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FINAL REPORT PRODUCT

Poster Presentation


RWJF Grant No. 72055

This study examines the following question: Does cross-jurisdictional sharing (CJS) influence the volume, intensity, and unit costs of services delivered by local health departments (LHDs)?
Exploring Cross-Jurisdictional Sharing Among Local Health Departments in Four States

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Background

The question: Does “cross-jurisdictional sharing” (CJS) affect the cost and efficiency of local public health services?

Cross-jurisdictional sharing (CJS) defined: Sharing of financial, human, and other resources between local health jurisdictions (LHJs) on an ongoing basis.

Hypothesis: More formal, intensive CJS associates with: 1) lower service delivery costs and 2) more efficient service delivery.

Key policy issue in many states today. Is CJS a viable policy alternative to consolidation, regionalization, and other structural changes in local public health service delivery?

Methods

Comprehensive survey on CJS activity sent to all LHJs in four states: New York, Oregon, Washington, Wisconsin; Response rate 65% (N=145)

Combined survey results with data on: 1) Public Health Activities & Services Tracking (PHAST) “MPROVE” measures; and 2) administrative data on annual LHJ spending

Empirical analysis of a sub-sample of Washington LHJs:
- Propensity score matching to compare per capita spending for CJS vs. non-CJS WA LHJs
- Data envelopment analysis (DEA) to compare technical efficiency for CJS vs. non-CJS LHJs

Ten case studies of service delivery - five CJS and five non-CJS jurisdictions across all four states

Effects of Cross-Jurisdictional Sharing

Per Capita Spending on Five Communicable Disease Service Areas for WA LHJs, CJS vs. non-CJS Jurisdictions (N=12)

<table>
<thead>
<tr>
<th>Service Area</th>
<th>2010-12 CJS</th>
<th>2010-12 Non-CJS</th>
<th>Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Immunizations</td>
<td>1.50</td>
<td>1.75</td>
<td>-0.25</td>
</tr>
<tr>
<td>Food Service Inspections</td>
<td>2.00</td>
<td>2.25</td>
<td>-0.25</td>
</tr>
<tr>
<td>STI Prevention</td>
<td>1.75</td>
<td>2.00</td>
<td>-0.25</td>
</tr>
<tr>
<td>Tuberculosis Prevention</td>
<td>2.25</td>
<td>2.50</td>
<td>-0.25</td>
</tr>
<tr>
<td>Water System Inspections</td>
<td>3.00</td>
<td>3.25</td>
<td>-0.25</td>
</tr>
</tbody>
</table>

Note: Lines denote a 95% confidence interval around the mean

Efficiency Rankings for WA LHJs, CJS vs. non-CJS Jurisdictions (N=25)

<table>
<thead>
<tr>
<th>LHJ Characteristics</th>
<th>Efficiency Score Rankings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Density</td>
<td>CJS vs. non-CJS Jurisdictions</td>
</tr>
<tr>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Cross Vaccinations</td>
<td>3</td>
</tr>
<tr>
<td>STI Prevention</td>
<td>3</td>
</tr>
<tr>
<td>Tuberculosis Prevention</td>
<td>3</td>
</tr>
<tr>
<td>Water System Inspections</td>
<td>3</td>
</tr>
</tbody>
</table>

Shaded cells = jurisdiction has CJS for communicable disease services

Qualitative Evidence

Interviews with LHJ leaders suggest CJS is most effective for:
- “Goldilocks” LHJ populations - not too small, not too large
- LHJs willing to trade informality and flexibility for formality and transparency
- LHJs with strong coordination among communicable disease, environmental health, and epidemiology
- Communities with strong relationships among public health, health care, public schools

Next Steps - CJS and Service Reach

Childhood Vaccination Completeness Rates, CJS vs. non-CJS LHJs (N=33)

Conclusions

Local health jurisdictions use CJS principally to improve services and make better use of resources

No evidence that cost savings is a distinct motivation or a clear effect of CJS

Jurisdictions that employ in cross-jurisdictional sharing tend to be more technically efficient and serve smaller populations

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