Considering Consolidation to Build Stronger Local Health Departments

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ABSTRACT

Local public health departments are facing extreme budget cuts, which are forcing departments to eliminate programs, staff, and reduce the level of services they are providing to their communities. This works against the mission of improving the health of communities. The expectations and demands of public health are increasing, yet funding to support programs is decreasing. Consolidation of local health departments is one solution to retaining staff and services, while trying to operate with restricted budgets. Consolidation could help relieve the burden on taxpayers and still provide the services that people want, need, and deserve. There are many potential opportunities associated with consolidation such as: achieving possible cost savings; increasing capacity of services and providing essential services; being better prepared for public health emergencies and future state mandates; and reducing duplication of services. While there are many opportunities linked with consolidation, there are many concerns and hardships as well, such as loss of local control, minimal cost savings, individual community needs not being a priority, negotiating a contract among multiple communities, and the overall feeling that change can be difficult. Consolidation may work for smaller health departments who are geographically close, have similarities in their populations, and are common in per capita wealth. When deciding whether to consolidate, a formal decision process should be followed. Strong leadership must be present, as well as support from elected officials, boards of health, residents of the communities, and staff members.
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LIST OF ABBREVIATIONS

NACCHO  National Association of County and City Health Officials
NALBOH  National Association of Local Boards of Health
PHAB    Public Health Accreditation Board
**Background**

The public health profession is increasingly concerned with the confounding problems and the insufficiencies of present-day programs. Local health departments all share a common mission and goal to improve the health of a community, but working toward this goal or fulfilling its obligation is becoming more difficult. Public health is continuously faced with the increasing scope of demands, the rapidity of change, the mounting pressures of new and growing health problems, the shortages of qualified personnel, the need to obtain more knowledge through research, lack of funding and resources, and the overall difficulty of coordination in the planning and execution of activities (National Association of County and City Health Officials [NACCHO], 2011). In spite of continued efforts by many people on many fronts, public health as a whole is not succeeding in its competition for funds and personnel (Robert Wood Johnson Foundation, 2009). It is becoming more common to wonder whether the profession can mobilize its abilities and increase its strength adequately and rapidly enough for success in meeting these challenges (Weisfeld & Wexler, 2009). This paper will take a closer look at the possibility of local health departments consolidating in order to pool efforts and resources, to continue to work toward improving the health of communities.

**Definition of Consolidation**

A meaning of consolidation is to strengthen or secure forces (Quade, 2010). Consolidation also brings unity, which in turn, brings strength. Generally, to consolidate means to make firm by bringing together in close union to form a compact body or mass. In a consolidated health department, the participating jurisdictions become one identity, and they must obligate themselves to direct their functions toward the specified objectives of the joint
effort; consolidation means an actual merging into a single unit, as when several small health agencies are combined under one administrative head (Mays et al., 2009). The meaning of "strength" should be considered in terms of the ability of the public health system to meet present and future problems. The reservoir of potential strength for public health accomplishment is in the professional training, abilities, and attitudes of workers in the various fields that can contribute toward the aims of public health (Russo, 2007). To be effective, this potential strength, once developed, must assume and support public health needs in a way that presents an opportunity for success. This concept of strength in a public health program does not suggest a highly centralized organization of dominant power, but rather a well managed movement of flexible composition and structure. In order to be strong, a program first of all must have unity of direction. To operate successfully it must have the prestige, momentum, variety of resources, and flexibility of function necessary to fulfill any important public health requirement (Turnock, 1994).

