all public policy on the federal, state, and local levels. As LHDs are forced to cut back, regionalization has surfaced as the most reasonable way to preserve the full complement of existing local public health services.

Identified barriers to regionalization include:

- time constraints, as some LHD heads find themselves too strapped for time in meeting current obligations to develop plans to regionalize programs

- fear of loss of LHD jobs
- lack of funding to support new services or the mechanics of accreditation
- county commissioners' interest in safeguarding local control
- the state Department of Health and Environment's lack of support for regional agreements independent of state control
- overall resistance to change, on the part of LHD personnel, county officials, and clients, and
- liability concerns arising from the provision of services by employees of one county to residents of another county.

### ***Regional Cooperation and Leadership***

'Regional cooperation'—the voluntary, planned, and structured sharing of services within a region, without merging existing agencies or creating new agencies—is overwhelmingly favored as the best regionalization vehicle for meeting accreditation standards. Regional cooperation is strongly preferred both to consolidating into a regional health department and to maintaining the *status quo* of entirely separate county entities and programs. (NACCHO and the other project sponsors consistently have supported regional cooperation, once Kansas participants in the project identified it, early on, as the approach they wanted the project to take.)

During the 2008 project year, the Northeast region concentrated on developing a strategic data plan, while the North Central region concentrated on developing a strategic approach to communications. Implementation of these plans now falls to the respective groups, without assistance from the team of NACCHO project consultants, who lent their expertise in group facilitation, LHD assessment, finance, communications, law, and local public health policy and development.

Leadership appears to be the key to future progress in regionalization. LHDs in each region must design a regional structure, and leaders must emerge who are energetic and dedicated, talented and trusted.

The Northeast region provides the model of a region strongly supported by a large LHD. Personnel from Shawnee County, which

includes the state capital of Topeka, are responsible for much of the regional cooperation initiative's success and related gains.

The North Central region provides the model of a more atomized team. LHD heads there are all so short on resources that they must work together regularly, but there's some concern within the group that one or more members could gain too much prominence or control through regionalization.

### ***Strategic Communications***

In the current fiscal climate, it is doubtful that local public health will advance or even preserve its position in Kansas, with or without regionalization, unless more effective advocacy for it emerges. This may require the combination of a limited but wise investment of resources in communications, a strategic approach to advocacy, and creativity.

LHD heads believe that county commissioners are the primary audience for communications about the importance of local public health services. The commissioners set county budgets.

Some commissioners may respond more readily to anecdotal information and scenarios than to health statistics. As elected officials, all are likely to respond to public pressure, so a strategic communications approach would include improved efforts to influence public opinion. Already, LHDs have found success in burnishing their image by, for example, forming coalitions with community groups.

Both a commissioner and an LHD administrator from each of 35 counties attended a health regionalization "summit" in September 2008, supported by the Kansas Health Foundation, Kansas Association of Counties, and Kansas Association of Local Health Departments. Part of the larger regional cooperation initiative, this summit provided an opportunity to engage elected officials in discussions about the benefits of formal inter-local agreements, such as ensuring that their populations are adequately covered by public health services.

State legislators and policy-makers are another key audience to which LHDs must justify local public health services. Regionalization clearly offers greater opportunities for communicating effectively with officials at the state level.

### ***The Road Ahead***

In the early aftermath of the 2008 activity, momentum toward regional cooperation remains fairly strong. For example, the Northeast group is working toward hiring student interns to collect and analyze data, in order to implement the strategic data plan it developed during the project. Events are proceeding against the backdrop of the lowest level of federal funding support for public health in the nation and the absence of other meaningful external drivers of progress in local health, other than the national move toward accreditation.

There is no single best route toward regionalization. Administrators in the North Central region, in particular, expressed in the confidential interviews that they generally would prefer to blaze their own path toward regional cooperation, rather than follow a course plotted by state officials or others. This attitude reflects the pioneer spirit of rural Kansas. The NACCHO team, the Kansas Association of Local Health Departments, and other sponsors of the regional cooperation initiative have fully supported it.

Due in part to that same pioneer spirit, there is reason to be guardedly optimistic about movement toward regionalization in the Sunflower State. Although steep, the trail many of these LHD heads are blazing is wide.

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*[End of "Summary, Findings, and Conclusions"]*

### III. KANSAS AND THE PROJECT TERRAIN

#### *Living and Dying*

Kansas is a quintessential 'home-rule' state; there's a high degree of autonomy for county governments and relatively little control by the state government. State mandates are relatively light, and county governments sometimes subtly resist state agencies' reporting demands and performance requirements.

Kansas's home rule tradition sits alongside a natural conservatism. "People live and die here. Their families are in the community. They're very resistant to change."

Counties are allowed to regionalize services, through formal agreements. Under the state's Inter-local Cooperation Act, a county may join with one or more other counties to perform cooperatively any function that state law allows it to perform.

"At one end of the teeter-totter you have this goal of maximizing local rule, and on the other end the goal of producing the greatest economy. Where's the fulcrum, in the context of Kansas?"

#### *A Horse-ride Away*

The state consists of 105 counties, with populations as low as 1,500. Kansas history buffs explain that the formula for creating counties in the 19<sup>th</sup> century was that anyone should be able to mount a horse in the morning to ride to the county seat, conduct business there, and ride back home before nightfall.

Kansas counties are diverse. One county may have a high percentage of new residents, visible multi-cultural influences, a strong economic base, and not much sense of identity, while its neighbor may have a declining economy, a largely homogeneous population, and a strong sense of identity. Several counties in the two Kansas regions have high concentrations of elderly residents.

Although cooperation among counties is common for several services—such as real estate appraisal, engineering, and mental health care—local public health is fractionated.

Within the two regions of Northeast and North Central Kansas, one Northeast county is more populous than the others by an order of magnitude. Shawnee County, which includes Topeka, the state capital, is home to 173,000 people.<sup>1</sup> As a participant in the project, Shawnee’s health department appears willing to learn from smaller departments that, despite extremely limited resources, have developed particularly fruitful partnerships with community agencies and even have even outperformed Shawnee on some measures, such as percentage of normal birth weights and rates of certain immunizations.

### ***Family-friendly***

To an impressive extent, public health in Kansas has succeeded. “They’re doing their job,” says one informed observer, adding that “people who haven’t needed the [public health] resources don’t realize how much is done.” According to this source, most county commissioners—members of the powerful elected boards that oversee county governments—“understand the basics” of what public health does.

Another source says that people in the area view public health practitioners as a resource in Kansas’s tightly knit rural communities. This source notes that the sense of community there is very personal. While out and about, residents encounter “the most affluent people in town and the poorest people in town.” Everyone greets everyone else, regardless of social status. In this milieu, the public health practitioners are seen as a part of the community, rather than as part of a somewhat aloof, or hard to approach, elite.

Although Kansas is 85 percent white, minorities form a significant presence in many counties in the two regions. Some areas are experiencing a substantial increase in Latino residents. One county has a Pottawatomie American Indian reservation.

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<sup>1</sup> U.S. Census, 2006 data.

While many or most counties have large proportions of residents aging in place, there is substantial mobility. Some new workers have found jobs in the Topeka area or with a few attractive firms (such as a construction company and a machine manufacturer) elsewhere. After leaving the area, some former Kansans return to rear their children in the state's family-friendly environment.

### ***Tight Money***

Manufacturing and economic development are in short supply in most of the two regions' 21 counties. The economy rotates mostly around farming. Declining populations have led to consolidation of schools—a painful process, even affecting restaurants and other enterprises that huddle around schools—and other retrenchments. Yet, rates of unemployment and poverty are not very high.

