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GOVERNANCE MODELS FOR REGIONAL PUBLIC HEALTH PROJECTS

Prepared for:
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SUMMARY

The New York State Department of Health (DOH) provides public health services at the regional and local levels. The Western Regional Office of DOH has established a team of Local Health Unit (LHU) Directors and Regional NYS DOH representatives called the Local Health Coordination and Support (LHCS) Team. The LHCS team is interested in identifying various alternative administrative approaches, or governance models, for regional, or multi-county, public health projects.

Governance Models Each Have Strengths, Weaknesses

Members of the team expressed the need to establish a procedure for a systematic assessment of the strengths and weaknesses of particular governance models. An assessment tool of this nature would ideally be used when new programs are being created, improving the long-term effectiveness of the program. For example, while the most prevalent governance model is the "single-county lead" (in which a single county takes on the role of lead agency), this approach generates many problems for all involved counties, as discussed below. In many instances a different model would be preferable—the "single county lead" model is adopted out of administrative simplicity and familiarity, not necessarily because this is the best organizational model for the particular program.

CGR was engaged by the NYS Department of Health to help the LHCS team identify alternative governance models, to evaluate the pros and cons of such alternatives, and to describe a case study in which a new alternative might be adopted.

Models in Other States & Regions

CGR spoke to public health staff in other states to assess the status of regional public health in other areas of the country. While some states have taken new approaches to regionalism, most are still focused on public health at the town, county, or state

level. We also evaluated models that exist elsewhere in New York state, and were able to identify several alternative governance models that might be considered for regional public health projects in Western New York.

One promising governance model involves creating a new not-for-profit organization, or using an existing not-for-profit organization as the lead agency. This approach has been used elsewhere in the state with much success. The not-for-profit lead alleviates many of the concerns that exist with the single-county lead, and has very few drawbacks. A second alternative involves the use of inter-municipal agreements. While these are useful in only selected situations, they are well understood and might be selectively applicable when only two counties are involved. A third alternative is the use of the Western Regional DOH Office located in Buffalo as a lead agency. This alternative was not as popular because of potential conflicts of interest. Finally, we explored establishing a Health Authority. To establish an Authority is a long and expensive process, but the advantages and disadvantages are worthwhile to explore.

Criteria for Selecting Models

Once a variety of models were identified and evaluated, CGR developed a list of specific criteria to be used when evaluating models and selecting the most appropriate model for a given public health project. With the help of the LHCS team, ten criteria were selected as the most important characteristics a governance model should have.

Finally, with the not-for-profit lead the most promising alternative to the single county lead, the last chapter of the report explores the steps the LHCS team might take to begin to use an existing not-for-profit organization, or to create a new NFP for the express purpose of serving the Western New York region as the lead agency on regional public health initiatives. A number of important issues and questions are identified and discussed.

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INTRODUCTION

> *The most often-used governance model is the "single-county lead," in which a single county takes on the role of lead agency.*

The New York State Department of Health (DOH) provides public health services at the regional and local levels. In recognition of the Department's regional responsibilities, the DOH is involved in a multi-phase, internal assessment of the Department's regional initiatives. In addition, the Western Regional Office of DOH has established a team of Local Health Unit (LHU) Directors and Regional NYS DOH representatives called the Local Health Coordination and Support (LHCS) Team. This team's objective is to improve the relationships between the NYSDOH and the County LHUs. In addition, the team is interested in identifying various alternative administrative approaches, or governance models, for regional, or multi-county, public health projects. The most often used governance model is the "single-county lead," in which a single county takes on the role of lead agency; unfortunately that approach generates many problems for all involved counties.

CGR has been enlisted to help the LCHS team identify alternative governance models, to evaluate the pros and cons of such alternatives, and to describe a case study in which a new alternative might be utilized. While both established public health *programs* and periodic public health *projects* could be affected by a change in governance structure, for the purpose of this report we will use the term *project* to refer to both.

Why Collaborate Regionally?

Counties work collaboratively on public health projects for a variety of reasons. A collaborative effort might involve collective purchasing, or might result from state requirements. NYS DOH encourages regional projects that lead to collaboration across public/private lines, rural/urban lines, and other barriers. Some states, such as Ohio, simply inform their local health units that they must collaborate across county lines in order to be eligible for funding. A third reason for working together may be to share ideas, expertise, and experience. Some informal coalitions form because two heads (or three or four) are better than one. Fourth, state funding for projects is usually temporary. A regional project may more easily find alternative sources of funding to maintain the project after state funding expires.

Regional initiatives do not necessarily have to follow county boundaries. In many cases, public health issues such as radon, West Nile virus, or certain types of cancer might be prevalent in a particular geographic area that touches portions of a number of counties. In such instances, the public health project might be more appropriately targeted at providers within the area of prevalence or disease "footprint" rather than at the county level. A governance model that can address such a public health concern would be useful.

An additional reason for an increase in regional initiatives may be the emphasis on devolution of authority in the public health sector in many states. States including California, Michigan, New York, Wisconsin, and Washington have all demonstrated a shift towards decentralization in the last decade. Wisconsin is at the extreme end of decentralization. The Wisconsin Department of Health performs only technical assistance, program coordination, and general public health leadership. In New York State, the central office performs these tasks along with core services such as environmental health and public health nursing in counties that lack the necessary resources. In highly centralized states, such as Alabama, Florida, and Mississippi, county health department staff are state employees (Wall, 1998). As evidenced by these examples, there are a variety of reasons why multi-county public health projects are on the rise.

The Institute of Medicine believes that the health of a community is the shared responsibility of several entities including health service delivery organizations, public health agencies, other public and private entities, and the people in the community (IOM, 1996). As states aim to simultaneously devolve central authority for public health and pursue coordination of local activities, new challenges will emerge. Both state and local agencies will face demands to increase local autonomy and authority, avoid duplication of effort, and improve communication and efficiency.

Objectives and Study Approach

The primary purpose of this project is to help the New York State DOH identify a limited number of alternative governance models that can be used effectively for multi-county public health projects in the western region of New York State. While the single-county lead model is often used, it is not ideal in many multi-county initiatives. As a result, counties do not currently have a single,

clear, workable model to follow in terms of financing, accountability, politics, and other important parameters.

The single-county lead model, discussed in more detail below, presents a number of problems from multiple perspectives. As the entity named on the contract, the lead county feels that it takes on a disproportionate amount of legal and other liability under this arrangement. Meanwhile, the non-lead counties may feel a lack of control over grant dollars, or may feel marginalized by the set-up.

This report summarizes the information obtained from a series of interviews. Perceptions and experiences of counties involved in regional initiatives are important. Each county has unique experiences in this venture depending on the county's size, geographic location, political climate, and other factors. In addition, the perspective of the state and not-for-profits located in the western region are of interest. To determine whether successful models exist outside of the western region of the state, Departments of health in other states were also contacted and interviewed when appropriate. A comprehensive list of individuals and organizations interviewed can be found in Appendix A.

First, experiences from other states are described. Second, a number of possible models were identified and are described in this report, along with the pros and cons of each model, and examples. Third, information collected in the interviews was used to assemble a set of criteria that can be used to evaluate prospective governance models. Fourth, an example of how to use the criteria to evaluate potential models is shown for a specific public health project. Finally, we describe a case study in which a new alternative governance approach might be used effectively.

REGIONAL PUBLIC HEALTH IN SELECTED STATES

The public health system is undergoing transition nationwide. The early public health system focused on population based services. Later, clinical services became an important component as well. Today, as Medicaid rolls drop, the public health system may be shifting back to a focus on traditional services (Wall, 1998). In general, state health departments focus on policymaking, setting state priorities, data collection and analysis, financing issues, and

oversight of local public health activities. Nonetheless, public health systems vary substantially from state to state.

While many states are moving towards regionalization and the coordination of local activities, they are simultaneously shifting authority for public health activities to local health departments.

Local public health activities are most often organized around county health departments. In some cases, large cities have their own city health department, and in other cases, cities and counties operate a joint department. Two states, Massachusetts and New Jersey, vary widely from the traditional county-based public health system. Massachusetts has 351 town boards of health that vary widely in expertise and capability. New Jersey has 578 local boards of health, along with 100 or more local health departments. Both Massachusetts and New Jersey rely heavily on contracts with private providers for provision of public health services.

Many states have begun to coordinate county-based services using regional or district offices, and New York is one example. Generally, regional offices are responsible for supervision, coordination, and technical support for local units. Very few regional offices provide services. Interestingly, while many states are moving towards regionalization and the coordination of local activities, they are simultaneously shifting authority for public health activities to local health departments (Wall, 1998).

A state's urban/rural mix may also contribute to the state's interest in regionalism. New York is unique because of its blend of urban and rural counties. While downstate urban areas might be less likely to see a need for regionalism, the Western part of the state includes mostly rural counties that could perhaps benefit from a regional approach. This section describes the experience of a handful of states, both rural and urban, that are experimenting with regional initiatives. Some lessons learned might be useful for application here in New York.

Pennsylvania

The Pennsylvania Public Health system is dominated by the state DOH. There are only nine County or Municipal Health Departments throughout the state. The state DOH has six regional offices that provide an extensive level of services to the regions they serve.

The Pennsylvania Department of Health started a new health planning process in 1997 called the State Health Improvement Plan (SHIP). The state DOH views itself as a convenor and facilitator in the SHIP process. The intent of SHIP is to

encourage the state DOH and local communities to work together to develop creative solutions to health problems. SHIP has several goals including encouragement of state and local partners to share risk, responsibility, and resources in joint projects, and to shift to a shared responsibility model in community health planning (Pennsylvania DOH, 1999). As part of this new planning process, seven pilot community-based health improvement partnerships ("community partnerships") are underway, including the Partnership for Community Health of the Lehigh Valley, and the Capital Region Health Futures Project, described below. Among all seven initiatives, only these two serve multiple counties. The state DOH goal is to work with a community-based health improvement partnership in each of the state's 67 counties.

The Partnership for Community Health of the Lehigh Valley was started in 1992, and consists of member hospitals in Lehigh and Northampton Counties. The Partnership identifies and implements activities related to the promotion of health in the community, and seeks cooperative ways to improve the health of the Lehigh Valley population. Funding for the Partnership is generated through member dues paid by the hospitals, along with some funding from the Pennsylvania State DOH.

Major initiatives of the Partnership include a Community Services Network that provides support, training, and technological infrastructure to health and social service providers. Another initiative is a Medicaid HMO, the Partnership Health Plan, which is incorporated and serves over 8,000 members. The Partnership is also involved in developing training materials for the Coalition for a Smoke Free Lehigh Valley, a school-based Hepatitis B immunization program, and an online children's immunization registry.

The Partnership represents an area that encompasses three main cities plus several smaller municipalities. The population in the area totals 500,000. The two-county region includes two city health departments, but no county health bureaus. In Pennsylvania, each county decides independently whether it wishes to maintain a health bureau. Neither Lehigh nor Northampton opted to establish a bureau.

The Pennsylvania DOH does not currently provide designated funding on a regional basis, but is interested in exploring that possibility. The regional mindset is growing, based on theories of economies of scale, and the tendency of public health issues to cross county borders. The Lehigh Valley region is working on regional initiatives outside of public health. The United Way and the Red Cross are both regionally implemented.

A second Community Partnership, the Capital Region Health Futures Project, serves four counties in the Capital Region of Pennsylvania (Cumberland, Dauphin, northern York, and Perry Counties). The four counties served by Health Futures range from a suburban, affluent county to a rural, low-income county. The mission of the project is to identify key health concerns in the region, determine how best to address the concerns, and urge the adoption of a regional health futures plan. Membership includes several private companies, health care organizations, Universities, and others.

