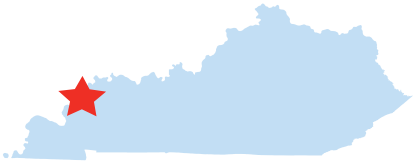
Center for Sharing Public Health Services

Rethinking Boundaries for Better Health

CASE STUDY:

Pennyrile District Health Department Crittenden County, Kentucky



PROFILE

Total population served (2013 Census Estimate): 54,181 (Caldwell, 12,823; Crittenden, 9,255; Livingston, 9,359; Lyon, 8,451; and Trigg, 14,293)

Total land area served (in sq. mi): 1,673.1

Average per household income: $38,655

Total revenues (fiscal year [FY] 2013–2014 est., Crittenden County alone):* $743,825

Total expenses (FY 2013–2014 est., Crittenden County alone): $975,071

No. partnering jurisdictions: Five counties

No. employees: 47 full-time equivalents (FTEs) and 6 contracted

Website: http://pennyrilehealth.org

*Revenue estimates are based on the population eligible for federal benefits within the county and on tax revenue contributed; expense estimates are based on Medicaid match and administrative costs for Crittenden divided among the five counties in the district.

Background

Crittenden County, a rural community in southwestern Kentucky, is part of the nine-county Pennyrile Area Development District designated by the State of Kentucky.[13] It is governed by a board of magistrates and a judge executive elected to a four-year term.[14] Historically, Crittenden County has often partnered with neighboring Lyon County and other counties within its state-designated area development district in matters of public health and economic development.[15]

Before the Pennyrile District Health Department was officially established in 1981, each of the nine counties in the Pennyrile Area Development District, including Crittenden County, ran its own independent health department. The state required that each county establish its own board of health (BOH) with a specific composition of practitioners, including a physician, dentist, pharmacist, fiscal county appointee, nurse, engineer, optometrist, veterinarian, and layperson.[16] Local BOHs met annually. Each county was required to fund local public health at 1.8 mills (or 1.8 cents per $100 dollars of property valued annually) in order to receive its share of public health funding from the state. Funds for the Crittenden County Health Department were appropriated by the county's fiscal courts, and some cities contributed funding. The state funded a few special programs to select jurisdictions, but funding primarily went to larger ones.

Around the late 1970s, conversations began among public health administrators in six of the nine counties in the development district. As they were running operations similar in size and services provided, these counties were interested in pooling resources to do more with their budgets. At a Crittenden County BOH meeting on December 28, 1979, Health Administrator Don Robertson reported that efforts were under way to organize a district health department, which organizers believed would produce cost-savings that would dramatically diminish this up-front investment over the next 30 years.

At the time, the state was offering financial incentives to encourage jurisdictions to come together to form district health

departments, and the state's commissioner of health engaged in conversations with the counties to begin setting it up. In April 1981, participating localities approved program plans and budgets.

Forming the Agreement

Crittenden County followed the same directed steps as the other partnering jurisdictions in the formation of the district health department:

1. The Crittenden County BOH acted to have the county's governing fiscal court pass a resolution to unite with the other counties in the district health department, and it sent a copy of this resolution to the State Division for Local Health.[17]
2. The Crittenden County BOH (as well as the BOHs of other participating counties) selected representatives for a "steering committee" for district formation. This committee worked with local health department personnel and the State Department of Human Resources to develop a district plan and budget, which were passed by Crittenden County on April 13, 1981, and sent to the State Department of Human Resources.
3. During the first regular meeting of the Pennyrile District Health Board on June 18, 1981, representatives from the five participating counties' BOHs met to elect a chairman and vice-chairman, as well as an executive board comprising a physician, nurse, dentist, fiscal court appointee, and member at-large.
4. On July 1, 1981, the state approved the formation of the Pennyrile District Health Department.

The location of the district office and employees was to be determined by the district BOH. The state suggested the taxing amounts that each participating county should be required to contribute to ensure fairness, eventually establishing a minimum requirement of 1.8 cents per $100 of valuation. Additional state funds were provided to support the district, and each county could provide further funding for building maintenance.

The Case for Sharing Administrative Services

Although motivations for the decisions made over 30 years ago require some conjecture today, financial benefit was most strongly cited as the initial and primary driver for establishing the district health department, followed closely by an increased ability to offer more health services to county residents. Before the district health department was created, the Crittenden County BOH had concerns about the disadvantages presented by greater bureaucratic control from the state level; however, the advantage of providing more health services to citizens at lower costs was the key decision point.