State budgets in 2008 have been tight. The second-term governor during the course of the project was Kathleen Sebelius, a Democrat, but Republicans controlled both houses of the Legislature. On April 28, 2009, Sebelius was sworn in as Secretary of the U.S. Department of Health and Human Services, following her nomination by President Obama and confirmation by the Senate. Succeeding her as governor was Lieutenant Governor Mark Parkinson, a recent convert from the Republican to the Democratic Party, who quickly announced he will not run for the governorship in the 2010 election.

Even in prosperous times, the state government does not provide much funding for local public health, leaving that to federal and county governments. But, as LHD directors in Kansas are well aware, a 2008 report by Trust for America's Health ranks Kansas absolutely last among the states in *per-capita* funding by both CDC and the Health Resources and Services Administration, the two federal agencies that provide the greatest support for state and local public health.<sup>2</sup> And, with small tax bases, counties are so small and hard-up for funds that they find little to spare for LHDs.

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<sup>2</sup> Trust for America's Health, "Shortchanging America's Health 2008" (Washington, DC), Available at <http://healthyamericans.org/reports/shortchanging08/>.

An LHD head sums up one county's situation:

The county was hurt when the state appropriated *ad-valorem* tax revenue for highway construction and maintenance. Maternal and child health funding has been cut. The challenge that I see is fiscal support once the emergency preparedness dollars go away.  
[We have no place to turn.](#)

### ***Other Aspects of the Landscape***

Weather is an important factor in the daily lives of people in rural Kansas—and a likely source of public health emergencies. The state is known for tornadoes, and during 2008 residents also faced ice storms, blizzards, waves of severe thunderstorms, and threats of other calamities; floods and droughts dominated weather news in the previous few years.

Many counties in the two regions have only a single small hospital, and some of these facilities are barely holding on. Most physicians are solo practitioners.

The Kansas public health scene includes several organizations that, according to participants in the regionalization project, are keys to an improved public health system. These organizations include:

- *the Kansas Department of Health and Environment*, which participants generally view as having the ability to influence regionalization, but was engaged in the NACCHO project in a limited manner
- *regional prevention centers*, which provide addiction services and other assistance to a mostly adolescent clientele
- *the Kansas Health Foundation*, a leading funder of public health activity in the state and longtime supporter of regionalization
- *the Kansas Health Institute*, a nonprofit policy and research organization supported by the Kansas Health Foundation, and
- *the Kansas Health Policy Authority*, a new state agency charged with coordinating state health care policy.

Even before regional emergency preparedness initiatives were launched in the wake of 9/11, regionalization had gained a foothold in local public health in Northeast Kansas. Since 1972, three counties

there have joined forces to contract administration of their LHDs to a single private agency, which employs the three health department staffs and reports to a unified board of health.<sup>3</sup> Advocates believe this multi-county approach produces a “higher level of service” at equivalent costs. The agency believes that other counties have chosen not to go this route because they want to retain autonomy and control and also maintain LHD-generated revenues.

#### **IV. NORTHEAST KANSAS: CONCERNS ABOUT REGIONALIZATION**

##### ***The Project in Perspective***

*Seven Years of Experience.* LHDs in the eight counties of Northeast Kansas have experienced regionalization in bioterrorism (BT) work, related aspects of emergency preparedness, and a few additional spheres of activity, such as WIC. Nevertheless, to one LHD head, regionalization in the Northeast is mostly a blank slate—an untested idea.

The BT experience resulted from the infusion of federal funding for public health preparedness after 9/11. Seeking to use a portion of the funds in a regional effort, LHDs in Kansas formed 15 BT regions. This exercise reflected the notion, as expressed by one observer, that “people do a better job when they can choose their partners.” This approach was viewed early on as an important strategy in building public health capacity in a rural state.

One LHD head expresses the prevailing sentiment that “our region does work well—it’s an excellent, strong region.”

*Need to Cooperate.* Most project participants in the Northeast region agree on the need to regionalize. They see federal, state, and private-sector mandates and reporting requirements as so cumbersome that they “have to search out buddies to help them navigate through the system in order to survive.” They believe that regionalization offers the potential of more guidance in completing

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<sup>3</sup> This three-county consortium is known as Northeast Kansas, or NEK—not to be confused with the eight-county Northeast region.

reports, so that each administrator does not have to decipher the reporting rules anew.

“It’s a matter of survival. We are working as hard as I know how to work to make this a success.”

Regionalization also allows a cooperative approach to meeting standards for LHD accreditation, a voluntary process now being rolled out nationally. (NACCHO sponsored the expansion of Kansas’s initiative to help determine how accreditation can be accomplished in rural settings within the context of regional cooperation.) Participants in the project predict that accreditation will drive future funding decisions; they expect federal agencies and other funders to require LHDs to be accredited in order to qualify for support.

Small LHDs would find it difficult to meet, wholly on their own, all of the standards outlined in NACCHO’s Operational Definition of a Functional LHD, the foundation for accreditation standards. This is especially true in Kansas, where rural LHDs concentrate on providing direct nursing care but are weaker in the population-based services—such as epidemiology, disease surveillance, and community health assessment—that are captured in the Operational Definition.

Almost without exception, the LHDs have viewed regional cooperation as a means to position themselves for accreditation and influence the development of accreditation standards and survey requirements. Primarily, they hope to be able to maintain their county identity and their programs while still obtaining accreditation. Expansion and improvement of services are additional objectives.

Besides being necessary, regionalization is quite feasible, in the opinion of most LHD heads in the Northeast. Precisely because outside funding levels are so low, the departments are fairly free to chart their own agenda, without having to answer to federal and state funders.

*Perceptions of Regionalization.* One anticipated advantage of regionalization is a system of accountability, to make sure services are effective. In fact, a mechanism to assure accountability in local

public health could serve as a template for regionalizing other county services.

Given satisfactory experiences so far and significant potential advantages, personnel in the Northeast are open to regionalization, even if most weren't initially enthusiastic about it. "Regionalization does not scare me."

Still, the concept of regionalization is vague to most participants in the project. One says, "I'm unclear what regionalization entails, whether something grandiose or just agreements." By 'grandiose,' this source means region-wide consolidation of LHDs—a prospect that nearly all participants fear.

'Regional cooperation,' unlike 'consolidation,' refers to a sharing of resources among LHDs that preserve their own identity. This term was generated from communications research undertaken early on in the Kansas initiative.

### ***The LHD World***

*Departmental Evolution.* LHDs in Northeast Kansas have experienced dramatic growth in capacity, services, development of policies, and specialization during the past 10 to 20 years. Many were established in the 1970s as small programs—situated in a hospital, courthouse, or even a private home—providing ambulatory nursing services. They've since moved to larger quarters, typically have their own buildings, and have expanded their roles, to include environmental health activities and other non-nursing public health functions. As their role has grown, they are now chafing against the walls of even their relatively new physical structures.

During this period, staff size has expanded. Several departments have grown from one to two, or two to four, full-time professionals, and a few are substantially larger.

The trend toward growth will be hard to sustain, however. Young people are generally not entering public health nursing (or, for that matter, public health in general). And, funding cutbacks jeopardize further expansions of services.

*Scope of Activities.* Virtually all LHD heads in Northeast Kansas are nurses. “I’m a clinician at heart, first a nurse—and that’s my comfort zone.” They look to regionalization for added support in planning, public policy, communications, and evaluation.

While Medicare-reimbursed home health nursing—along with hospice care—remains the backbone of LHD activity in the Northeast region, the LHD heads cite other activities as substantial elements of their practices:

- *cooperating with physicians* to establish a medical home for uninsured patients
- *maternal and child health* services, including Medicaid “KAN Be Healthy” assessments of children, participation in WIC, family planning, and school nursing
- *preventive services*, from immunizations to health maintenance visits to basic screenings, such as blood pressure measurement
- *environmental services*, such as water and pest control, which have experienced cutbacks in state funding so severe that one project participant finds environmental services in “dire financial straits”
- *disease surveillance*, which, instead of being formal, is routinely done in what might be called the “rural method”: through frequent but informal interactions with health professionals and other sources in the community, and
- *administrative responsibilities*, such as disease reporting, BT and emergency preparedness planning, billing, human resources, preparation of policies and procedures, budgeting, and meeting with county officials.