When Health Futures first began in 1993, it had a board of 50 members. The Chair decided to require annual funding of $25,000 from all board members, and the membership subsequently dropped to eight. Eventually, the annual funding required from Board members was reduced to $10,000, and the current Board has 15 members. While the majority of funding is from Board dues, the Project has received $14,000 from the state DOH because of its role as a Community Partnership. The project is administered by a single individual who provides services under contract with Health Futures. The Project has a number of task forces addressing issues such as immunizations, adolescent health, and diversity.

Minnesota

The Southwestern part of the state of Minnesota is not heavily populated. As such, many efforts are done regionally in an effort to pool resources. The public health sector is no exception. The Countryside Public Health Service is a five-county Health Department established in 1974. At the time of its creation the five rural counties realized they could obtain more funding if they could function as a regional health department. The headquarters is located in Swift County, but there are field offices in each of the five counties.

The participating counties are pleased with the arrangement. They realize that pooling their dollars leads to reduced administrative costs and helps them to obtain more grant dollars. They all realize that in some years one county might benefit more than another, but over time it all evens out. Countryside is not aware of any counties indicating that they would like to split off and become independent, because of the immense added level of administration that would entail.

The All Kids Count program entitled "Southwest Minnesota Immunization Information System" began in the traditional five counties of Countryside, but has now expanded to 21 counties, which is likely the biggest it will become. The project began in 1996, and initially included a regional advisory group that represented one health plan, one private clinic network, and the Public Health Directors from each county. Countryside is the lead agency for the 21 county region. *The Health Department now feels that a more formal governance structure for the project is needed, and they are in the process of outlining that structure. They have decided that they would rather have inter-agency agreements than joint powers. They want their individual county boards to feel autonomous and not overrun by a higher governing power. The governance agreement will delineate the expectations of the registry, the fee structure required from each county, how counties can pull out of the regional initiative, if they wish, and other important guidelines.*

All funds for the Immunization project so far have stayed at Countryside because the funding has been targeted for the development of an electronic registry. The rural counties are so small, with so little funding, it would be impossible for each county to set up a separate information system. Outside grants have paid for almost all start up and implementation costs.

Public health is traditionally divided by county borders, whereas the private sector tends to divide by rational service territories.

Running the Immunization Registry on a regional basis has worked very well. Public health is traditionally divided by county borders, whereas the private sector tends to divide by rational service territories. Private providers are an important component of the registry, and public health officials realized that if a private provider had to submit different immunization information to each county in a different format, providers would not be likely to participate willingly. Instead, since Countryside had an established record, it was a natural fit to allow them to administer a regional registry. While the pilot began with just the five county

Countryside group, they quickly realized that there were children going outside the five-county area to obtain medical care. Therefore, expansion to the 21 county area moved quickly.

Ohio

The state of Ohio is similar to Western New York in that there are a few larger metropolitan areas surrounded by very rural, agricultural counties. The experience of Ohio may be a good example for Western New York. The approaches described in this section were developed by regions within the state, but only at the prompting of the state Department of Health. *This shows the importance of the state's role in encouraging regional efforts.*

The ODH receives funding from the Center for Disease Control (CDC) to implement a Breast and Cervical Cancer Early Detection Project (BCCP). Seven core areas are involved in the project including coalition building, public education, professional education, screening, tracking and follow-up, surveillance, quality assurance, and evaluation. The CDC funds all 50 state health agencies, the District of Columbia, 15 tribal organizations, and 5 territories to conduct comprehensive breast and cervical cancer early detection programs. In Ohio, this screening program is solely federally funded while in other states, including New York, state funds are also available. The national program is now in its seventh year.

When the ODH initially received the federal funding for breast and cervical cancer screening, it realized that it would not be able to provide funding directly to its 88 county health departments and over 100 city health departments on an individual basis. Instead, ODH personnel determined that they could administer 12 to 15 programs efficiently. The ODH then began to look at what types of regional models were currently in place in the state, and quickly agreed upon the regional approach used by the Area Agencies on Aging (AAA). The AAA had divided the state up into 12 regions, which matched the number of programs ODH felt they could administer.

Prior to this screening initiative, the ODH had never run projects on a regional basis; all prior projects were run on a city or county basis. Therefore, when the ODH sent out the RFP, it clearly stated that a requirement of the proposals was to design a single project in each defined region that would reach all women

throughout the region, but which would name a single lead agency. Contrary to expectations, ODH received only one proposal from each of the twelve regions. This indicated to ODH that diverse partners including public health agencies, hospitals, and not-for-profits are capable of collaboration. The lead agency was required to have letters of support from other agencies and players in the region. Minor grievances arose during the proposal process, but ODH told the concerned parties that it was better to have a regional lead than to deal with ODH directly; there would be less administrative hassles down the line. Additionally, ODH told smaller counties that this approach would relieve them of the administrative burden of running their own program.

Each of the twelve regions functions somewhat differently. Of the twelve, eight selected a health department as the lead agency, three selected a hospital as the lead, and one selected a not-for-profit (Planned Parenthood). Two of the regional approaches are described below.

Region 4 includes the city of Toledo. The health department in Fulton County, to the west of Toledo, became the lead. Fulton County wanted to establish a presence in Toledo since that is the big city in the region, so they covered a half time person in Toledo. This was an excellent way to establish buy-in from Toledo players. In addition, the Fulton County HD pays for 5% of a public health nurse's time in each of the other counties in the region. This comes out to about $2,800 per year per county, which seems like a small amount of money, but it is a way to maintain buy-in and a presence in each county.

Region 7 includes part of Appalachian Ohio. The Ross County Health Department is the lead and has been successful. At first they divided the nine-county region into three parts, and placed a staff person in each sub-region. However, they later realized that most of the work could be done by telephone, so they have pulled all staff back into the lead agency offices.

Beginning in 1998, the ODH hired a Third-Party Administrator (TPA). It had become cumbersome for the lead agencies to handle so many provider contracts (there are over 600 providers throughout the state). The providers' primary relationship and contact is with the case manager at the regional lead agency.

Providers see patients, and then send patient data and bills to the case manager. The case manager approves the information, then forwards the data to ODH, and the bills to the TPA. Payment is made to providers within two weeks. Administrative cost to ODH for the TPA is approximately $8 per client per year, which ODH considers very cost-effective. The TPA provides utilization and cost reports to ODH, and helps ODH to monitor spending patterns among the twelve regions.

The grant dollars come to ODH on a five-year basis from the CDC. However, the ODH must go through the RFP process with its 12 regions on an annual basis. During the seven years that the project has been in place, the lead agency in each region has remained the same, which indicates that this is a stable arrangement. Once the RFP process is completed, the lead agencies are forwarded their first quarter payment up front, which includes funds for personnel, travel, maintenance (phones, postage), and contractual services (photo copier maintenance, etc.). The lead agencies then submit monthly expenditure reports, and are reimbursed by ODH each quarter.

In the first year of the initiative, one region complained that it should receive more funds because it was screening more women than budgeted, while another region was screening fewer women than expected. However, the ODH had set goals for each county in the state, and did not want to get involved in shifting funds so early in the project. After the first year this dispute settled down. Liability issues have not come up at all in the seven years of this initiative.

If the Project Director were to begin this project again from scratch, she indicated that there are a couple things she might do differently, although overall she is extremely pleased with the way it has developed. If she started over, she would go to the TPA from the very beginning because she sees it as administratively effective, and cost effective. Secondly, she might keep the patient data entry at ODH from the beginning. At first, ODH allowed each region to do their own data entry, but ran into trouble finding qualified staff, especially in rural areas, who could do this adequately. Eventually all data entry was brought to the central office.

GOVERNANCE MODELS FOR REGIONAL PUBLIC HEALTH

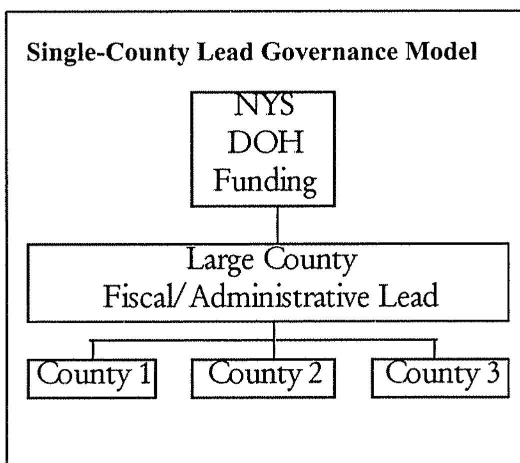
A number of potential governance and administrative models exist throughout the state and country. Some models are currently used in the Western New York State region, while others are not. Each model has its pros and cons; no single model can apply to all regional public health projects. Some models require an act of the state legislature, while others would be relatively simple to implement.

The Traditional Approach: A Single County Lead

Currently, many regional projects in Western New York are led by a single county. In this situation, a single county is named as the legal entity on the contract with the state DOH or other funding entity. Any funding for the project therefore flows directly from the funding entity to this single county, which then disperses dollars as described in the proposal or other documented arrangement. In the western region of New York, Monroe or Erie Counties often take the lead because of their larger size and their ability to process contracts efficiently.

Contract Arrangement

The model is relatively easy to implement fiscally and administratively. It has been in use for many years in many contexts, so it is well understood. It is a stable model of governance, given that counties will not disappear. Finally, the single county lead is cost-effective since it can take advantage of existing county staff and does not require an additional layer of administrative cost.



However, disadvantages also exist with the single county lead. County attorneys may become concerned about legal liabilities involved with this arrangement. For example, Monroe County has no legal authority to control performance outside its borders. Other counties are simply out of the Monroe County jurisdiction. If something goes wrong in another county, it is feasible that Monroe could be held liable by the state or some other entity. In addition, the lead county is contractually liable for how the money in the grant is utilized (Chuck Turner, personal communication).

Other drawbacks exist for the lead county. The lead is often responsible for equipment purchases, including computer hardware and software in some cases. If the grant funds expire, and the project continues, is the lead county responsible for maintaining software and hardware maintenance and updates? Who becomes responsible for such costs? Other problems for the lead county include concerns over maintaining confidentiality of data and responsibility for computer viruses when a project is data driven.

The non-lead counties involved in a regional project have also expressed dissatisfaction with a single-county lead. While in many cases the distribution of dollars seems fair and equitable, there is often a sense that the lead county could absorb a disproportionate share of the dollars, or at least has the opportunity to do so. This has been addressed by at least one county department of health, which devised an algorithm to use when dividing funds among counties in a regional project. The county provides a fixed base number of dollars for each county, plus a variable number of dollars based on population size. It seems reasonable to devise some such algorithm that counties agree on to avoid smaller counties feeling marginalized. Several examples of projects with a single-county lead are described below.

The Immunization Registry is an example of a single county lead model. There are several registry sites across the state, including one that involves Monroe and ten other counties (FLAIR). For this site, Monroe is the lead and most of the state money flows into Monroe County. Some of the money flows through NYSACHO to counties and community-based organizations in the counties.

The Chautauqua Area Regional Immunization Information System (CARIIS) includes Chautauqua, Cattaraugus, Allegany, Genesee, and Niagara counties. This is an example in which the lead county is not a disproportionately large county, because all five are reasonably similar in size. Initially Allegany was the fiscal lead, but that responsibility has shifted to Chautauqua County. As the lead, Chautauqua faces concerns over expenses for software and hardware, and the level of support for ongoing operations that will be available once direct state and federal funding of the immunization registry projects dries up. In the case of each of the

registries, it seems that a separate entity that could receive and expend monies on behalf of counties involved in immunization registry projects would be beneficial.

The Livingston County Women, Infants, and Children (WIC) program at one time was administered on a county-by-county basis with state funds. More recently, the state decided not to administer the program to two small counties, and indicated that Wyoming and Livingston counties should merge their programs and select one county as the administrative lead. In this case, Wyoming was reportedly glad to give up the responsibility and allow Livingston to take over.