The counties would be able to achieve greater economies of scale in administration, which would mean increased cost-effectiveness. "The ability to hire one administrator to oversee the office for five counties meant that each county paid only one-fifth of the cost for an executive administrator," noted Robertson. "Dollars saved from decreased administration costs could be allocated more heavily towards programs."

Additionally, because the counties are not large enough to be eligible for many state and federal grants, they realized that being part of a district would help bring in federal grant-funded programs. At the time, counties were seeing cuts in their programs; on February 6, 1981, the Crittenden County health administrator announced budget cuts in the Early Periodic Screening, Diagnosis, and Treatment program, with further cuts expected. For the counties to take advantage of several state and federal grants, a district health department could be a lead agent large enough for grant eligibility on special projects.

The Districtwide Shared Services Model: Establishing a Public Health Taxing District by Resolution

Today, the Pennyrile District Health Department in rural southwestern Kentucky oversees the operations of clinics in Caldwell, Crittenden, Livingston, Lyon, and Trigg counties, offering public health services to their 54,000 residents.

In accordance with Kentucky State Statue KRS 212.855, the Pennyrile District BOH comprises at least two members from each county BOH within the district; those members must be the county judge and at least one other appointed individual. Selection of those other members is guided by a state mandate, applicable to both county- and district-level BOHs, that requires representation by at least one physician, nurse, dentist, and fiscal county appointee. The district BOH meets quarterly.[18] In practice, it carries out the interests of the county BOHs, whose members are nominated by

anyone in the community and then approved by the Department for Public Health in Frankfort. The county BOH is a liaison between the community and the health department, explained Dr. Steve Crider, member of the Crittenden County BOH. "We are there to ensure that the public interest is being carried in the community. Since we have a chiropractor, a veterinarian, and other health practitioners represented, we can get a good feeling of what is going on in the county."

Each of the five participating counties has its own building, including Crittenden, whose new facility opened in 2010. Each county building does not have its own administrator but does have supervisors present, and an explicit chain of command is established between supervisors and senior management. All staff members are district employees. Since 2010, management, including the director and human resources and finance staff of the Pennyrile District Health Department, has been housed in a separate district building located central to the five-county district served by the city of Eddyville in neighboring Lyon County. Previously, the administrator had been housed in the Lyon County clinic.

The district health department receives state funding through a block grant, and it allocates funding according to need. It bills the state to receive its federal Medicaid allocation. Each county BOH has authority to collect its local health tax and contributes the amount collected from the mandated district health tax rate to department. Crittenden County's local public health tax was 3 mills (or 3 cents per $100 in taxable property value) in 2014. Of that amount, the revenue from 2.3 cents per $100 in valuation is contributed to the department, and the rest goes toward maintenance of county buildings.

Program focuses are decided by the state, and implementation is coordinated at the district level. For example, the state establishes requirements for programs such as WIC (Women, Infants and Children), health education, and disaster preparedness. The state provides some funds for compliance with state mandates, but not for all programs. With declining funding, state-mandated programs are prioritized, and decisions are made from there for additional programming.

Obstacles in Planning and Implementing the Agreement

The establishment of the district has resulted in increasingly effective and efficient administration over the past 30 years, with challenges in implementation most prevalent in earlier years. The original five jurisdictions that came together to form the Pennyrile District Health Department were not the same as those that participate currently. One of the original participants was incentivized by the opportunity to receive additional state funding; however, it later decided to separate from the effort and took its funds with it. But despite the unexpected loss of anticipated funds, the counties still succeeded in forming the department. Caldwell County, another neighboring jurisdiction that had initially hesitated to participate, decided to join one year after the department was established.

The loss of autonomy was an anticipated obstacle to the formation of the district health department that recurred at times during implementation. Gaining the necessary local support of the county fiscal courts, BOHs, and public health department staff proved challenging. The fiscal courts were reluctant to sign resolutions that reduced the amount of funding they controlled. More recently, a district-initiated tax raise presented a conflict between the district and the local BOHs. As has been noted, prior to 2010, each participating county's tax contribution was at 1.8 cents per $100 of valuation. When the district health department administrator prompted the district BOH to raise the mandated public health tax rate for each county to 2.3 cents per $100, it was troubling to those counties that would need to increase rates to residents.

Perceived favoritism by district administrators over the years also posed potential obstacles to implementation of the agreement. This has been evident in situations related to the placement of the district offices, as well as in perceived inequity in the level of services provided in some counties versus others.

Despite these challenges, the trust established between the counties and the centralized administrator, among BOHs, and between the system and the community has enabled success. "When consolidating, you give up some input," explained Crittenden County BOH member and county magistrate Donnetta Travis. "If there was a concern, it would be brought to the board. It's about establishing community trust. Knowing that somebody local is looking at the dollars coming in and decides on what taxes will be paid and how they will be used is an important aspect."