An overriding sentiment is that LHDs fall short of their potential, due to limited resources. For example, one LHD head is concerned about the lack of family planning services, despite high teen pregnancy rates, and about departmental inattention to sexually transmitted infections. Others see a need for more health education, and one is concerned that little disease surveillance takes place.

Evaluation also is a goal within a few LHDs. “I want to be able to confidently say, ‘this program is serving the people.’”

*Perceived Value.* Communities value public health services, according to most of the LHD administrators. Residents of the eight counties are said to:

- recognize that LHDs provide routine flu shots and other important services, such as a popular sexuality awareness program for parents and children
- view LHDs as a “valued silent partner,” which physicians in particular appreciate for investigation of communicable disease outbreaks and other public health interventions
- appreciate the expansion of services, extended hours for visits, and policy of accepting all who request assistance
- acknowledge LHDs as a “quiet presence” that makes an impact on the community through home health and hospice care—services that “tug at people’s heartstrings,” and
- value exceptional work, such as a drive-thru flu clinic that administered more than 500 immunizations in a single day.

But, some participants in the project look at the same glass of public esteem and see it as half-empty. Public health isn’t understood much, even by elected officials, says one source, and so it isn’t valued enough. One participant comments that “elected officials support us so long as it’s *status quo*,” meaning that, in the current economic environment, officials no longer will support additional funding or programming.

Those who see local public health as undervalued tend to favor public education as a path to enlightenment. “There’s a need to show people what public health is. It’s not just a ‘free clinic.’” A food recall is given as one illustration of a population-based intervention that prevents the spread of disease and would gain popular support.

*Tenures and Typical Days.* Among nine individuals interviewed for the Northeast case study who said how long they have worked for their agencies, the average (mean) tenure is 17 years. The long tenures reflect high job satisfaction. In describing their typical day, LHD heads talk about:

- an unpredictable and diverse clientele—“what I love is I don’t know if I’m going to be dealing with a newborn or a 99-year-old”

- enjoying conducting disease investigations—“it’s like ‘CSI’” (the popular forensic investigation TV show)
- about half of the work is direct nursing, including WIC, immunizations, sexually transmitted infections, family planning, KAN Be Healthy, and contract-based school nursing, and
- functioning as a leader and assuring readiness, by making sure staff will have the necessary equipment and other supports for the day’s work.

Local public health, the administrators find, is a dynamic field:

- “The day never starts out how it ends up.”
- My workday is spent putting out fires, with no time for strategic thinking and frequent “diversions” into lower-level tasks due to staff shortages—but “I wouldn’t want to be anywhere else.”
- “I can’t separate public health, focusing on the entire community, from some of the nursing services directed to individual clients—I enjoy both, and I feel welcome in every home in the county.”
- Despite the challenge of juggling family and work obligations, “I’m happy in public health.”

Most frustrations have to do with the administrative burden. One LHD head regrets having to give up accreditation of the department’s home health and hospice programs; the accreditation processes were just too cumbersome and expensive.

### *Moving Forward.*

“We have to convince the public that what we do is important. We can meet the mark when we get the money,” as with bioterrorism. LHDs accomplish much with very little.

Some local public health practitioners have attempted to gain public support and leverage resources. In one county, a community health alliance meets monthly and builds partnerships. Another county has ample local news coverage of LHD activities.

Several sources speculate where they might be in five years. They variously see themselves retired, semi-retired, moving into another field entirely, staying put but with an advanced university degree, or staying put but growing professionally and having a strengthened

agency. Even those who envision retirement want to make sure their department “keeps going”—fending off staff losses, fiscal pressures, and the demands of outside agencies.

There’s reason for confidence. LHDs in the region “are pretty strong and can take care of themselves.”

“We’re changing lives in public health.”

### ***Concerns About Protecting Autonomy and Services***

*Experiences Fuel Concerns.* Negative experiences fuel Northeast Kansas LHD heads’ concerns about regionalization. First, regionalization of Healthy Start—a program providing prenatal home visits—failed, partly due to the lack of a close relationship between regionally based personnel and individual clients. Second, WIC services have been partially “de-regionalized,” for similar reasons.

Third, most notably, centralization by the state Department of Social and Rehabilitation Services cut into county staff rolls and led to a perceived decline in services. This happened when a centralization initiative called Access Kansas replaced local field offices with its own kiosks—and new forms. One observer comments: “As offices closed in the name of ‘Access,’ there was a certain amount of cynicism to the experience.”

Not all previous regionalization programs have been negative. Cooperating to meet BT requirements has been a strongly positive experience. “Preparedness regionalization has been very positive, so I hope this will be, too.” Sharing environmental services, such as the services of a well inspector, also has worked smoothly.

Some LHD heads assert that regionalization would require support from the Kansas Department of Health and Environment (KDHE). Support could take the form of convening participants, offering guidance on best practices, and revising state data systems to provide LHDs’ unfettered access to data from their communities and to facilitate LHDs’ valid and reliable comparisons on performance

measures, both from county to county and from program to program. There is an almost universal feeling among the LHD heads that KDHE has not provided the type of support that would most effectively further regional cooperation efforts.

If local public health is regionalized, says one source, a home rule backlash will take place. This source notes that, when the Kansas Association of Counties previously explored regionalizing some services (by consolidating them, presumably), many elected county officials withdrew from the association.

*Concerns About Mandatory Consolidation and Funding.*

**AS IS EXPRESSED AT SOME 12 OTHER POINTS IN THIS REPORT, THE APPROACH OF REGIONAL COOPERATION USED IN THE KANSAS INITIATIVE DOES NOT INVOLVE CONSOLIDATION OF LHDs.**

The great regionalization bogeyman in the Northeast is mandatory consolidation of LHDs. The department heads view this as the dismal end for their county agencies. Even short of abolition of county LHDs, regionalization could mean, they suspect, dramatically less autonomy, reduced funding, and narrowed scope of services. It could also mean having to terminate some staff positions. However, the regional cooperation approach to regionalization specifically preserves county agencies and so is seen as an anchor for them.

Two views: “I want an equal voice and freedom in serving clients”; and “We want to retain our individuality.”

One LHD administrator opposed regionalization at the start of the project due to fear that it would lead to the replacement of LHDs with regional health departments—a fear that some leaders note was misplaced. But, this source expressed openness to sharing services, such as dietitian services. And, sharing services is the essence of the regional cooperation that the initiative promotes.

One regionalization scenario that Northeasterners worry about is a reduction in county funding for public health. If the state itself assumes control of local public health services—either by centralizing

services within KDHE or by setting up new regional entities staffed by state employees—county officials could decide that public health has become a state responsibility, justifying a sharp drop in county support. Given the low levels of federal and state funding, that’s a calamitous prospect. Clearly, regional cooperation provides a feasible and reasonable alternative to this scenario

Funding issues spark other regionalization concerns. For one thing, regionalization of some services generates travel costs—so-called “windshield time”—and even phone costs. For example, regionalization of certain home-based nursing services could compel LHD nurses to travel to other counties to deliver services, while regionalization of certain office-based services could compel residents to travel to other counties to obtain services. Travel is a significant burden; “it takes an hour to drive anywhere” in rural Kansas. But, regional cooperation does not contemplate the consolidation of most home-based nursing services.

Despite financial worries, LHDs in the Northeast are largely self-sufficient. The emphasis on nursing, especially home health and hospice, means that LHDs are able to bill Medicare, other third-party payers, or clients for most services they provide. But, LHDs must scrape to find resources to support their other activities, such as environmental services and other population-based public health functions.