The state recently announced that Monroe and Livingston counties will receive $400,000 for the Child Health Plus Facilitated Enrollment initiative. Monroe will receive $365,000, while Livingston will receive $35,000. While at first glance this arrangement may appear unfair to Livingston, a more thorough look indicates that it should work out well for both counties. Monroe certainly has a much larger population that Livingston, and as such should receive a larger portion of the funds. In addition, Monroe plans to use a large portion of the money to develop a media campaign, which will reach Livingston through television and radio advertisements. Rather than Livingston and Monroe doubling up their media efforts, the task can be left to Monroe to benefit both counties. Livingston can then use its $35,000 to focus on direct targeted outreach in areas of the county where it will bring in the most children. This is an example where the collaborative effort is more of a joint purchasing arrangement (media time) than a joint planning and implementation approach.

Letters of Agreement with Single County Lead

It can be difficult for the state to contract with counties because each county has its own unique structure. Contracts progress through different counties at very different rates. As an alternative to setting up formal contracts for state DOH grants, some DOH Departments have moved towards the use of Letters of Agreement (also known as Application and Agreement) in cases where the projects require statutory authority.

While contracts are required when dealing with a not-for-profit, which could dissolve over time, a county is not going to disappear. Therefore, the same stringent contract language is not always

necessary. A letter of agreement is sufficient even if the state finds it necessary to re-coup money from a county later for not fulfilling the terms of the agreement. The letter is often no more than two to three pages in length, and is submitted to the county along with a narrative of the requirements, a project schedule, and a payment voucher. Counties often are able to get a portion of the money up-front, and are then paid on an incremental basis.

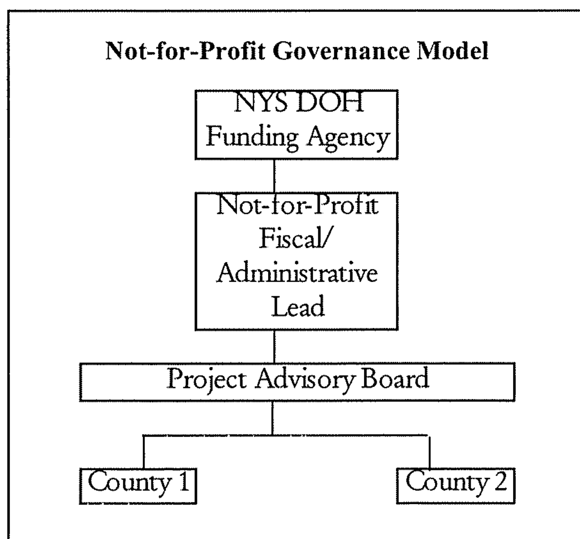
Letters of agreement have been used for public health campaigns (Erie), for tobacco control (Cattaraugus, Chautauqua, Erie, Livingston, Niagara, Orleans), rabies programs (Allegany, Cattaraugus, Chautauqua, Erie, Livingston, Niagara, Steuben), and other statutory county obligations. These activities are mandated by the state, so the counties must participate. Statutory authority can come from an appropriation from the state legislature. The Attorney General's Office specifies that letters of agreement should be constructed in such a way that enforcement and accountability of actions are spelled out, similar to the language used in a contract.

While in the majority of cases letters of agreement can only be used when there is statutory authority, there ar e occasional exceptions. One exception was $1 million provided to DOH by the Governor to provide AIDS education in the wake of the case of a man in Chautauqua County who infected a number of young women with HIV. In this case, the DOH put out a mini- bid to all counties and asked them to respond if they were interested in receiving a portion of the money. While some counties responded individually, others responded jointly. For example, Monroe, Wayne, and Ontario responded together, but named Monroe as the lead. The division of the dollars among the three counties was established up front before it was approved by DOH. A written justification was required in order to avoid the requirement of statutory authority.

The State DOH Central Office Alternative Procedures Subgroup has developed a list of State DOH programs currently using letters of agreement to fund municipalities, and the statutory basis for these awards. While letters of agreement may potentially relieve some of the administrative burden of contracts, they still rely on the single-county lead as a governance structure. Therefore, they do not address the serious concerns described by the counties.

Alternative Governance Model 1: A Not-for-Profit Lead

The not-for-profit lead model is used in western New York, and may have the potential for more widespread use. We identified four distinct types of not-for-profit leads: Provider consortia, Associations, other not-for-profits, and a university lead. Each is discussed with examples below. The not-for-profit lead is a stable model of governance. It does not rely on one county public health director or on the support of one county legislature. Not-for-profits are able to take advantage of regional expertise more effectively than counties could on an individual basis. Not-for-profits, and provider consortia in particular serve as a sort of clearinghouse for expert information. They have their own internal expertise, and are aware of regional experts who often consult on various projects. If an NFP is aware of an expert working on one project, it can easily enlist that individual to work on another project as well.



Small counties are often pleased to allow a not-for-profit to administer a project because that leaves less risk to the small county. When an initiative is first funded with state or federal funds, counties are pleased to participate. But if a county is the lead on a project, that county is left to find a way to fund the ongoing efforts when the state funding ends.

There appear to be few disadvantages to the not-for-profit as a lead entity. One potential problem is the issue of sustainability. Any organization that survives primarily on grant dollars is subject to fiscal trouble if the money evaporates. Another potential problem is philosophical differences. Allowing an NFP to have control over project implementation can lead to tension if county LHUs would prefer to approach the problem differently.

Incorporated Provider Consortia

Provider consortia form for various reasons. They often begin as collaborative efforts around a particular issue or goal. Over time the collaborating partners develop a specific mission, and narrow their focus to a single product or issue area. At this point the consortia often elect to incorporate. Incorporated provider consortia are strong candidates for the lead role on regional public health projects. This arrangement seems to work very well from

the perspective of the consortium, which functions as a lead entity, and from the perspectives of the counties involved.

The Upper Hudson Primary Care Consortium, Inc. (UHPCC) is a not-for-profit, 501(c)(3) state-licensed provider organization. It was founded in 1987 under Article 28, which provides for the licensing of health facilities including hospitals, nursing homes, central service facilities, and others. UHPCC falls under the central service facility category of Article 28, and was initially formed to support health care provider organizations that are also licensed by the state. Four independent not-for-profit provider corporations form the membership of the consortium, and each corporation sends a specified number of Directors from their Boards to serve on the UHPCC Board.

The UHPCC quickly grew beyond its initial charge and began to provide administration for regional DOH projects in the late 1980s and early 1990s. The projects reach into seven counties including Franklin, Clinton, Hamilton, Essex, Warren, Washington, and Saratoga.

Three major state public health related projects are administered through the consortium. The first is a perinatal provider network that initially began in the late 1980s in urban areas of the state, and then was expanded to suburban and rural areas. The project's goal is to provide a coordinating mechanism for providers of perinatal services in the seven county region. The network also holds quarterly educational meetings and develops pamphlets for public distribution.

Because the perinatal project was successful, the consortium was approached by the NYS AIDS Institute to take on a second DOH project. An HIV educational program began in 1993, and involved the same seven counties. The purpose of the HIV project was to educate providers about HIV treatments and to help providers become comfortable with providing care to the HIV community. Often rural providers needed guidance with the new technologies and methods of care for HIV-positive patients.

A third, and most recent DOH project is the regional immunization registry project. Three sites are involved throughout the state, and some would argue that the Upper Hudson site is the most successful to date. Project

implementation began in Warren and Washington counties, and involved the development of a network that enables health providers to enter information on office and field-based computers and download the information to an in-house database maintained at the consortium. Now in its third year of implementation, the project has expanded into all seven northeast New York Counties as specified in the contract.

For each project a separate advisory board is formed that consists generally of public health directors, a representative from state DOH, consortium members, experts involved in the project, and in some cases members of other county agencies or persons from the private sector. This approach permits each county to maintain their own local nuances but to also share ideas and experiences.

The consortium's role is to manage the projects, but also to provide the administrative glue that holds the independent collaborators together. Projects involving sporadically populated rural areas often benefit from approaches that improve economies of scale. Also, organizations from two or more counties frequently have difficulties sharing responsibility. In both instances, it is helpful to have the consortium available to serve as a neutral coordinator.

An example of the consortium functioning as a neutral coordinator is its role in the Immunization Action Program (IAP). In this case, the DOH funds flow directly to the consortium. The counties each submit separate bills to the consortium, which then combines the bills and submits a single bill to DOH. In other cases, funds are earmarked for the counties, but the counties may prefer to have those funds flow through the consortium. Non-health related issues can sometimes create a sense of mistrust between counties, and in those instances it is easier to have the dollars flow through a neutral party. The LHU Directors discovered that it is possible to take advantage of available funding by letting the consortium function as the neutral coordinator.

Both consortium members and LHU Directors feel that the arrangement is highly cost effective. Most state grants permit a 10 percent maximum for administrative costs, and that is generally what the consortium receives. The LHU Directors feel that the amount of time they save by permitting the consortium to administer the projects is well worth the administrative cost. In

fact, one LHU Director indicated that if the administrative costs saved by each county were summed, they would likely be greater than the amount paid to the consortium. This is an important point in light of the Western Region's interest in providing as many dollars as possible to the LHUs.

The consortium and LHUs feel that seven counties is an appropriate size for this consortium and are not interested in expanding to include additional counties. *By sharing administrative costs across a number of funding initiatives, the UHPCC has ensured its long-term viability even if one initiative is terminated.* While all organizations supported by grant funding are concerned if the funding from a large project ends, UHPCC has created a sufficiently large network of funding to sustain an infrastructure that sup ports a variety of regional initiatives.

In another example of a provider consortium, the Lake Plains Network is a state Rural Health Network that involves three rural counties— Genesee, Orleans, and Wyoming. As a Rural Health Network it is funded in part by the NYS Office of Rural Health, and also by membership contributions. The group began over concerns that health systems from Rochester and Buffalo would increase their competitive efforts in these three counties and consume all local health system components. The participants in the group wished to ensure that the local health system would retain its rural community-focused nature, and maintain high quality care. The group began meeting in 1992, received a Kellogg grant in 1994, and incorporated into the Lake Plains Community Care Network in 1997. Staffing of the Batavia office includes a half-time CEO, full-time Assistant Director, full-time Care Management Developer, full-time Information Technology Developer, and full-time Administrative Assistant.

Prior to incorporating, the Genesee County manager assumed responsibility for the administration of the network because he saw the substantial benefit to the county of supporting such an entity. Over time, the Network recognized that in order to brin g in additional funding, they needed an incorporated stand -alone group. While they had named various participating organizations as the lead entity on grant applications prior to incorporating, they did not want a small number of participants to influence the agenda, nor to have the appearance that this was occurring. They

wanted all participants to leave personal agendas at the door, and that is still working today.

The incorporation decision was made because the group had a specific goal— to develop a provider network and an insurance product. The benefits of incorporation included the ability to draw additional funding, and the added organized structure. The Network has a governing Board of Directors, including representatives from county government, public health, mental health, social services, hospitals, and physicians.

An important component of their current mission is to put together a health insurance product with a preferred provider panel that includes hospitals, physicians, and ancillary pro viders. They hope to market the product to companies that are currently self-insured and to other small insurance groups. Lake Plains wishes to emphasize the local nature of care management, to use existing resources for the promotion of health and the re duction of health care costs. They contributed financially to the regional health risk assessment piece coordinated by the Western New York Public Health Coalition. Lake Plains hopes to use the findings of that study to target service to the underserved.

Lake Plains is involved in other multi-county efforts, including the Child Health Plus Facilitated Enrollment project. They will administer the project to their three -county area. The grant money will flow directly to Lake Plains who will then distribut e dollars among provider organizations with whom they will contract for services. There will be no separate advisory board for the project; instead, it will be governed under the Lake Plains Board of Directors.

Since the Board includes a number of public health representatives, the Lake Plains Network may become involved with a variety of public health initiatives. The Board is likely to approve such efforts so long as projects relate directly to the organization's central goal to maintain local control, strengthen the medical community, and develop a local managed care product.

The Lake Plains organization feels that it is very similar to the Upper Hudson Primary Care Consortium, which has been so successful at administering multi-county public health pro jects in the Northeast corner of the state.