Advantages

"When I was administrator in Crittenden and Lyon Counties," Robertson reported, "the total budget was $70,000 for operations and services. We continued to expand over the years, and when I retired in 2003, the annual budget was $2.3 million and we

had 40 employees. From everyone pulling together to lower administration costs, operations became more efficient. As a result, more money could be directed to serving citizens, which was the main goal."

The anticipated financial advantage resulting from this arrangement was achieved and has resulted in more cost-effective service delivery. The shared services arrangement increases economies of scale in allocating funds, personnel, and other resources. Four environmentalists can work among the five counties, reducing the cost of providing that service. Multijurisdictional contracting for specialized services, such as legal services, is more cost-effective when centralized and shared.

"When we had to eliminate services for a program, we didn't know what the legalities were of transferring funds," explained Dr. Crider. "Through a lawyer we were able to hire through the district, we found out that we could not eliminate those services."

Estimated costs for Crittenden County alone in FY 2013–2014 were $975,071; however, the county's estimated revenue contributed from taxes and Medicaid allocation was only $743,825 (suggesting that the county might have to provide its current level of services with $231,246 less in revenue). Reduced cost has been especially advantageous in an environment of increasingly diminished revenues to minimize negative impact. In the past four years, the state has moved to managed care with Medicaid, so the reimbursement rate at the district health department has been dropping. Additional savings have resulted from cheaper procurement. The department pays less for supplies and equipment by buying in bulk for five counties rather than one.

In allocating staff, the shared administrative agreement also ensures greater reliability of services through greater staffing capacity. In case a nurse or other service provider cannot come into work, the district can reallocate staff to fill that service gap and ensure continuity of health services in all counties.

Additionally, the district health department provides a logical placement for staff and programs designated by the state to serve multiple counties. For example, the state funds an epidemiologist who provides services to the nine counties in the state-designated Pennyrile Area Development District. The district health department can house this epidemiologist and cover associated expenses, and the epidemiologist will conduct investigations for all counties in the district, including those five that receive services from the Pennyrile District Health Department and the other four in the state-designated area. This is the case for other federally and state-mandated and funded programs, such as a preparedness program and grants from the Centers for Disease Control and Prevention.

One final advantage identified is the network enabled by the district health agreement. Interacting with and learning from other counties and their experiences has been valuable for community building and maximizing knowledge to guide decision making. "There is a big benefit in a larger pool of experience and knowledge," said Crittenden County BOH member Carol Harrison. "Many of the districts face challenges. [Through this arrangement], counties can help each other in solving problems that they have."

Key Takeaways

- Sharing administrative services is critical in small rural areas.
- Management, staff, and elected officials who understand their roles working for the entire district community are critical in maintaining working relationships to achieve success. Fostering trust between board members is a component of this. Getting people on board can prove to be a challenge in the beginning. "The key is effective go-betweens within the district," said Dr. Crider. "You have to trust the district administrator. That's where accountability comes in."
- The primary driver and benefit of shared administrative services is financial. This benefit results from increased economies of scale in allocated funds, personnel, and expertise, as well as from incentives and increased funding opportunities from state and federal sources.
- Shared administrative services significantly enhance the capacity of public health departments to provide a range of programs and services, meet federal and state programmatic requirements, and address specialized challenges, such as legal issues, that independent public health departments could not address on their own.

Study Participants:

Allison Beshear, public health director, Pennyrile District Health Department

Stuart Collins, member, Crittenden County BOH

Steve Crider, member, Crittenden County BOH

Raymond Giannini, former administrator, Pennyrile District Health Department and Caldwell County Health Department

Carol Harrison, member, Crittenden County Board of Health

Perry Newcom, judge executive, Crittenden County; member, Crittenden County BOH; Member, Pennyrile Area Development, District board of directors

Gaye Porter, member, Crittenden County BOH and Pennyrile District BOH

Don Robertson, former administrator, Pennyrile District Health Department and Crittenden/Lyon County Health Department

Roberta Shewmaker, member, Crittenden County BOH

Donnetta Travis, member, Crittenden County BOH, and magistrate, Crittenden County

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The Center for Sharing Public Health Services helps communities learn how to work across jurisdictional boundaries to deliver essential public health services. The Center serves as a national resource on cross-jurisdictional sharing (CJS) by building evidence and producing and disseminating tools, methods and models to assist public health agencies and policymakers as they consider and adopt CJS approaches. The Center is funded by the Robert Wood Johnson Foundation and is managed by the Kansas Health Institute.