### ***Practical Concerns***

*Feasibility and Finances.* Besides concerns for safeguarding their independence, LHDs raise practical concerns about regionalization, even in the form of regional cooperation. One set of concerns involves feasibility. The departments’ current staffing configuration, heavily dependent on nurses, does not include the skills needed to provide all the services intended under the Operational Definition of a Functional LHD.

And, as LHD heads often note, nursing services don’t easily lend themselves to a regionalized approach. Patients in the Northeast feel most comfortable with nurses from their own communities, several LHD heads insist: “It’s hard to provide a service here if you’re an

outsider.” Further, traveling long distances to make home visits is costly and inefficient. For these and other reasons, direct-care nursing services are extremely unlikely to be regionalized under any foreseeable version of regional cooperation.

Not only do LHDs receive little money from federal and state government, but also they lack easy ways to attract greater local funding. “Public health doesn’t have sirens and brightly colored vehicles to bring attention to our needs.”

Accreditation itself will take money, LHD heads recognize. LHDs may have to find resources to demonstrate compliance with complicated standards, prepare accreditation applications, conduct demonstration surveys, and submit accreditation fees. So, success with accreditation—which some LHD heads see as the great advantage of regional cooperation—“depends on whether there’s money,” even if accreditation wouldn’t require additional staff to meet the Operational Definition.

Linking regionalization to accreditation raises a specific concern to some participants. An accreditation requirement that department directors or other senior personnel have an advanced degree would hurt those who have a baccalaureate degree, perhaps in nursing, but no master’s, unless the accreditation process includes a grandfathering or waiver provision. An accreditation requirement of an advanced degree is pure conjecture, however.

*Project Operations.* Although participants in the Northeast region generally give it high marks (and frequently express appreciation for the assistance provided by NACCHO staff and consultants), they do raise a few concerns about how the project is unfolding.<sup>4</sup>

One concern is that a few LHD heads attend meetings only infrequently. This suggests to some participants that region-wide improvement is not universally considered very important. LHD heads who don’t consistently participate in the planning phase may be unlikely to participate in implementation activities later on.

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<sup>4</sup> The project is being separately evaluated.

Another concern is that Shawnee County conceivably could control events. One participant admits to finding this prospect “a little scary,” despite the Shawnee contingent’s unflinching cheerfulness, cooperation, and sensitivity. But another participant thinks that “it may be necessary to have a Shawnee County to get regionalization going” in a mainly rural region—providing that the more populous county doesn’t dominate the process and deprive the smaller counties of their sense of ownership. (No one suggests that such domination has occurred.)

On the whole, familiarity with the project is breeding support. “It took a while for me to figure it out; now I’m looking forward to a good communications product,” meaning that an impressive data report—as described in the next section—could be used to communicate to officials the value of local public health in general, and the value of regional cooperation in public health in particular.

### ***Regionalization’s Anticipated Benefits***

*Financial Advantages.* Most of the LHD heads believe that regional cooperation could enhance their departments’ finances. First, it would facilitate cost savings, such as sharing of resources and equipment. It could lead to common procedures and economies of scale in delivering services, such as maternal and child health and family planning, and to lower administrative costs for activities like billing.

Second, regionalization could boost the visibility of public health and thus loosen controls on state funding. “Public health [now] has no priority—we’re the silent little screen that keeps the flies out of the house.”

Regional cooperation might enable better pay for staff. One administrator mentions that regional salary data could be used to raise pay for severely under-funded individuals.

*Improved Services.* Other potential benefits of regionalization would include more thorough investigations of disease outbreaks, more comprehensive maternal and child health services, and more valid

data, grounded in a larger population base. Similarly, regionalization could increase access to specialized health care services.

For at least one LHD head, the bottom line is that regionalization would help citizens become healthier. Partly, this gain would result from improved communications across the region; outbreaks and other health events don't stop at the county line.

“You get used to working in your own little world and never thought about this before,” one administrator says about the need to perform all components of the Operational Definition of a Functional LHD. “We need more collaboration” to meet these essentials.

*Focus on Data.* As the first step toward regionalization, the Northeast LHD heads chose to look at data—specifically, “documents, protocols, and processes for data integration, analysis, and sharing.” This entails community health data, not management data like expenditures or number of immunizations performed or wells inspected.

The choice of data as the focus of project activity is widely supported:

- The participants regard data as a basis of public health, a way to improve the health status of the people they serve. (One observer notes that data are the foundation for assessment, informatics, monitoring, and evaluation.)
- They see data as information useful for strategic planning, until funding for a comprehensive community health assessment becomes available.
- They want data formats to be consistent across their counties.
- LHDs are constantly asked for information, and it's hard to respond without local analysis of data. (The state health data system, now under revision, has generally not allowed LHDs to generate local reports.)

Within the wide realm of data, and through structured group exercises, the participants chose two main functions for their data development effort:

- making health data more available to LHD staff and managers, county officials, and other stakeholders, including the general public, and

- formalizing data-related activities, identifying leaders to coordinate these activities, and engaging stakeholders.

*Internal Advantages.* Some LHD heads believe regionalization would benefit staff and that staff members would take advantage of regionalization to become more competent. Another draws on the experience of regionalization of preparedness operations—which has been “nothing but a success”—to predict that LHDs will gain both greater “voice-power” and the uniformity of standards and practices that facilitate backup in emergencies.

“We get back more than we give due to the scale,” this source sums up the preparedness experience. Another source mentions improved backup as an advantage of regional cooperation, while a third notes that it would build on existing relationships.

The timing is right for regionalization, one participant says, because a lot of the workforce is nearing retirement. New staff members will expect more of the technology and opportunities that will accompany regionalization. But, “the transition will be rough.”

More systematic development of policies and procedures is mentioned by one LHD head as an advantage of regionalization. These could address immunization standing orders, vaccine storage, laboratory services, personnel policies—and development of community health assessments.

Accreditation is a personal goal for some LHD heads. They believe accreditation—a driver of regionalization, as described earlier—will standardize services and increase efficiency, services, access, and protection of the public.

*The bottom line may be this:* Participants in the Northeast project express trust in each other and say that the initiative has added new perspectives to their work.

### III. PIONEERS IN NORTH CENTRAL KANSAS: THE BOTTOM-UP APPROACH

#### *The Project in Perspective*

*Thirteen Counties.* The North Central region, one of 15 Kansas regions formed to meet public health emergency preparedness requirements, is emphatically rural. In the early years of the 21<sup>st</sup> century, this means that the 13-county region is slowly losing population. School enrollments are down. Much of the population is aging. On average, counties have fewer than 7,000 residents.<sup>5</sup>

“We have a declining population and no industry. The largest employers are dairies and hog operations, with one or two small equipment manufacturers.”

The decline has exceptions. Near cities like Salina—whose population is approaching 50,000, just outside the region—upscale housing is being built for new residents. Wind farms and other new-tech enterprises are being established, offering the prospect of jobs and revenue for county governments. Federal support for ethanol is boosting corn production. Here and there, economic development agencies are active. Improvements in the ways some counties are managed have led to the creation of reasonably well-paying jobs providing county services. In at least a few counties, populations may have bottomed out after years of losses.

Overall, however, generally declining economic conditions are increasing the need for local public health services. “We have more teen pregnancies, drug use, domestic violence, and dysfunctional families.” As many as one-third of families served by the Healthy Start program are said to have problems like these, with families of temporary workers at especially high risk.

Relationships between LHDs and the health care system can be fragile. In some places, a physician effectively controls the local small hospital, exercising power seemingly arbitrarily. Some indigent

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<sup>5</sup> U.S. Census, 2006 data.

patients have no access to dental care. Physicians have been known to ignore LHDs—even though, says one LHD head, “we could do so much together”—and to block a community health assessment initiative. In other counties, however, physicians are gaining awareness of the wide range of services provided by their local LHD and are becoming enthusiastic partners of the public health system.