Associations

A second type of not-for-profit that could fill the role of lead agency on a regional public health project is an Association lead. The pros and cons are similar to those under the provider consortium. Depending on the association, some may have a strong vested interest in encouraging regional public health projects.

The New York State Association of County Health Officials (NYSACHO) is a statewide association representing each of the 58 local health departments in New York State. Their membership includes health commissioners, public health directors, deputy commissioners, and directors of patient services. New York's local health departments vary widely depending on the programs offered, their demographics, and the public health needs of their constituents.

NYSACHO works with county health departments in several programs where regionally contiguous counties have joined together to address health problems from a multi-county perspective. These programs include immunization initiatives, healthy heart programs, and a data institute. In the future, counties may choose to explore a regional approach to the provision of other public health programs such as environmental programs, home care, or even some epidemiologic programs. These initiatives can be challenging because of municipal laws and county governance structures.

NYSACHO is very interested in assisting its constituents in any way possible. They are currently partnering with other state wide associations that represent community-based organizations that are partners locally with county health departments. NYSACHO is a member of Partners for Children, whose membership includes several state agencies and organizations such as NYS DOH, NYS Office of Children and Family Services, and the United Way of New York State. NYSACHO is also a member of the New York State Community Health Partnership along with the Milbank Memorial Fund, the NYS Public Health Association, the Business Council of New York State, and others. NYSACHO exists to promote public health in New York through assuring a vital local structure, strong linkages to the New York State Health Department, and partnering with all others interested in the same objectives.

Another association, the Western New York Healthcare Association (WNYHA), represents the eight western-most counties in the state. It functions primarily as a provider membership group, representing hospitals, health care systems, hospices, and other health care organizations. The Association's mission is to serve as the center of health information in Western New York and to serve as an advocate, educator, convener, communicator, and clearinghouse for information. The Association has a Board of Directors, and raises funds through a dues structure and also through its subsidiary shared service and group purchasing organization.

The Association has been involved in a number of multi-county health-related projects. Most projects have been member-oriented, and therefore have not involved Departments of Public Health. However, the Association recently was awarded a grant to conduct Facilitated Enrollment for the Child Health Plus program in four Western New York counties: Erie, Niagara, Chautauqua, and Cattaraugus. The state DOH put out an RFP with the intent of identifying six or seven regional coalitions to lead community-based organizations in an effort to reach out to hard-to-reach children. The WNYHA was asked to lead this effort. The counties wanted to select a regional leader that was neutral and completely non-biased, and that would support the needs of the various counties in the region. Initially the coalition was to include the above four counties, and Orleans, Genesee, and Wyoming. However, the Lake Plains group (discussed above) decided to submit a separate response for these three counties. The grant was awarded in November 1999.

The administrative structure of the Western New York regional initiative is unique in that it is able to address concerns of the various counties and the concerns they have with regionalism. In addition to the lead organization, which is the Healthcare Association, there are three sub-leads. When the regional effort was under design, participants recognized that each county faces very different needs and contains many different populations. If someone from Erie County tried to do outreach in the most rural areas of Chautauqua, there would not be a high success rate. Therefore, a sub-lead was identified in each sub-region including the Erie County DOH for Erie and Niagara counties, the

Southern Tier Health care System for Cattaraugus, and Chautauqua Opportunities for Chautauqua County.

While the lead agency functions as an Executive Director, the day to day operations and responsibilities are performed by the sub-leads. One particular benefit to this administrative structure is that project leaders can approach various organizations in different ways, depending on the organization's perspective. It is more efficient for the health plans to deal with their clients/patients via a regional approach. However, Departments of Social Services each have their own way of doing things, so they prefer a localized approach. With the lead and the sub-leads, they are able to use both a global/regional and community/grass roots approach.

The grant money flows to the WNYHA, which then passes money on to the subleads. The grant is for $400,000, and the Healthcare Association receives 6.3 percent, while the subleads and their contractors will receive the remainder for facilitated enrollment. The state DOH was concerned initially that adding the subleads would just add another layer of cost. However, by working together as a coalition the Healthcare Association has saved enough money to justify the role of the subleads. They do not feel that this structure has added any cost. In fact, they calculated the money they would save by working as a coalition, and put that money towards the rural counties after they realized that outreach costs more money per child in rural areas than in urban areas. The rural counties therefore received slightly more than they would have under a more traditional administrative structure. Staffing includes one FTE each in Chautauqua and Cattaraugus, and several FTEs in the Erie/Niagara region.

The Association feels that it could be a good organization to use in the administration of regional projects. However, they do have two concerns: (1) they do not currently have the staff to provide additional services, and (2) their Board of Directors would need to determine whether this type of service fits with the organization's mission. However, the Association acknowledged that there is a need for an umbrella coalition of some sort in the western region. Numerous small rural coalitions exist throughout the region. If these coalitions could all work together, it seems likely that many dollars could be saved.

In the Rochester area, the Rochester Regional Healthcare Association (RRHA) has 21 member hospitals in a nine-county region. While the organization has not been involved in any regional public health initiatives, it has coordinated regional projects for its members. The RRHA received a grant from the state DOH and state DOL to coordinate workforce retraining for persons in the healthcare industry. The project required coordination between hospitals, BOCES, other learning institutions, and industries in the nine-county area. In another DOH grant, the RRHA coordinated a Technology Assessment project about five years ago. This project resulted in an approach used by hospitals to evaluate their own technology needs to encourage appropriate and effective funding of new technologies.

In another region of the state, the Iroquois Healthcare Association serves a large area of New York State including the North Country, Syracuse, Albany, and everything in between. This Association has two arms: the Healthcare Alliance serves as the legislative research and lobbying side, and the Healthcare Association serves as the educational arm of the organization. The Association conducts grant program coordination to help members pool resources and seek efficiencies where possible. The Association might be another good example of a group capable of administering regional projects efficiently.

Other Not-for-Profits

Several not-for-profits in the western region have taken on the role of facilitator for regional projects. The advantages and disadvantages are similar to those under the provider consortia examples above.

The Wellness Institute of Greater Buffalo is a 501(c)(3) founded in 1988. The Institute started with the mission of promoting the regional community's achievement of the Healthy People 2000 goals through worksite, school, and community health promotion collaboration. Their first service contract was to manage the City of Buffalo's Wellness program for city employees and their families. Over the years, the Institute has evolved towards achieving a community wellness culture through intersector involvement and coalition building with the full range of community stakeholders. Today, the Institute serves as a regional resource and advocate for the healthy community movement.

The Institute considers itself progressive and was ahead of the community curve regarding regionalism. Its focus transcends city and county boundaries. In 1991 the Institute developed New York State's first community wellness council to bring together schools, worksites, and community representatives and later worked with several communities (Niagara, Rochester, Albany) in initiating a community wellness council. Currently the Institute manages the 15 month old NYS Physical Activity Coalition.

The Institute's funding comes from contracts with cities, counties, the state, and the federal government, and from donations and fundraising activities. The Institute's marketplace includes both public, private, nonprofit and civic institutions. Much of their focus is on coalition building. Because the Institute is a non-partisan entity, it has been successful in bringing different sectors together.

One regional project housed under the Institute was the regional tobacco coalition. In 1991, National Cancer Institute funding was available to the Buffalo region. When none of the local associations (heart, lung, cancer) were able to take the grant application lead, the Wellness Institute was approached to facilitate the process and agreed rather than see the money lost for the community. The Institute's Executive Director served as the co-chair of the coalition. With the grant dollars the coalition hired a program coordinator and an administrative support person. The Institute received a portion of the grant money for administrative management costs. For the first five years the coalition was focused on Erie County, and was instrumental (through advocacy) in creating New York State's strongest countywide clean indoor air act. In the sixth year of coalition operation a merger was facilitated between the Erie and Niagara County coalitions to create a single regional pro-health anti-tobacco Coalition. While this partnership did work, there was a challenging element of building trust that was critical. The Coalition is now housed in the Erie County Health Department and managed by Roswell Park. The Institute is very proud of the facilitating role it played in developing the regional coalition. The Institute continues as an active member of the coalition.

A second potential example of a non-provider not-for-profit could be established by the Master Plan Index (MPI) Governance

Council, created in July, 1997 in Monroe County. The Council was composed of representatives from a variety of health care organizations throughout the Rochester area. The Council's charge was to consider cooperative implementation and operation of an MPI system. One of the important outcomes of the Council in terms of setting up a governance structure for the MPI was the recognition that concerns over confidentiality in a product such as a patient index rendered a need for a legal entity of some sort. While they briefly considered other arrangements such as ownership of the data by one of the participating healthcare organizations on behalf of the MPI project or ownership by a community "umbrella" organization such as the United Way, those options were quickly ruled out. Council members recognized that they needed a legal entity that could be held legally liable in case something went wrong.

Once the decision was made to establish a separate legal entity that would own the MPI, the next step was to determine who would have control over the data. Control and fairness of funding were the two most contentious issues. Because different participants would bring various levels of funding to the project, and other participants would bring data and little or no funding, there were a number of permutations presented for evaluation. In addition, the Council members varied substantially on their personal preferences. For example, some members felt that ownership should be determined solely by financial contribution. Others felt that financial contribution should not be the only deciding factor. In the end, the Council agreed to develop various "classes" of owners, with each class appointed different levels of voting power.

Funneling money through existing contracts with NFPs

When DOH has an ongoing relationship with a not-for-profit, dollars can funnel through such existing contracts. For example, DOH has an ongoing, renewable contract with the AIDS Rochester organization. If AIDS Rochester became interested in being the lead agency for a new initiative to provide AIDS education on a regional basis, DOH could simply add more money to their existing contract and use them as a conduit to give money to a number of counties. This is a situation where DOH already has an established relationship with the provider, and the provider organization is familiar with DOH protocol.

University Lead

A variation of the not-for-profit lead is the University Lead. The structure would be similar to the NFP, but University contracting procedures would be somewhat different. The University of Buffalo Department of Family Medicine's mission includes examination of community health issues, which makes it a natural fit for public health projects. Universities can be a source of great technical expertise for use in regional public health projects.

While some unincorporated consortia have considered using the University as a lead agency, it would not be cost-effective to do so because of the University's high administrative rates. Cost is the biggest disadvantage to the University Lead model.

The Western New York Public Health Coalition often contracts with the University of Buffalo for certain project tasks, but does not ask the University to take the lead on projects. The University functions more often as a project facilitator than as a lead.

Alternative 2: Inter-Municipal Agreement

Inter-municipal agreements fall under Article 5-G of the New York General Municipal law. The contractual arrangement allows one municipality to perform a service on behalf of another municipality, or for multiple municipalities to share in the provision of a service. This approach is often used when a county and town need to make arrangements for services such as water and sewer lines, but any type of municipality pair could be involved such as county-city, county-town, or county-county.

One condition for inter-municipal agreements is that the contracted service must be one that all involved municipalities are legally authorized to do on their own if they so choose. For example, if one county wishes to provide a public health service such as medical examiner services for another, that is acceptable because both counties could do it independently if they wished.

Because public health has a somewhat overriding state purpose or function as well as county-level functions, it is possible that the state would have to approve any inter-municipal agreements surrounding public health issues. The State would likely need to ensure that the agreements would serve the State's interest.

The inter-municipal agreement is often used and is well understood. The simplicity of the approach might be particularly attractive in some cases, such as joint purchasing endeavors. The

institutions are already in place; it does not require any new infrastructure or staffing. The key component is the contract, which does require substantial thought up front. The contract includes a fixed payment for services, and must be approved by either the County Legislature or Board of Supervisors. This agreement accounts for liability incurred by the county providing services. If Monroe feels that providing services to another county brings with it some amount of liability, Monroe can factor that into the price for services, if permissible under the state statute.