One county owns and operates its health care system, which includes a home health service, essentially putting that county’s LHD out of the home health business. Still, the LHD provides a substantial amount of nursing services, such as immunization services.

In some counties, politics are a powerful obstacle to public health advancement. “One of the biggest barriers is that most county commissioners in the region don’t want a lot of change.” In general, though, today’s county commissioners are considered more “forward-looking” and better educated than some of their predecessors. Some LHDs are hampered by vacancies in county offices, like the position of coroner, or by less than fully cooperative county attorneys or other officials.

*General Attitudes Toward Regionalization.* LHD heads in North Central Kansas feel that regionalization is afoot. “It’s so helped doing emergency preparedness as a group.” Initial regionalizing efforts—undertaken before the project discussed in this report—have included approaching another county for help in administering a program. A broader effort involved immunizations; LHDs were disappointed that this region-wide project did not result in greater funding.

Clearly, development of a national program to accredit LHDs and state health departments would spark major change. The drive toward accreditation is grounded in an expectation that LHDs will provide—alone or in concert—all components of the Operational Definition of a Functional LHD.

Beliefs about the value of regionalization are mixed:

- “I don’t see how my single county can do a lot of things and be the best at everything. By partnering with other counties, we can pull each other up. But, it would make more sense to

partner three to five counties than all 13, due to the distances involved.”

- “It’s going to depend what it looks like.” Regionalization among peers could improve overall efficiency and comprehensiveness of services, but systematic coordination by one department for the entire region could actually impede cooperation on specific projects.<sup>6</sup>
- The region is well equipped for greater coordination. “We’re all the same kind of people, committed to public health and serving our counties, but in different ways.” For example, some emphasize a personal approach, while others are more comfortable working with state and national organizations and reporting mechanisms.
- “We communicate among ourselves a lot already. Our region is very good about that.”
- Regionalization will mean greater efficiency, a higher level of service, a more proactive approach to public health problems, and more specialization: “We’re all jacks-of-all-trades now.” But, regionalization will likely cost some people their jobs.

The prospect of specialization makes several LHD heads optimistic about regionalization. “It can only improve things. There’s so much in public health no one person can know it all, and the community deserves it all. With regionalization, we can each become an expert in something and then share that.”

Even this source, though, says that many services—like the nursing services that dominate the activities of rural Kansas LHDs—have to be delivered one-on-one in North Central Kansas due to the strong sense of community: “When you hear a siren here, you probably know who it is.”

### ***The LHD World***

*Departmental Evolution.* One North Central LHD, purportedly the state’s first rural health department, arose in the 1940s and 1950s to meet needs for immunizations and home health services. Another

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<sup>6</sup> Dominance by a single department is not a characteristic of regional cooperation.

early LHD began with immunizations and family planning, then quickly added home health. All 13 LHDs are led by women nurses.

LHDs in the region have progressed in different ways. “We’ve embraced technology. We’ve freed up our time to do education on physical activity and nutrition, and we do a better job partnering with people in the community. We’re out in the public more, so they see us as more consumer-friendly and approachable and as a good source of referral information. [We’ve changed our culture slowly.](#)”

One department has expanded its staff, added programs, gained visibility, and undertaken a new role in emergency preparedness and BT. The last was “a big change that has taken a lot of time.”

A long-time administrator says, “[There are more demands on us, as I feel whenever I come to work in the morning.](#)” She laughs as she says this, reflecting a natural cheer—and a tendency not to take her own complaints too seriously. She adds, “We’ve gained support from the public and providers. We’re seen as part of a team.”

Some departments have more than doubled their staff size; one example is an increase from two nurses and one clerk to four nurses, two aides, and a clerk. One department grew from a few part-timers to more than a dozen full-timers. Like many LHDs in the region, this department moved to a larger and better space—in this case, from a basement to its own building.

Success at gaining better visibility is mentioned by another administrator, who describes it as “[showing we’re for everybody and not just the poor.](#)” Generally, says this source, she and her colleagues in the region are “good at direct tasks but not sure how to achieve a community-health focus.”

In a similar vein, one LHD head lists a community block grant, a new building, and an energetic coalition on adolescent health as key achievements of the past several years. Others point to breaking down virtual walls separating program silos, creating a calendar of activities, initiating cross-training of workers, and achieving teamwork and better customer service, such as scheduling appointments for specific time slots.

*Scope of Activities and Typical Days.* As in Northeast Kansas, nursing services—such as home health visits, immunizations, and blood pressure checks—take up much of local public health practitioners’ time in the North Central region. “I see walk-ins, do physicals and ‘KAN Be Healthy’ assessments [the Medicaid screenings for children], blood pressures, and foot care” is how one LHD head summarizes her typical day.

Two views: “Direct nursing is what I like best”; and “We’re the primary care provider for a lot of people, especially single women.”

The commitment to nursing is striking. “To me, customer service comes first. I still do home visits, to preserve continuity of care for my long-time patients. People are so much more important than paperwork.”

One LHD head relates that “today I have eight appointments with clients in the office.” These visits involve lots of health education, concentrating on diabetes and nutrition, often for patients referred to the department by a physician. This administrator estimates that her time divides up as 70 percent care and 30 percent administration.

Other activities listed by LHD heads include:

- disease outbreak investigations
- drug screen tests
- organizing a benefit tournament and serving on community committees
- orienting a day care provider new to the area
- rabies control
- mediating staff disputes
- renewing an employment agreement, and
- preparing board minutes.

LHD heads constantly re-prioritize. “There is no typical day. I do a mixture of administration and nursing and feel that I should be the backup person when everyone else is busy. I like the variety, but some days there’s a little too much variety.” (Laughter follows.)

The need to provide backup is emphasized by an administrator who says. “If you want to be an effective manager, you have to take the low person on the totem pole’s role, like doing hearing tests. My staff knows I’m willing to dig in the trenches with them.” Another says she’s making hospice visits due to a temporary staff vacancy.

Another describes being busy all day, taking work home and not taking a lunch break. This source finds “it’s a challenge every day—totally different.” But, she notes, “It would be nice to have time to be proactive instead of just putting out fires.”

“I take one day at a time so as not to be overwhelmed. I don’t know until I get here what I’m going to be doing. There’s never a dull moment.”

The administrators have found themselves moving into new spheres of activity: “Personnel problems are the worst and the least productive use of my time”; but “Now I love public health despite starting in home health.” One administrator just began treating her first case of active TB, involving three closely related families. Another mentions learning how to function in government and suggests that there are advantages to reporting to a county administrator rather than reporting directly to the entire board of county commissioners.

Public health practice in a rural community is intensely personal: “A family called me to complain about head lice on a child. I realized there was a child custody dispute, so I dealt with it accordingly.” That meant sensitively targeting educational messages to individual family members. This administrator says the rural method means staying in touch with the community—by attending Friday night high school games, for example.

*Perceived Value.* Do residents of North Central counties appreciate their local public health systems? “Sometimes I really question whether we are valued or not. Only home health and some immunizations are clearly valued.”

Young families—who come in for immunizations or WIC and then are educated about lead poisoning, child safety seats, and other health

promotion issues—and older families needing home health care do tend to show the greatest appreciation, says another LHD head. One administrator sees a trend where many residents “don’t appreciate our services as much, because they see us only to seek help in a crisis, when they don’t know what else to do financially about their health care.” This source notes, however, “We have little successes that make it all worthwhile.”

Others note that public health is more valued than understood: “They don’t know what public health is until it happens to them”; and “People think of it as direct service rather than as population-based.”

Appreciation is increasing, according to several administrators in the region. “We’re seen now as a resource, but many people don’t totally understand what we do. They see us as the people who give shots.” Another administrator notes that emergency preparedness activities have enhanced her LHD’s prestige among other agencies and health care providers.

Residents “see more value now than before because I’ve made it a point to make it more visible.” Greater involvement in community-based grant projects and coalitions with schools and towns have led to greater understanding about local public health, explains another source.

*Frustrations.* Like any work environment, the LHD landscape in North Central Kansas includes frustrations. Regional cooperation, or any other broad strategy intended to improve the situation, would reasonably take some of these frustrations into account, almost as a sort of needs assessment.

One administrator expresses the positive side of administering an LHD in the North Central region: “I know I’m lucky. I have support, finances, and a wonderful staff with low turnover—I don’t have a lot of stresses.”

Most of the LHD heads’ major frustrations center on paperwork requirements. “I’m a doer, so the paperwork is a burden. I’d rather just do the care.” To another, that burden is so heavy that “there’s not enough time to do everything to my satisfaction.” For example,

the various state forms on grants and budgets may not always be completed fully and accurately.

BT accounts for much of the frustration over the administrative burden. One administrator notes that presumed partners—from law enforcement agencies to hospitals—don't involve themselves in BT activities. Another complains that the BT burden was imposed on LHDs without enabling them to hire additional personnel.

“Understanding the billing component” is mentioned by one LHD head as her primary frustration. “Personnel problems” gets the nod from another as the greatest source of angst: “I’m a gutless wonder, and then the problem gets out of hand. I have no training in human resources.”

One administrator emphasizes the low pay: “The county doesn’t always see us as professionals, and the commissioners just don’t approve pay increases.”

In one county, integration of the health care and public health systems prevents competition among agencies and providers, according to the LHD head. The negative side of this lack of competition is that “it can lead to complacency, due to the lack of an incentive for progress. New ideas take a long time to be implemented.”

*Moving Forward.* Among nine LHD heads who said how long they’ve administered their departments, the average tenure exceeds 10 years. For the most part, these tenures appear likely to grow substantially longer.

Many of the LHD heads look forward to improvements in the content of their jobs under regional cooperation:

- “Paperwork will take less time, and I’ll be more experienced.”
- “I hope I’ll have more time to take on more projects.”
- “We’ll have more services,” such as wellness programs developed in partnership with third-party payers and employers.
- “We’ll move out of home health, an area where private agencies can be more cost-effective.”

Other anticipated improvements involve the administrators' own return to school for advanced degrees.

Some administrators express only the “hope” that they’ll retain their jobs for many years, reflecting doubt that their local departments will survive. One says she tries not to think about the changes that are likely to occur, because already “I tend to be a perfectionist and put too much pressure on myself.” This source expresses enjoyment with the job of heading an LHD and says, “There’s a great group of people I work with.”

One administrator says she may not want to continue in her position but that change to another job would be hard. Another says she plans to retire within a few years.

The extent of current gaps in meeting components of the Operational Definition is unclear. Some North Central administrators feel that assessments of their departments performed as part of the NACCHO-supported regional cooperation project do not adequately capture the full range of services that rural LHDs provide. To illustrate, small departments typically perform some services, like disease surveillance, in informal, but effective, ways (what may be called “the rural method”). Further, small departments rely on other county, local, or state agencies—from schools to county attorneys—to perform some activities related to public health.

### ***The View of Regional Cooperation***

*Desired Improvements.* As suggested earlier, the administrators of most North Central LHDs perceive concrete advantages to regional cooperation. What, specifically, are those advantages—and are they offset by the disadvantages? One of the real advantages, in their eyes, is a lessening of the administrative burden.

A “huge” benefit, says one administrator, would be the development of uniform policies and procedures, or a template that each LHD could individualize. These documents could include job descriptions or immunization guidelines, for example. Another administrator foresees a lessening of paperwork “so we could just do the work” of providing public health services. A third wants regionalization to

result in taking most BT administrative responsibilities off her hands. Others mention the ability to complete grant reports in the same way without having to spend inordinate amounts of time figuring out the specifications for each report form (“we’re nurses, not accountants”).

Another anticipated advantage of regionalization is a higher level of expertise and service. One LHD head says sharing of some staff would be “wonderful—we would have backup when someone’s on vacation, we could get a social worker for the region and better tobacco control, and our dollars would go further.”

Others also talk about expanding, sharing, or improving coordination of professional services—not only those of social workers, but also dietitians, epidemiologists, day care inspectors, business managers, and health educators.<sup>7</sup> For health education, some LHD heads suggest that each administrator in the region could specialize in a specific topic, such as breast-feeding or diabetes.

Cost reduction and increased funding are a large impetus for regional cooperation. Group purchasing of prescription drugs—which are hard for a small county to buy in bulk, due to expiration dates—and supplies would save LHDs money. On the revenue side of the ledger, regionalization is seen as an excellent way to help obtain more grant funding (although there’s also some concern that a regional entity could generate another layer of expenditures) and professional-level salaries.

“To my way of thinking, independent health departments will be a thing of the past, although every county needs a department.” The key, in this view, is the relationship among departments—maintaining a strong local presence while boosting regional coordination throughout the region.

Administrators list diverse other advantages:

- a regional health assessment, because “in the future we’re going to have to have the data to document what we do and

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<sup>7</sup> One observer sees specific value in regionalizing inspections because a regionally based expert could be more objective: “It’s hard for a local person to be an inspector.”

- [what we need](#)"; “we would know if we’re going in the right direction, and so we could get grant funding”
- *best practices*—“getting together and sharing best practices is a great aspect of regionalization, helping counties get up to speed and get rid of our frustrations and push the concept of public health”
  - *a reduction in health disparities*, even though this will be very hard because any community contains groups with a disproportionate share of health problems
  - *better communications*, to “[make us more visible and the community more knowledgeable](#),” and
  - *a more effective response to a pandemic*, which “would take everyone working together, so regionalization can only be beneficial,” as has happened in emergency preparedness.

*Reservations about Regionalization.* Just as the administrators see concrete advantages to regionalization, they also hold specific reservations. “Regionalization has been talked about for many years, usually as a threat.” The threat is that LHDs will lose funding, autonomy, identity—and jobs. (This threat only applies to a forced or consolidated approach to regionalization, not to regional cooperation.)

Other unwanted changes include evaluations of LHDs and of administrators: “I don’t want to take another test!”

Travel distances are frequently mentioned as a barrier to regionalization of certain services. “I can see some things being done on a regional level, such as technology and education and disease surveillance. The part I struggle with is the actual care, including WIC and family planning. Consumers won’t go somewhere else, especially with \$4-a-gallon gas. I don’t know how to make this efficient.”

With 13 counties, some say the region is too big. “It also has too much politics to do very much together. Some counties are very resistant. If we split into smaller regions, we might get more base funding and we wouldn’t have to contend with having to do group process with as many as 13 people.”

“How can we get everyone on the same page?” asks one administrator. To standardize services will be difficult, she comments. Different counties treat consumers in different ways, depending on the county’s size, resources, and level of support for public health.

Even the nature of the 13-member group is seen as a potential problem. “We tend to argue about policies and procedures,” says one member—almost as if agreement on important points should come easily. “We do tend to beat the dead horse,” says another.

So, how has the region developed an approach to secure the advantages of regionalization and avoid the pitfalls? The answer lies partly in the spirit of Kansas.

*Pioneers.* The North Central Kansas administrators have insisted on a “bottom-up” approach to regionalization. This means that the administrators themselves make decisions about which activities to coordinate, and they design those activities during meetings of the entire group. The Kansas Association of Local Health Departments helped develop and has strongly supported this approach, and NACCHO, too, has welcomed it. Indeed, the bottom-up approach is inherent in the entire regional cooperation initiative.