The model also has disadvantages. It is inefficient because it requires contracts which can slow down progress, and because the contractual approach limits flexibility. Since public health initiatives sometimes require that changes be made midstream, an arrangement that requires tweaking of the contract at every turn might not be conducive.

The limitation that only services that both municipalities are authorized to perform can be contracted may preclude certain public health activities. In addition, services provided are strictly limited by the boundaries of the contract. Contracts must therefore be carefully constructed up front. Issues to consider in the contract draft include the scope of services, the commitments made by the entity providing services, price to be paid for services, liability, expertise, and the availability of facilities, staff, and other resources. Many of these items are difficult to anticipate at the start of a project. It is possible to change a contract midstream when problems arise, but this requires that the counties go back to their legislatures for approval. These issues are typical of contract negotiation, and in fact can be beneficial in that they force all involved parties to think through a host of issues.

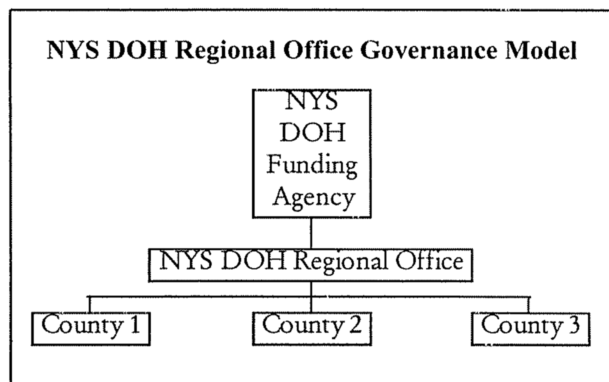
A drawback from the perspective of the non-service providing county is a perceived lack of control. While details can be spelled out in a contract, the bottom line is that services are not being provided by the county's own personnel. While the non-provisional county can voice concerns to the county providing services, there is no direct mechanism for discipline or other recourse. In addition, if the municipality providing services decides it is unwilling or unable to continue providing services, the recipient county may find itself in a bind trying to find another

county to provide the service, or finding the resources to do it on its own. However, the contract can account for this with requirements for a multi-year contract or with a provision that requires substantial advance notice if the provisional county wishes to pull out.

Alternative 3: Department of Health, Regional Office

The DOH Regional office in Buffalo is involved in county public health programs, but is not involved in the administration of public health projects.

The administrative structure for DOH is centrally located in Albany. Much of the administrative work is done face to face with staff familiar with such tasks. That seems to be an efficient way to run the administrative component. Nearly all respondents indicated that the Regional Office does a very good job at a programmatic level in the region because it is located in Buffalo and can be tangibly involved. However, many concerns arose regarding the prospect of the Regional Office taking on a lead administrative role for regional projects.



Several individuals indicated that the Regional office is strong in its programmatic role for public health program areas, but is not as strong at providing administrative oversight and support. Many individuals indicated that to provide the Regional office with the resources to administer projects seems duplicative with the Central office role.

If the Regional Office were to move in the direction of a lead administrative role for regional projects, many of those interviewed indicated that several changes would have to take place. First, a clear shift of authority from the central office to the regional office would have to occur. If a Regional Office lead just added another stopping point for contracts, that would be problematic. The Regional office must be given the power to make decisions and to move grants through.

Second, many expressed concern that staff members at the Regional Office in Buffalo are not familiar with issues facing smaller rural counties like Wayne or Livingston. There is a perception that the Regional Office tends to have relatively high turnover rates among their program personnel. This leads to staff

persons who are not knowledgeable about the history of their programs. Staff knowledge levels vary substantially throughout DOH based upon several accounts.

Third, the central office in Albany would have to communicate better with the regional office. The structure of supervision at the regional office was described as confusing in some cases. There are some staff persons with both regional office and central office supervisors, which leads to trouble with clients, and confusion over authority.

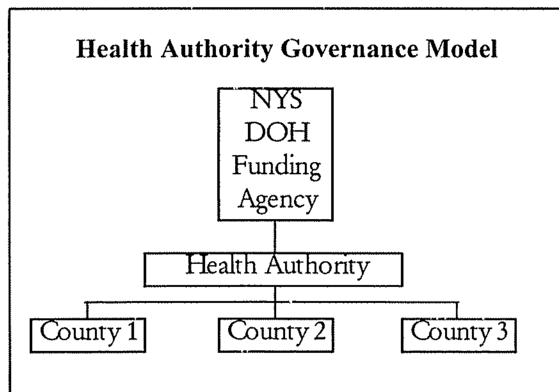
Fourth, the flow of dollars would need to be streamlined. Some of those interviewed described logistical trouble with cash flow from state grants. Often money is tied up at the state level due to budgetary or other problems. In the case of the tobacco coalition, one recipient had to cover expenses up front to keep the project moving along while they waited over six months for reimbursement. However, some tobacco coalitions in other parts of the state had to fold because of the hold up. If the use of the Regional office as an administrative lead were to add another stopping point for reimbursement, this could be detrimental to the local health units.

In the future, the Regional Office may take more of a lead role in regional initiatives. But for now, it does not have the staff or resources to do so. For example, to be the lead on the current asthma initiative the Regional Office would need to hire two to three fulltime staff people to be able to do all the administrative and coordination work. Instead, they were involved in the evaluation of proposals and the selection process, and will able to provide limited technical assistance during the initiative, but would not currently be able to handle daily administration of the project.

In addition, even if the Regional Office were to be provided the resources necessary to administer more public health projects, there might be some projects that simply would not be appropriate for Regional Office oversight. For example, on occasion the counties wish to explore issues related to their relationships with the state, which would certainly not be an appropriate avenue for a Regional Office lead.

Alternative 4: Health Authority

An authority is a special-purpose government entity. Authorities traditionally are associated with public works industries, such as transit authorities, water and sewer authorities, and port authorities. Since authorities can operate in jurisdictions that overlap county boundaries, they are appropriate for regional initiatives. Often authorities are formed when a body of government recognizes that it is no longer the most efficient entity to administer a particular operation.



While legally an authority can operate in multiple counties, few precedents for multi-county authorities exist in NYS. In fact, two examples exist that did not succeed. A solid waste authority that involved several counties south of Monroe disbanded over time because of competing interests. Another multi-county solid waste authority between Oneida and Herkimer Counties has facilities up and running, but has faced problems over turf issues. One County may feel taken advantage of in this situation. As evidenced by these examples, the track record in the state for multi-county authorities has been spotty.

To create an authority requires state legislation, or an authorizing act, which requires draft legislation. Politics are heavily involved in the passage of authority legislation. Those drafting the legislation must pay careful attention to the language because once the legislation is passed it will be a point of reference for many years. The language must be drafted to provide sufficient flexibility so that unanticipated problems can be handled expediently. Drafting legislation is not an inexpensive process. It requires substantial time and many revisions. The legislation then must be pushed through both houses of the legislature, each of which will have its own concerns. Opponents of the project will take public shots at it, while others will publicly support it but privately oppose it. While the Monroe County airport authority legislation passed in a single session of the state legislature, it was for a single county rather than a region, and was still extremely difficult to push through.

Authorities are separate legal entities; they are not county agencies or county departments. However, they are public entities that perform public functions. Authority governance structures can

vary dramatically. As a public entity, an authority has its own board. While the board members are appointed, it can vary as to who makes the appointments. It could be the County Executive, or the Legislature, or some other body. If the authority carries out functions then it can have its own employees as well. The board structure is among the most fought over of battles. The ability to gain local and state support for creation of an authority is often dependent on whether the drafted board-appointing provisions are agreeable to all participants. For example, it may be necessary to ensure a balance of political parties, of county representation, or of other groups. It is important to prevent participants from feeling that they will be outvoted and will not have an opportunity to be heard. Voting powers should be carefully outlined. Different voting structures may be necessary for different types of issues. For example, a simple majority may be sufficient for everyday decisions, while a super-majority may be required for big picture decisions such as bond resolutions.

Authorities must raise money on their own, because they do not have taxing authority. The authority needs to recognize revenues by charging for its services or facilities. Likewise, it must have the ability to contract, to buy and sell lease property and personal property, and to borrow money.

Given the complex regulatory framework for public health, it would be important to first determine whether state law would recognize a health authority. While authorities are generally thought to take politics out of fundamental decisions, this noble intent does not seem to carry through. Authorities can be as intensely political as any other structure. Their design results in a double-edged sword: they are separate governmental entities which should make them less subject to political will; however, they are generally viewed with some suspicion because as a separate entity they are not directly controlled by the municipality. If an authority makes a decision within its domain, the county and town governments may not have the power to disallow the action. Again, the flip side is that when constituents are unhappy with actions taken by the authority, the authority has to deal with complaints, not the town or county government. There are pros and cons to relinquishing that control on the part of the county.

CRITERIA FOR USE IN EVALUATING GOVERNANCE MODELS

One project objective is to develop a systematic method for selecting a governance model for new or existing regional public health programs and projects. A first step towards this objective is to identify issues, or criteria, that are important to public health officials when evaluating the best way to govern a new project. A governance model may or may not address certain criteria well when applied to a given public health project. This section serves to describe criteria deemed important by DOH and LHU staff, as compiled through interviews, and based on our own professional experience.

The nature of a particular public health project or program dictates which of the following criteria are important. While all the criteria discussed below are generally desirable, inherent conflicts between some of them make it nearly impossible for a single governance model to address them all simultaneously. Further, it is difficult to evaluate how any governance model will perform on the various criteria in absence of a specific project. Governance models will handle the various criteria differently depending on the public health project under consideration.

Ultimately, the goal is to "match" each project of interest with the most appropriate governance model. The criteria presented here will aid in the matching process. While the use of criteria to evaluate governance models provides some structure to the decision process, it is not intended as a definitive approach to be used in the absence of subjective interpretation or consideration. Rather, the use of criteria is intended to help encourage discussion and debate, and to foster more well-rounded consideration of models that are most useful in various situations.

Below we define the criteria, and briefly discuss each criterion's relevance as it relates to regional public health initiatives. We then describe how the criterion applies to one or more specific public health projects. Finally, we illustrate what it would mean if a governance model were "strong" in a particular criterion. The discussion of parameters that follows should help the process of

matching individual public health projects to the most appropriate governance model.

1. Compatible Purpose and Scope: Governance structure is consistent with the project's goals and objectives.

The project purpose and scope (breadth and depth) should be explicitly identified, and compared to the missions and other characteristics of all participating organizations and the proposed governing institution(s). If a project scope is large relative to the proposed governing institution, project execution could be problematic. Alternatively, a project that is very small when compared to the scope of the institution may not receive sufficient priority.

Example: New York State commonly awards the responsibility for a regional project to one of the state's larger counties. Monroe County, for example, leads FLAIR (Finger Lakes Area Immunization Registry), which covers eleven counties. In this instance, the scope of the project requires an organization that is large enough to manage its disparate parts. The health department in a rural county would likely not have the administrative resources to manage such a complex project.

Similarly, the project mission and that of participating institutions should be compatible. An organization may be technically capable of implementing the project but may lack the internal perspective required to promote effective implementation.

Example: The NYS DOH has accepted proposals for regional collaborations that include entities involved in the diagnosis, treatment, prevention, and management of asthmatic children. Objectives of the project are to reduce the burden of asthma, promote delivery of high quality care, and develop data necessary to describe the current regional burden of disease, among others. Suppose one proposal includes a collaboration of hospitals, and another proposal involves a collaboration of County Departments of Health. While the hospitals might have the technical competence to implement such a project, their primary mission is diagnosis and treatment. Meanwhile, the Departments of Health would likely be more preventive-minded. Both the DOH and the hospital have the best interests of the children in mind, but might approach the problem from different perspectives. When

selecting the best lead agency in such a collaboration, a county DOH might be a more compatible home for the project than a hospital.

A high rating on this parameter suggests close conformity with the scope and mission of the project and the governing institution(s). Such conformity improves the likelihood that a project will receive the priority and attention it warrants.