The administrators say that Kansas grew as a state of “trail-blazers” who stood on their own two feet, tamed a frontier, and refused to let others make decisions for them. Aware that their hard-working forebears built their own communities and structures, the LHD heads assert a right to help design any system used to improve, administer, or evaluate their departments and their performance. They insist that funding levels should be matched to realistic expectations, so that they will have enough resources to meet the accreditation standards applied to them.

The LHD heads describe their compulsion to make their voices heard:

- “I want to be on the bandwagon.”
- “I won’t be pushed into another [regional] legal entity that will make me lose ground with my community partners.”
- “We’re making all the decisions as locals.”

- “We’re keeping our small-town focus.”
- “It’s exciting to be part of a national project!”

Even pioneers often have guides, and the North Central administrators struggle with finding a balance between self-direction and direction from outside. One LHD head describes the struggle as one of professional liberation:

As nurses, we’re so used to being told what to do that it’s hard for us to decide what we want. In nursing, our comfort zone is to be told what to do, and we’re trained to follow orders and complete forms. We’re all workers and doers. Our profession doesn’t tell us to think outside the box very much.

Concern also exists that the state will take over the regionalization process, as opposed to supporting the “bottom-up” approach that LHD heads have hailed as critical to this initiative’s success.

One administrator says, “I don’t see how we could have done it ourselves—we need outside expertise. It’s all quite overwhelming and intimidating, especially when we’re so busy day-to-day. I’m still uncertain, but I’m learning along the way.”

Another point of skepticism involves the horizon: “We could do things regionally that would really help everybody. But it’s too monumental to regionalize everything at once. You can only do it in bits and pieces—and then sustainability is a problem.”

Several participants say that support for regionalization will grow if, and only if, regional cooperation project produces something worthwhile and tangible in the short term—a product that “grows into something important.” For the initial achievement, the group chose to develop a communications plan for informing county, local, and state decision-makers about the role of local public health.

### ***The Trail of the Future***

*Communications and Commissioners.* “I was surprised that communications was picked, but you need it to do everything else.” Others agree on the necessity of reaching key audiences with a

message about the importance of local public health. “There’s a lot of room for education about what we do or could do.”

Some LHD heads are heavily involved in communications, showing an enterprising approach to positioning their department. These administrators prepare and distribute annual reports, regularly brief their county commissioners on programs and problems (“taking the time to do that builds trust”), advertise services, produce and distribute promotional products like refrigerator magnets, and conduct market research to determine what services residents want.

When you ask the heads of most North Central LHDs about communications, they answer by referring to the need to persuade their county commissioners to provide sufficient support to public health. Holding the power of the purse renders the commissioners the key audience for county agencies.

But, commissioners are elected officials; they respond to the views of county residents. So, says one administrator, “I’ve gone to lots of community meetings to show people what public health is. I made my own PowerPoint presentation that even showed how much each homeowner was paying for public health and how each of the Ten Essential Services of local public health relates to their group.” Such groups included the Lions Club, church organizations, 4-H, and others. “These conversations went pretty long and were well received.”

Another way that LHD heads have found to influence their commissioners is to recruit them to help with publicity about programs. Yet, even commissioners who are recruited for this purpose aren’t necessarily persuaded to support more funding. One administrator who has done this says, “They still don’t realize our work load, though. Local public health is unique, but we’re lumped in with all the other county offices. When we show them how much we do, they’re flabbergasted—but they expect us to handle it and take us for granted.”

To further build support with commissioners, LHDs rely on the Kansas Association of Local Health Departments, whose executive director wins praise as “a mover and a shaker,” and the Kansas

Association of Counties. One administrator says that, when leaders of these organizations explain the role of local public health, “that makes more of an impact than what I can do talking to the commissioners.” This LHD head believes that commissioners tend to have difficulty conceptualizing public health: “If they look at a bridge in need of repair, they know what to do, but public health is very abstract. It may be 20 years before you see a result from educating the commissioners.”

In some counties—especially counties seen as leaders in local public health—the commissioners are very supportive of their LHDs. Commissioners with a health-related background—notably, in one county, a former public health nurse—are considered more supportive than commissioners with a primarily agricultural background. Commissioners who are invited to, and attend, LHD advisory board meetings become better informed than commissioners who are never included in LHD discussions.

From a communications perspective, the challenge of reaching county commissioners and other important audiences involves the framing of messages. “Commissioners don’t respond to statistics” about public health, which suggests a need to provide meaningful anecdotes and scenarios to illustrate the importance of the LHDs’ work.

*Coalitions.* In the North Central region, a great deal of LHD success results from finding time to tap into community networks and to join or form coalitions. LHDs that pursue this route appear best equipped to defend their need for greater resources. Not only do they have partners willing to speak up for them, but also they are best able to obtain grant funding and help produce demonstrable improvements in county residents’ health status. What’s important to the North Central LHD administrators, however, is that they and others in their communities form their own partnerships, rather than having partnerships imposed on them by outside authorities.

Some North Central LHD heads report that involvement in grant-funded community projects has increased appreciation for local public health in their counties. Partners have included schools and towns, and projects have involved recreation and teen substance abuse

programs. At least one county has the advantage of a community foundation to support coalition-based activities; its LHD learned that a community health assessment is itself a great way to build awareness of local public health and to organize for the future.

As local health departments in the North Central Region move forward, it is anticipated that greater cooperation will emerge through:

- informal contacts among LHD heads to discuss common problems
- regional meetings to craft programs and present a united front
- compatible information systems and comparable data sets, and
- a more welcoming attitude toward public health organizations and advocates from outside the region.

## **VI. THE VIEW AT THE END OF THE PROJECT**

### ***Early Impacts of the Recession***

*Falling Revenues.* By late 2008, as the nationwide and global recession began to complicate all government and social programs, the prospects of public health regionalization in Kansas grew murkier. Will tougher economic times force LHDs to share more resources, or will they lead administrators to hunker down and avoid new endeavors, including cooperative ones?

With a stable housing market and a tradition of fiscal conservatism in county government, the Sunflower State is better equipped than many to weather the storm. But, in January 2009, the governor proposed a series of immediate cuts, and the state government faced a potential \$1-billion budget deficit in FY 2010. Already meager, state funding of LHDs is almost certain to decline.

County tax revenues also may fall. At least one county treasurer announced a drop, due in part to slower payments by taxpayers. Another county imposed a blanket 10-percent cut on all departments for non-personnel items. Some local health officials took five-percent pay cuts along with reductions in cell phone use and mileage reimbursement.

*Rising Volume –and Other Pressures.* By January 2009, the results of cutbacks are already apparent. “We’re no longer able to contract for services in child care review and environmental health and maybe won’t much longer in chronic disease. Evaluation has gone down, too.” Another agency eliminated child care licensing and positions in home health, social work, and environmental services. In a different county, the LHD head says low salaries prevent her from competing with the private sector for top-flight nurses. “In tough times, preventive health goes right out the window,” laments another administrator.

Meanwhile, demand for services is up, as people lose their jobs. Almost all LHDs report an increase in demand for WIC services, which one administrator says is growing “almost daily.” Another says demand for home health services is so high that, for the first time, her agency has had to reject qualified patients.

And, there are additional economic pressures. “Core services pay very little.” Another administrator offers an example: Private insurers, this administrator says, pay as little as \$3 for flu immunizations when the vaccine alone costs as much as \$47 per patient. Other pressures include:

- Private insurers continue to treat rural health departments unfavorably as non-network providers, even in counties that don’t have any network providers.
- Departments are receiving lower payments for personal health services, as many patients now have lower incomes and so pay lower rates on sliding fee scales.
- Fewer home purchases mean less demand for fee-based environmental services, such as well inspections.
- Hospitals and physicians compete with local health departments for those health care services that are adequately reimbursed, such as KAN Be Healthy assessments.