2. Flexibility: Governance structure can accommodate changes in the character of the project, consistent with the original project purpose.

Projects that cover a wide geographic area may require flexibility to allow local health units to implement projects based on individual county or service area needs. Projects that are difficult to define at the outset may require flexibility to allow for changes in scale, strategy, disease severity or prevalence, or project goals that often occur during the course of a project.

The type of flexibility required might dictate a very different structural solution. If the resources required for the project are difficult to predict, then the governance structure must include an organization or organizations that can hire additional staff relatively quickly and can deploy and re-deploy staff with ease.

Example: An anti-smoking television and radio campaign can be clearly defined at the outset of the project. Once initiated, changes in the project are likely to be modest. The sponsoring agency might choose to enter into a contract with a private entity that allows little flexibility once the project is underway.

On the other hand, a project intended to identify, then implement, an approach to reduce the incidence of asthmatic attacks in children may require significant flexibility. Early stages of the project will provide information that could alter the interventions anticipated at the project's outset. Research may show that interventions need to differ for children in urban versus rural populations, for example. To ensure that the project has an effective outcome, the governance structure must accommodate a range of intervention options.

A high rating on this parameter indicates that the model will provide adequate flexibility as needed for a particular project. The need for flexibility will vary from project to project. A less flexible structure may be perfectly acceptable in some instances. As various parameters are occasionally in opposition to one another, it is important to recognize when one parameter—such as flexibility—is critical and may need to take priority over other desirable but less important characteristics.

3. **Authority**: Lead entity possesses sufficient statutory power and professional stature to accomplish the project's objectives.

Organizations need sufficient power (legal, regulatory) to accomplish project goals. Funders hold the lead agency accountable for performance. The lead agency, therefore, must have adequate authority to oversee project activities and achieve results. In addition, the public trust is critical as public health agencies move to establish goals and functions that the public understands (IOM, 1996). Public trust contributes to an agency's authority to carry out its charge.

Example: County health departments are responsible for testing drinking water. Along with the obligation to test comes the authority to enact swift change if a problem is detected. A project is not likely to be effective if the governing institution(s) lacks sufficient authority to implement the project.

Authority should always be judged in the context of need. A high score on "authority" should simply indicate that the amount of authority vested in the governance structure is sufficient to the task, nothing more. An informal multi-county consortium has relatively little formal authority. In some instances this is perfectly acceptable to the task at hand. Where the ability to formally enact change is more critical, the governance structure must be more robust.

4. **Accountability**: Parties involved in project implementation can be held accountable to the appropriate stakeholders.

All public health projects are conceived with a set of more or less measurable outcomes encompassing factors such as cost, morbidity, mortality, and effectiveness. The extent to which the organization or organizations implementing the project are

accountable to the initiating agency depends on the power relationship between the initiator and the implementer. A collaborative effort in which all partners are voluntary participants often possesses a relatively low level of accountability. Alternatively, a contractual relationship can specify rewards or sanctions for particular outcomes.

Example: There are several immunization registries in place throughout the state. In all cases, primary care practitioners (PCPs) play an important role in immunizing children, and in placing the immunization information on the registry. If the PCPs are to be held accountable for these tasks, they must be given the proper training and resources to do so and their compliance must be monitored.

In order to ensure the best possible compliance, the governing body must have sufficient resources to monitor compliance, and sufficient authority to impose sanctions on PCPs who do not comply. In this instance, the structure of health care practice and the limitations of resources limit the extent of accountability.

The various registries in NYS are governed in different ways. The FLAIR registry is administered through the Monroe County DOH, while the registry in the Northeast corner of the state is administered through the Upper Hudson Primary Care Consortium, a consortium of provider groups. If the PCPs do not follow through on their tasks, Monroe County DOH may not be able to hold them directly accountable. However, the PCPs under the Upper Hudson Consortium are likely to be members of the Consortium, and therefore are more likely to be held strongly accountable for their actions. Different governance structures may provide different levels of accountability.

Once again, the key question is whether a structure provides *sufficient* accountability, subject to other constraints on the project. A high score should indicate the appropriateness of the level of accountability conferred by a particular structure for a specific project.

5. Cost: Governance structure encourages efficient administration and project implementation.

Governance structures bring highly variable levels of cost. The implementation methods used, the type of personnel available, the conformity between an institution's primary mission and that of the project plus other factors can alter the cost of achieving a particular set of goals. These costs can be broken into program costs and administrative costs. Here again, the scale of the lead agency can be significant and the first parameter (scope and mission) can influence cost. A large project administered by a small agency may have higher administrative costs than the same project administered by a larger agency. In addition, some potential lead institutions may have the ability to leverage other resources, such as bonds, while others do not have that ability.

Example: A project designed to reduce the regional burden of asthma would require a wide range of expertise and potentially the use of specialized equipment. This type of project would be expensive to house in an agency that lacked the needed equipment, and in which most professional staff are generalists, not specialists. Either the generalist staff would be forced to learn new skills or significant elements of the project would have to be provided through a subcontract with needed specialists.

Some structures will be highly cost effective with one project, yet inefficient with another. A high score on cost indicates that the model will be cost-effective for the identified project. Each pairing of governance structure and project can be rated on relative cost-effectiveness. The importance of cost effectiveness relative to overall project goals should be determined. Projects that are very important yet have severely limited budgets might have to sacrifice other characteristics in deference to cost-effective management.

6. Sustainability: Ensures that the project will not end prematurely as long as the public health need exists.

A necessary condition for sustainability is compatibility between the scope and mission of the governance structure and the project. If a project is to be sustained, then the governance structure must be established with that goal in mind.

The nature of the project also will dictate its sustainability. A state grant designed to be temporary may stimulate a sustained effort if a project's primary costs are in the start-up phase and if the size

and mission of the lead agency are compatible with the project's goals. If the financial obstacle is operational, however, then sustainability is in danger if the funding is intended for only the short-term. Governance models should provide a mechanism to identify which project components should be maintained for the long-term, and how to finance them.

Example: The State DOH will soon require mandatory HIV reporting. The State may provide one year of funding to counties to help with implementation costs. As this effort begins, alternate sources of funding and the level of funding required for ongoing operation should be identified since the effort is intended to last beyond the one-year State funding period.

A project/governance structure pairing with high sustainability will demonstrate compatibility in scope, mission and available resources.

7. Technical Expertise and Management Capabilities: Ability to access and apply technical and management expertise.

As discussed above in the context of cost, an appropriate match between the technical and management resources of the lead entity and the needs of the project is very important. The lead should be able to provide staff capable of efficient management and sufficient technical sophistication. Both project quality and cost effectiveness are at risk if this expertise is lacking.

Example: If the development of an immunization registry requires substantial computer programming expertise, which is located in only a handful of counties throughout the state, it is unreasonable to require each involved county to develop their own registry. It is more appropriate to use existing expertise either in a single county or in a private organization, and to assign a governance structure that allows for the use of that expertise.

A high score indicates compatibility between the needs of the project and the resources available within the lead entity and partner organizations.

8. Protection of Local Interests: Ability to recognize the variation among counties and communities in terms of needs and concerns.

Some public health projects are funded on a regional basis, but require different implementation techniques among participating communities. Projects designed around integrated funding, planning, budgeting, and delivery of services may ultimately provide services that are unnecessary in some communities, and yet are inadequate in other participating communities. Centrally managed projects often ignore the particular needs of smaller, more rural partners. In some ways, this parameter is closely linked to flexibility.

The state of New York is geographically diverse, with extremely urban areas downstate, and extremely rural areas in the North Country. Even the Western region is diverse, with the urban counties of Monroe and Erie, and the rural farmland in Cattaraugus, Allegany, and other counties. To select a governance model that can accommodate such geographic diversity requires careful consideration of local interests.

Example: Funding for the FLAIR immunization registry flows directly from the state into Monroe County. While Monroe is the lead county on paper, Monroe does not administer the project to all counties. Livingston County, for example, independently plans and carries out its own registry activities under the contractual arrangement. This approach preserves Livingston County's autonomy in the project.

In this instance, the type of project is less influential in evaluating a model's ability to perform well on the criterion. A higher rating indicates better protection of local interests among participating communities.

9. Political Feasibility: Ability to address political concerns about regional initiatives.

Public programs create risks and rewards for elected officials. A regional public health program has to adequately address the effect of the program on various constituencies and recognize the political consequences of program implementation. A regional program can help remove significant public health issues from the political arena and help insulate elected officials from unpopular, but important initiatives. Decisions around the degree of control and accountability afforded local officials must be made in the context of the political climate.

Example: Some public health concerns have more political visibility than others. Projects that concern AIDS, contraception, abortion and other socially-charged initiatives cannot be implemented in a community without adequate support from elected officials.

Example: To propose a multi-county immunization registry under a large-county lead model was politically acceptable to both lead and non-lead counties. To propose a single county immunization registry would likely be politically feasible in a larger county, but infeasible in smaller counties. Smaller counties would likely be concerned with their ability to administer such a project and to fund the project long term.

Especially in smaller counties, it can take just one or two opposing individuals to keep an initiative from moving forward. A model would rate strong on political feasibility if it were able to assuage concerns of stakeholders about costs or any other issue. A model should be able to supercede the politics of any single county for the good of the regional effort.

10. **Communication**: Ensures that all involved parties exchange relevant information in a timely, efficient, and effective manner.

Some regional projects involve multiple parties that are diverse in geography, culture, goals, and other dimensions. While communication among participants is important in any project, it becomes more challenging with such diversity in place. Any project that has high public visibility with significant political consequences is subject to increased scrutiny and it becomes imperative that all parties have consistent information.

Projects that involve direct provision of patient services, especially if service provision is decentralized such as in the immunization registry, are more likely to require timely communication. Further, any projects that require coordination of local health units, a regional DOH office, as well as the central office in Albany, will need an efficient communication system in place to ensure that tasks are not duplicated nor overlooked.

Example: Response to the West Nile virus is an excellent example of a potential regional project that would involve health departments at all levels along with public and private health care

providers throughout the entire state. Response to the spread of any emerging pathogens requires communication among involved parties on incidence, geographic spread, pathology, treatment, and many other issues.

Other Considerations When Selecting a Governance Model

Two other considerations are excluded from the parameter section above, but warrant a brief mention. First, privacy concerns arise when health-related patient data is collected, especially without patient consent. The proposed Rochester Area Patient Information Directory (RAPID) includes plans to collect and make widely (although in a confidential manner) available a variety of information including personal information and health history information. Concerns exist over whether the State and Federal governments will condone the aggregation of data for Public Health purposes without patient consent.

A second consideration is the potential for liability for the provision of medical services. A governance structure should be able to accommodate the legal liability involved when a county or other entity provides direct medical services. For example, immunizations are a medical service that only a licensed facility can provide. Conversely, an educational project on the benefits of a healthy diet could be carried out by almost any entity without the constraint of liability concerns. When medical liability is present, the governance model should be able to account for such concerns.

HOW DO MODELS PERFORM BASED ON THE CRITERIA?

In order to help evaluate and compare the various governance models, each model can be evaluated on the ten criteria with a particular project in mind. For each criterion, the models could be scored numerically according to different criteria. This is not to imply that these characteristics can be precisely measured; it is often helpful to use a rating system to achieve a rough ranking of different models by characteristic. In the example below, models are scored from 0 to 5, with 5 as the highest rating. In addition, the importance of each criterion for the given project is assigned a value from 0 to 5. The models are then evaluated based on a weighted sum of how they perform on the criteria. This approach is certainly subjective, and different participants in a designated

project might score the models in different ways depending on their perspective and interests. However, this may serve as a starting point for discussion, and should help participants to select the most appropriate model in a structured manner.

In this example, we try to select the best model for a proposed regional effort to provide dental health to the underserved population. Dental care for the low-income population is problematic because many providers will not accept Medicaid or Child Health Plus patients, and in rural areas there is a shortage of providers even for patients with private insurance. An unincorporated consortium called the Rochester Oral Health Coalition has formed to address the shortage of dental care for the underserved. The coalition is applying for funding, and if awarded funding would need to take on a more formal structure. Currently, providers in Monroe and Livingston counties are involved in the coalition. However, for the purpose of this exercise, we will suppose that the coalition will involve multiple rural counties and one urban county, and will be a joint effort between county health departments and provider organizations. The table below illustrates how to use the identified criteria to evaluate the various models, given the specific needs of a program such as this.

Proposed Project: Multi-County Initiative to Provide Dental Care to the Underserved

Criteria and Their Relative Importance		**Single-County Lead** *Strengths:* 1. Cost 2. Accountability *Weaknesses:* 1. Flexibility 2. Protection of Local Interests		**Not-For-Profit** *Strengths:* 1. Flexibility 2. Tech/Mngt Expertise *Weaknesses:* 1. Cost 2. Political Feasibility		**Inter-municipal Agreement** *Strengths:* 1. Cost 2. Political Feasibility *Weaknesses:* 1. Tech/Mngt Expertise 2. Purpose/Scope		**DOH Regional** *Strengths:* 1. Purpose and Scope *Weaknesses:* 1. Communication 2. Authority		**Health Authority** *Strengths:* 1. Authority 2. Accountability *Weaknesses:* 1. Cost 2. Protection of local interests	
Criteria	*Importance (0-5)*	Weight (0-5)	**Total Score**	Weight (0-5)	**Total Score**	Weight (0-5)	**Total Score**	Weight (0-5)	**Total Score**	Weight (0-5)	**Total Score**
Purpose and Scope	*3*	4	**12**	4	**12**	2	**6**	5	**15**	4	**12**
Flexibility	*2*	1	**2**	5	**10**	3	**6**	2	**4**	3	**6**
Authority	*4*	3	**12**	4	**16**	3	**12**	2	**8**	5	**20**
Accountability	*4*	5	**20**	5	**20**	4	**16**	4	**16**	5	**20**
Cost	*4*	5	**20**	2	**8**	5	**20**	4	**16**	1	**4**
Sustainability	*3*	2	**6**	4	**12**	2	**6**	4	**12**	4	**12**
Technical and Management Expertise	*1*	2	**2**	5	**5**	1	**1**	3	**3**	5	**5**
Protection of Local Interests	*4*	1	**4**	4	**16**	2	**8**	2	**8**	2	**8**
Political Feasibility	*5*	3	**15**	3	**15**	5	**25**	2	**10**	1	**5**
Communication	*4*	2	**8**	5	**20**	2	**8**	1	**4**	3	**12**
Other________											

Once this exercise is complete, persons collaborating on the project can take a closer look at those models that appear likely to perform well on the most important parameters for the oral health project. In the example, we intentionally exclude a "total" score line for the models. While it is natural to look for a total score, the best use of this tool is in generating discussion among participants, not in ranking the models based on a score generated by these criteria. This exercise would be done separately for any regional project, or even any county-specific project that is ongoing or upcoming.

Different Governance Models for Different Project Phases

Projects pass through a variety of phases as they move from a simple concept into full implementation. Certainly no single governance model will fit the bill throughout this entire process. It is possible that different models will fit the needs at different stages. For example, informal models such as the unincorporated consortium may function quite well for the planning and developmental stage. However, once a project is ready for funding, a more formal model will be necessary for implementation and operations.

Re-assessing the Best Governance Model for an Ongoing Project

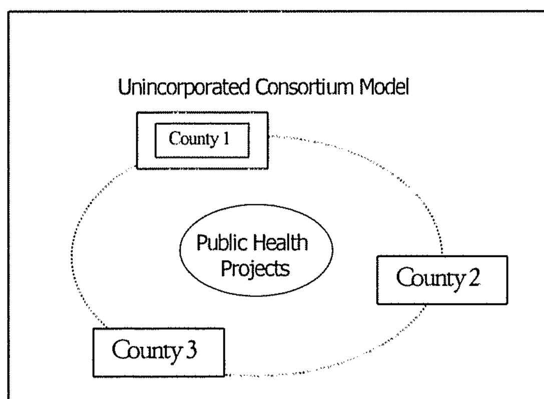
Once implemented, projects may still continue to change over time. While a set interval for re-evaluation is unlikely to be helpful, it may be worthwhile to consider the various models on an annual basis, or whenever a project is in transition. For example, the FLAIR registry is currently in transition and faces an end to funding as well as technical challenges. One option is for the program to merge with the Oneida immunization registry, which has developed a less-expensive registry structure. If this merger moves forward, the newly formed program would require a different governance structure. Public health programs are likely to face occasional changes such as these.

CASE STUDY: TRANSITION OF WESTERN NEW YORK PUBLIC HEALTH COALITION TO AN INCORPORATED NOT-FOR-PROFIT

In searching for alternative governance models for regional public health initiatives, several individuals mentioned the unincorporated consortium as a potential lead agency. The difficulty here is that unincorporated consortia are ineligible as lead agencies because they are not legal entities. Therefore, the consortium must rely on some other incorporated institution, such as a county or a not- for-profit organization to take the lead role. Subsequently, the next question is, "what does it take to convert an unincorporated consortium into a not-for-profit 501[c][3], and what are the pros and cons of doing so?" This section describes two current examples of unincorporated consortia in the western New York region, and discusses how one, the Western New York Public Health Coalition, might approach the transition to incorporated status for the purpose of taking on the lead role in regional public health initiatives.

The Unincorporated Consortium: How Does it Work?

Unincorporated consortia are non-legal entities that develop when a group of leaders agree to collaborate on a project, but have no legal obligation or ties as an organization. One of the benefits of unincorporated consortia is their informal nature. They require voluntary participation, and in many ways render each participant an equal. Voluntary arrangements require that each participant be involved on a personal and professional level, and provide resources for the good of the communities served. To alter these special arrangements through incorporation would result in some benefits, but might alter their special nature.



The primary problem with an unincorporated consortium as a lead is that non-legal entities cannot assume legal responsibility for projects. Some non-legal consortia that work very effectively together are powerless to submit grant proposals or to receive grant dollars directly because they lack legal status.

Instead, one county or another entity takes on the responsibility of the lead role. While this can work, it places an administrative burden on the lead county, and leads to the same concerns that currently exist with a single-county lead. Below we describe two currently active unincorporated consortia.

SSAY Rural Health Network

The SSAY Rural Health Network began in 1997, and includes Steuben, Schuyler, Allegany, and Yates counties. When the Network began, the participants realized that as a non-legal entity they could not name the Network as the lead on grant applications. Instead, one county was selected to be the lead on grants. Yates county was selected because of the ease of the grant application process in that county, and because the Public Health Director was willing to accept this role.

A variety of regional projects have been conducted under the Network including updates of policy & procedure manuals, a radon awareness project, and facilitated enrollment for Child Health Plus. The projects do not always include all four counties, but even the projects that exclude Yates are still administered through Yates.

The governance structure of SSAY includes an advisory board (formerly the implementation team) with four representatives from each county. Each county sends a legislator, a consumer representative, the Public Health Director, and a social services representative. In addition, an external consultant participates in the meetings.

As in the single-county lead model, Yates faces burdens as the lead county for the network. Yates staff persons spend non-reimbursable time on Network projects and administration. There is also a financial risk in being the lead agency. In many cases the projects begin before the money begins to flow from the funding agency. For example, a Robert Wood Johnson foundation project to enroll children in Child Health Plus began in April 1999, and as of November 1999, Yates had not yet received funds from the foundation.

While the SSAY model seems to work for the time being, the long-run sustainability is in question. All public health directors must answer to their county legislature, and often legislatures have a limited mindset when it comes to geography; it can be difficult to

encourage legislatures to think and plan on a regional basis. Legislatures are reportedly concerned that regional projects might result in the loss of dollars to another county. As long as SSAY projects have been state-funded, the county legislatures have been cooperative. However, if SSAY begins to look for county dollars, this support could quickly shift. The legislatures would likely require SSAY to become accountable for county dollars, and this could be the point at which incorporation would be necessary.

In spite of the risks associated with being the lead county, the Yates Public Health Director sees substantial benefits to the county as a result of participation. In addition, there are cost efficiencies to running the grants out of a county rather than establishing a separate entity that would require its own staff and overhead costs. Yates has certain expertise in place that also makes it a natural lead county. Other counties involved in SSAY indicate that they are very pleased to let Yates be the lead, because it saves the non-lead counties a substantial amount of time, and because the non-lead counties trust Yates to do an outstanding job.

Western New York Public Health Coalition (WNYPHC)

In another example of an unincorporated coalition, the Western NY Public Health Coalition (WNYPHC) is an eight-county coalition that began about three years ago. Representatives from the eight counties meet approximately every six weeks to discuss issues of mutual benefit to the region. The group discusses funding issues, grant possibilities, inter-municipal and inter-agency issues, public – private partnerships, and other topics. The WNYPHC serves as a sort of gatekeeper for much of what the Health Departments are doing in Western NY.

The Coalition recently applied for grant funding under the NYS DOH Asthma Initiative. Since the Coalition is not incorporated, they submitted the application under the Erie County Department of Health. If the grant application is successful, the project will function as a single-county lead model.

The Coalition has produced a number of documents as a result of its work together, including a doctor's guide to public health. The guide, produced by the UB Department of Family Medicine, educates doctors about the public health services that are available in the eight county area. This project generated communication

between the doctor's offices, the public health sphere, and the managed care sphere.

A state DOH grant provided the resources for the Coalition to conduct a behavioral risk assessment survey for eight counties in the region. Erie County took the lead on the project because of the ease with which Erie is able to submit grants compared to Genesee County and some of the others. The University of Buffalo was hired to write and conduct the survey. The survey results were presented at the Healthy People 2010 conference in Washington, DC.

The Coalition often utilizes the expertise available at the University of Buffalo's Department of Family Medicine. If UB were to take on a lead role, a much larger portion of the grant dollars would go to indirect costs and overhead expenses at UB, and less funding would be available for the projects and for the LHU's use.

Using the Erie County Department of Health as the lead on the health assessment project did not lead to any particular problems according to WNYPHC leadership and to Erie County DOH personnel. In fact, several advantages were named including the ability of the County to pay up-front for services prior to reimbursement from the state, and the ability of the project to use County staff time and other resources for "free." However, an important limitation to this approach is its reliance on the "spirit of cooperation" among all involved. It is a system that relies on certain individuals and political climates, any of which could change suddenly. If similar projects were run through a 501c3, such sustainability issues would not be as relevant.

While the leadership of the WNYPHC does not feel any immediate need to move away from the single-county lead, they nonetheless acknowledge that the concerns of county legal departments are valid and justified. As discussed earlier in the report, county attorneys become concerned about legal liabilities involved with a single-county lead. For example, the lead county has no legal authority to control performance outside its borders. Counties simply do not have jurisdiction over other counties. If something goes wrong in another county, it is feasible that the lead county could be held liable by the state or some other entity. In addition, the lead county is contractually liable for how the money

in the grant is utilized. On the other hand, some smaller counties reported feeling that the lead county has an advantage as the fiscal lead, in as much as it has the ultimate control over the flow of dollars.

Transitioning an Unincorporated Consortium to an Incorporated Not-For-Profit

The use of a not-for-profit as a lead entity can take one of two approaches. To use an existing not-for-profit such as the Lake Plains Consortium is a more simple approach. Use of an existing not-for-profit is called "fiscal sponsorship" or "fiscal agency." With fiscal sponsorship, unincorporated individuals or groups can legally receive tax-deductible grants under the tax-exempt umbrella of an existing not-for-profit. The sponsoring organization generally provides a variety of administrative and other staff support, and in return receives a percentage of the grant dollars, often 10%. The Lake Plains Consortium has provided fiscal sponsorship for multi-county projects in the past, and is likely to continue its willingness to administer selected projects.