*Impact on Regionalization.* The Kansas administrators haven’t lost their optimism, though. Many pin their hopes on “a new administration in Washington”—one that might provide “more dollars

for public health,” especially for preventive services like family planning.<sup>8</sup>

What’s the bottom line? Several project participants anticipate that the recession will speed the pace of regionalization, because “sharing is more economical and cost-effective.” Indeed, “all government organizations” throughout the state are considering regionalization. But, a regionalization champion sees several barriers to progress, ranging from competing time pressures on LHD heads to a lack of enthusiasm for regional approaches. As if to illustrate the point, one administrator expects to be “too busy” completing grant reports and meeting other obligations to pursue regional cooperation.

### ***Dealing with Policy-makers***

*State Responsiveness.* The regionalization enterprise may have helped improve relations between LHDs and state officials. The state Department of Health and Environment is “starting to use us as a resource, contacting us for information about how we do things.” Further, the department is making strides at improving data collection and analysis.

Nonetheless, many state policy-makers appear to remain generally aloof to public health needs. “We’ve created some awareness at the local level,” a leader of the regionalization initiative says, “but we have a long way to go with state elected officials.” KDHE has little clout in the Legislature, especially after crossing swords with legislative leaders over a controversial power plant issue. And, an LHD-oriented application for state funding of maternal and child health services was recently turned down.

In Kansas, regionalization efforts suffer because areas set up as regions for one program, such as WIC, contain different counties than areas set up for another program, such as emergency planning. State officials recently directed that large WIC regions be divided into smaller units. This change created stress in a WIC region that incorporated most of the 13 North Central counties.

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<sup>8</sup> This comment, like all interviews for this report, was made before Governor Sebelius’s appointment as U.S. Secretary of Health and Human Services.

*Responsiveness of County Commissioners.* According to LHD administrators, many commissioners in both regions are now more enlightened about public health issues. One commissioner even wants the LHD to become more involved in policy change.

Commissioners learned about the importance of local public health and reasons to share some services at an intensively planned local health regionalization “summit” in September 2008, supported by the Kansas Health Foundation, Kansas Association of Counties, and Kansas Association of Local Health Departments, and attended by both a commissioner and an LHD administrator from each of 35 counties. A similar session took place at a Kansas Association of Counties meeting two months later.

But, many commissioners remain skeptical about regionalization. One spoke up at the latter meeting to point out that a commissioner’s responsibilities stop at the county line. Unimpressed with this logic, one LHD head responds:

This is not the kind of mindset that’s going to work. We’ve got to have cooperation. Diseases don’t respect county boundaries.

As elected officials, county commissioners are sensitive to the views of county residents; increased respect by the public for local public health will translate into budgetary and administrative support for LHDs. And, this project and the summit have contributed to “steady growth in awareness, understanding, and appreciation of public health—we’re more often brought to the table.”

*Communicating with the Public.* Local public health programs themselves build support for LHDs. In rural areas, word of mouth is often the best advertising. “All it takes is one or two laid-off people who lose their health insurance and realize they can get services with us, and they tell other laid-off workers.”

LHDs in Kansas still lack a full-blown communications strategy. “We’re still at the stage of educating the public and getting our message out that we’re not just for poor people and not just free

services.” One administrator captures, perhaps inadvertently, the contradiction between working quietly and seeking greater support:

You don’t sound the sirens whenever there are 20 cases of something. You just have to work discreetly to see that threats are contained to keep people safe. The public has to demand that something be done. It’s what the commissioners and legislators hear about that gets addressed.

“We don’t do a good job of tooting our own horn. Unless you need our services, we’re invisible.” A colleague agrees: “We’re all bad about advocating for funding of public health infrastructure.”

## **Regionalization’s Future**

*Project Results.* The regionalization project was a huge learning experience, says one administrator, adding that it gave LHD personnel a feeling of control. “We were like the Petri dish,” this source says.

The administrators believe they still have to improve their group skills. “We have to learn how to be better decision-makers and problem-solvers.”

As the project officially wrapped up, the group of eight Northeast LHDs began making plans to continue their regional cooperation efforts by recruiting student interns from the nearby University of Kansas (KU) to collect and analyze data—plans that later came to fruition. Developing a strategic plan for collecting and analyzing data was the focus of the group’s activity during the regionalization undertaking. One reason that emerged during the project for regionalizing data collection is assembling sets of data that cover a large enough population to attract the attention of outside funding agencies. The LHDs decided to donate their own funds from the undertaking in order to pay the interns \$9,000. They also intended to rotate attendance at monthly regional planning commission meetings, in order to show the public health flag to the commission.

To a participant from the three-county multi-county health department, the project was “frosting on the cake,” expanding the benefits of cooperation across county lines.

But, strapped for time and other resources, six of the eight Northeast LHDs decided against participating in another project developed to help prepare public health departments for accreditation: Phase III of the Multi-state Learning Collaborative. And, perhaps due to unrealistic expectations or a lack of intense involvement in the latter stages of the project, two Northeast administrators expressed some dissatisfaction that the data effort hasn’t yet yielded “usable data” or “any progress.” Similarly, some sentiment exists in the North Central region that participants “have not seen anything” concrete come out of the communication effort—its analog to the Northeast’s data effort.

*Regionalization Benefits and a Concern.* In the Northeast, participants express appreciation for the Shawnee County contingent’s leadership. “They were great at getting our input and going the extra mile to keep people happy”; and “We’ve gleaned a lot of benefits from having Shawnee County in our region, and we all realize that.”

A few participants believe their regions must develop a community health assessment, in order to track progress, identify gaps, and assure that LHD programs match community needs and concerns. “That’s something that’s truly lacking in our area and needs to be done regularly, with focus groups and surveys and community involvement. I learn so much talking with the community about their expectations.” (Community health assessments also can serve as a vehicle for strengthening links between an LHD and the community.)

At the end of the project, participants were identifying the types of services they might share in the future: epidemiology, health education, grant-writing, BT coordination, family planning, actual WIC services (not just coordination), and the services of social workers, dietitians, and child health specialists.

One driver of regionalized services could be the aging of the public health workforce. One administrator is nervous that almost all LHD

heads in her region might retire within the next five years, with no region-wide planning for this contingency.

Legal liability may be a concern. LHDs that contract with another county for services don't want to be liable for the other county's mistakes.

*Prospects for Regionalization.* Progress toward regionalization in Kansas may be linked to accreditation. Assuming adequate funding, one administrator says counties will regionalize if accreditation takes place, perhaps even hiring a regional administrative coordinator. Another administrator sees accreditation as an "opportunity to learn how we compare with other counties" and to obtain recognition. But, another view is that LHDs in rural Kansas have to build greater capacity in order to qualify for accreditation, and that people in Kansas aren't yet ready to support greater capacity-building.

"I think we'll get there eventually," one Northeast administrator says of full regional cooperation. "We collaborate daily, but we're not at the point of putting programs together."

One observer says the process may move faster in the Northeast, benefiting from Shawnee County's resources and leadership. But, this observer says regionalization also will advance in the North Central region, where there's more "natural interdependence," because departments are smaller and so "tend to try to work together with their neighbors." One of the North Central administrators says coordination of bioterrorism preparedness will continue to be regionalized, but, as for other areas, "I'm not sure."

Even in the Northeast, one administrator who's a regionalization advocate says some administrators have so much "passion" about certain activities that they won't give up control. Another agrees: "I'm very positive about regional cooperation, but the hardest part will be to define the management structure," when LHD heads don't want to give up local control. Still, another considers regionalization a "[way for small health departments to survive and even to flourish.](#)"

Asked in the immediate wake of the project, in January 2009, what they considered the best of three ways to meet accreditation

standards—continuing the *status quo* of separate departments, consolidating into a full-scale regional department, or sharing services through regional cooperation—nearly all of the re-interviewed administrators support regional cooperation. The lone exception backs consolidation, in order to cope effectively with resource shortages during tough economic times. And times, indeed, were growing tougher.