To create a new not-for-profit organization expressly for the purpose of governing regional projects is a much larger undertaking, but in the long-term, may be the best option for the Western New York region. While some not-for-profits, such as the Lake Plains consortium exist, they may not be the best organizations to provide such services over the long-run. Therefore, the western region should carefully consider the creation of a new not-for-profit organization, designed expressly to deal with regional public health projects. Several issues must be carefully considered in the creation of a new not-for-profit organization.

Prior to the legal and logistical steps required to convert an existing unincorporated organization into a not-for-profit or to form a new NFP, individuals considering this approach should consider some preliminary steps. First, is there a true need for the organization? As mentioned earlier, given the expanding number of regional projects, and the increasing concerns regarding the single-county lead, a need has certainly emerged. Second, are there core supporters for the approach? Incorporation requires a substantial amount of work, and in order to pull it off will require the work of several counties. Third, where will the money come from to form the corporation initially? The new corporation will require space, staff, supplies, etc. Fourth, what about a business

plan? While the articles of incorporation and other legal paperwork do not necessarily need to be completed this early, some type of business plan or other planning document should be under review.

- Is there a true nee for the organization?
- Are there cor supporters for th approach?
- Where will the see money come from?
- Is a business pla developed?

Formal incorporation has its pros and cons. An independent organization has a stronger identity when incorporated than the groups and organizations that comprise it. In the western New York region, where the single-county lead has been dominant in regional public health efforts, sensitivity surrounding a single county acting as fiscal agent runs high. Incorporation of an independent organization can alleviate such concerns. Incorporation also lends an organization more legitimacy, allows it to receive grant funding, provides greater continuity for projects, and forces the participating organizations to clarify the organization's roles and responsibilities (Weiner and Alexander, 1998).

In addition to the benefits of incorporation come some downsides. To formalize an organization through incorporation reduces its flexibility to vary membership or change its focus spontaneously. In addition, some would argue that incorporated organizations and their governing boards by definition do not foster consensus decision-making or equality participation (Weiner and Alexander, 1998). Some individuals in the western New York region reflected the same concern; they indicated that SSAY and the Western New York Public Health Coalition function well precisely because they are not legal organizations. Participation is fully voluntary and lends itself to the collaborative spirit of both organizations.

Pros and Cons of Incorporation

Pros:	Cons:
1. Stronger Identity	1. Reduces flexibility
2. Legal legitimacy	2. Potential lack of consensus
3. Alternative to Single-county lead	3. Initial costs

Despite the drawbacks, incorporation of a tax-exempt not-for-profit corporation (501c3) may be the best option for governance and administration of regional public health projects in the western New York region. Once the decision to create an incorporated not-for-profit is made, attention

must quickly turn to governance issues, including the roles of various players, Board construction, and other issues as discussed below.

Clarify organization mission and vision

Before any other design component is underway, the founders must clearly and concretely define the organization's mission and vision. A common mission and vision will unify participants and help focus attention on the design of a successful governance structure, rather than on differences of opinion over the purpose of the organization under construction.

Governance Roles for Various Stakeholders

The NYS DOH role in regional public health projects administered through a regional not-for-profit will remain important. The state DOH should be influential in evaluating program and project outcomes, and in contributing to policy decisions and program planning (Halverson et al., 1997). The regional DOH offices also play an important role in communicating information between the local health units and the state DOH.

Stakeholders in Regional Public Health Initiatives

- NYS DOH
- Regional DOH
- Local Health Units
- Community at large

Local Health Units are also critical stakeholders. With the variation in size, public health issues, and other characteristics of the counties that comprise the Western region of New York, representation issues in the not-for-profit will require thorough consideration.

The role of the community-at-large must not be ignored. While the not-for-profit Board members will need technical data regarding the community's health needs, they also need information on the community's perceptions of health needs. Whether community members should have a formal role on the Board or participate in some other capacity is one of many decisions to be made in this process.

Governing Body Design

Governance involves multiple tasks. At one level, a governing body must provide advice and authority to an organization. At another level, decisions must be made regarding day-to-day operations and on a project-specific basis. In order to address both components, a possible solution is to create an executive committee composed of all LHU commissioners that provide advice and authority; and a separate Board of Directors that is more representative of geographic size, and that includes some appointees agreed on jointly by all participating counties. Some

predetermined parameters regarding representation should be developed to frame the precise Board composition.

Once the two governing entities are designed, voting powers must be discussed. It may be reasonable to construct multiple levels of voting power, depending on the issue at hand. For example, everyday decisions could be determined by simple majority, while issues of far-reaching importance might require a super-majority in order to protect smaller counties against votes decided by representatives of larger counties.

Along with voting powers, those designing the governance structure must determine whether the governing body(ies) will have policymaking authority independent of the individual counties to make decisions such as establishing partnership initiatives, allocating resources for partnership activities, and reporting partnership performance to the communities they represent.

Similarly, if the governing bodies are granted wide decision-making authority, who should be responsible for the decisions? Should the regional governing body or the local government representatives be responsible for decisions (Veenstra and Lomas, 1999)? Who should be responsible for outcomes of the decisions? Accountability for decision-making is an important component to determine early in the design process.

Governing Body Design Issues

- Representation on Board(s)
- Voting powers
- Policymaking authority
- Accountability
- Keeping Board informed
- Conflicts of interest

To keep the Board of Directors informed can be a challenge for a new not-for-profit organization. Nonetheless, an informed Board makes better decisions that in turn leads to improved outcomes for the NFP. To inundate the Board with information is not keeping the members well-informed. Rather, to provide Board members with selective, relevant, timely information is the key goal.

Conflict of interest can be problematic if different counties involved in a regional project have mutually exclusive goals. Since nonprofits exist to serve the broad public good, board members are ethically bound to put the welfare of the organization before their own personal benefits. A written policy on conflict of interest should be in place and should be reviewed regularly. Conflict of interest points can include policies on full disclosure

regarding connections with groups and individuals doing business with the NFP, board member abstention from discussion and voting if a potential conflict of interest exists, and NFP staff abstention from project involvement if a potential conflict of interest exists (NCNB, 2000).

Funding Issues

Funding for a not-for-profit can come from multiple sources. First, participating counties might be required to pay annual dues. The amount could be based on population or some other scale. Second, since the primary reason for creation of the entity is to facilitate administration of regional public health projects funded primarily through state DOH grants, the not-for-profit will be funded with some percentage of grant dollars, perhaps 10%, depending upon the extent of the roles and responsibilities of the not-for-profit.

Summary of Governance Challenges For New Not-for-Profit

As implied by the multiple steps and considerations that go into the development of a governing structure for a not-for-profit, the process involves many challenges. From defining a common vision and mission to determining accountability for program outcomes, a governance structure thought through carefully in advance will save untold future disagreements and difficulties.

To establish clear roles, responsibilities, and relationships of the various stakeholders in such an effort is no small undertaking. To generate policies that carefully address issues of accountability and other concerns requires teamwork, commitment, and a sense of purpose.

Questions for counties to consider in establishing a not-for-profit organization charged with the administration of regional public health projects are the following:

Questions for Consideration When Starting a new Not-for-Profit

- When and why do we want to create an incorporated NFP organization?
- What is the organization's mission and vision?
- Who are the stakeholders in the organization?
- What type(s) of governing bodies will we implement? How many?
- How will the organization be funded?

To answer these questions and resolve the problems and issues they raise is certainly the most challenging aspect of creating a new not-for-profit organization. The legal requirements are straightforward and simply require an attorney to file the necessary paperwork.

CONCLUSION

There are many different ways to organize a regional public health program. The purpose of this project was to identify these alternative models and develop criteria by which these different models could be compared to one another. The ultimate goal is to establish procedures that will enable policymakers to select a governance model that is best suited to the project or program at hand.

As an example, the single-county lead governance model is widely used in Western New York for administration of regional public health projects. While in some cases this approach works well, concerns exist on the part of the lead counties as well as those counties who tend not to take the lead. Concerns over liability, the flow of dollars, reliance on county executives and county legislatures, and others are important and cannot be dismissed. Many argue that there is a problem with an arrangement that accords one county all of the responsibility for a project, but only part of the rights to the control of a project.

Alternatives to the single-county lead presented in this report include letters of agreement, inter-municipal agreements, formation of a Health Authority, or formation of a not- for-profit organization. In many cases in which the single county lead model has been adopted, the best alternative appears to be formation not-for-profit organization designed expressly to serve the needs of Western New York counties interested in pursuing regional public health projects with state or other funding. While it has its own limitations, the not-for-profit lead offsets many of the problems identified with the single county model.

Individuals representing various domains of the health care sector demonstrate a desire to work together to provide public health services in the most effective and efficient manner possible. The

Western region of New York State hopes to adopt a more systematic, orderly approach to regional public health administration. Conversations with dozens of people have included very frank comments about both problems and benefits of the current approaches to multi-county public health projects. The information and procedures developed in this report are intended to help the LHCS team sort through the various models and the characteristics of each. Local and state health officials will be better equipped to discuss alternative models and to come to some agreement on the best approach for future programs and projects.

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APPENDIX A: LIST OF INTERVIEWS

State and Regional DOH Personnel

Gregory Balzano, Program Director, Communicable Disease Control, Western Regional Office

Michael Linse, Assistant Director of the Western Region

Carolyn Martin, Family Health Program Director, Western Regional Office

Michael Nazarko, AIDS Institute, Liaison for State DOH Alternative Procedures Subgroup

Stephen Paluch, Senior Administrative Assistant, Wester n Regional Office

David Register, Narcotic Investigator, Western Regional Office

Sanford Rubin, former State Assistant Regional Director

NYS County DOH Personnel

Ann Abdella, Health Planner, Chautauqua County

Andrew Doniger, Health Director, Monroe Count y

Joan Ellison, Health Director, Livingston County

Katrine Kretser, Health Director, Franklin County

Joseph Mabon, Health Director, Wayne County

Patricia Munoff, Health Director, Washington County

Gary Ogden, Health Director, Allegany County

Donald Rowe, Health Director, Genesee County

Lauren Snyder, Health Director, Yates County

Samuel Thorndike, Health Director, Chautauqua County

Out-of-State Public Health Representatives

Kathleen Boyle, Cardiovascular Disease Risk Reduction Program, Ohio Department of Health

Douglas Green, Director, South Shore Boards of Health Collaborative, Hanover, MA

Lois Hall, Breast and Cervical Cancer Project, Ohio Department of Health

Suzanne Koebel, Arthritis and ElderHealth Program, Ohio Department of Health

Sandy Macziewski, Countryside Public Health Service, Benson, MN

New Jersey Department of Health

Diane Pickles, Director, Healthy Communities Tobacco Awareness Program, Andover, MA

Nancy Teichman, Partnership for Community Health of the Lehigh Valley, Bethlehem, PA

Donna Warner, Director, Tobacco Control Program, MA Department of Public Health

Mikell Worley, Capital Region Health Futures, Harrisburg, PA

Mary Youngworth, Countryside Public Health Service, Benson, MN

Others

Scott Ball, Consultant, Rochester Health Information Group

JoAnn Bennison, Public Health Director, NYS Association of County Health Officials

Leo Brideau, CEO, Strong Health Systems

Jennifer Clock, Western New York Health Care Association

Phillip Haberstro, Wellness Institute of Greater Buffalo

Patrick Malgieri, Managing Partner, Boylan, Brown, Code, Vigdor & Wilson; former Monroe County Attorney

Kenneth Oakley, CEO, Lake Plains Community Care Network; CEO, AHEC

William Pike, Executive Director, Western New York Health Care Association

Lynne Silverberg, Grants Coordinator, Upper Hudson Primary Care Consortium

Robert Swinerton, Diane Ashley, Rochester Regional Healthcare Association

Robert Thompson, Executive Director, Monroe Plan for Medical Care

Charles Turner, Monroe County Attorney

Peter Whitten, Director of Planning and Development, Upper Hudson Primary Care Consortium