**Consolidation vs. Regionalization**

Consolidation should not be confused with regionalization. As previously discussed, consolidation is the combining to become one entity or a formal merger of agencies. Regionalization of local health departments, on the other hand, is a strategy to help smaller health departments meet standards by working with other health departments, thereby ensuring that their combined populations all receive the essential public health services that they have the right to expect; regionalization is a collaborative effort to make up for health departments' shortfalls (NACCHO, 2011). With regionalization, each health department remains a separate entity, yet they may share services, grants, equipment, or staff. As agencies enter into
agreements to share resources and coordinate activities, the scope, quality, and effectiveness of public health services will be improved for all jurisdictions involved (Massachusetts Health and Human Services, 2011). Regionalization, unlike consolidation, is a voluntary, planned, and structured sharing of services within a region, without merging existing agencies or creating new agencies. Thus, each identity is preserved (Weisfeld & Wexler, 2009).

**Opportunities of Consolidation**

There are several driving forces, pushing local health departments toward consolidation. Merging of health departments has the ability to bring along many opportunities. Some of the possible opportunities include cost savings, having a larger population to compete for grants, increased capacity to provide services, being able to provide core functions and essential public health services, being better prepared for public health emergencies, better able to prepare for future public health service requirements, and reducing duplication of services.

**Potential Cost Savings/Ease Budget Constraints**

There are many opportunities that come along with consolidation, particularly for health departments that are facing tight budget constraints. Funding is becoming scarcer for local public health departments, yet roles, responsibilities, and demands keep increasing. In 2010, the National Association of County and City Health Officials (NACCHO) surveyed a sample of local health departments nationwide to measure the impact of the economic recession on local health departments’ jobs, programs, and budgets. The findings show that local health departments have experienced deep job losses and cuts to core funding that are resulting in the reduction or elimination of essential public health services. In the last six months of 2009, NACCHO reported that 46% of local health departments were forced to cut positions, losing the
people needed to help protect the health of their communities. These cut positions included layoffs or attrition, in which employees left the health department and their positions were not filled due to budgetary constraints. Further, it was found that due to budget cuts and loss of public health positions, nearly three-quarters (73%) of the United States’ population lived in the jurisdictions of local health departments that lost at least one job in the last six months of 2009. In 26 states, more than half of LHDs lost jobs due to layoffs or attrition. Figures 1 - 4 show just how severe the funding cuts and loss of public health positions have been on a national level (NACCHO, 2010). With budget cuts and position reductions, programs have to be cut as well. Though local health departments are responsible to improve the health of their communities, loss of funding, positions and services makes it more difficult, if not impossible to work towards improving the health of a population.

**Figure 1. Population Impact** (Source: NACCHO: Local Health Department Job Losses and Program Cuts – Findings from January/February 2010 Survey)
Figure 2. Job Loss by State (Source: NACCHO: Local Health Department Job Losses and Program Cuts – Findings from January/February 2010 Survey)

Percentage of LHDs that Lost Jobs Due to Layoffs or Attrition (July–December 2009)

Figure 3. Budget Loss Summary (Source: NACCHO: Local Health Department Job Losses and Program Cuts – Findings from January/February 2010 Survey)

Magnitude of Budget Loss in Dollars, by Population Category

<table>
<thead>
<tr>
<th>Population Category</th>
<th>Median Budget Loss</th>
<th>Mean Budget Loss</th>
<th>Median Budget Loss Adjusted</th>
<th>Mean Budget Loss Adjusted</th>
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<tr>
<td>&lt;25,000</td>
<td>$20,000</td>
<td>$27,000</td>
<td>$19,800–35,000</td>
<td></td>
</tr>
<tr>
<td>25,000–49,999</td>
<td>$40,000</td>
<td>$125,000</td>
<td>$66,000–184,000</td>
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<td>$128,000–223,000</td>
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<tr>
<td>100,000–499,999</td>
<td>$334,000</td>
<td>$535,000</td>
<td>$370,000–700,000</td>
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<tr>
<td>500,000+</td>
<td>$1,625,000</td>
<td>$2,841,000</td>
<td>$7,546,000–3,136,000</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>$54,000</td>
<td>$190,000</td>
<td>$288,000–399,000</td>
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Figure 4. Program Cuts by State (Source: NACCHO: Local Health Department Job Losses and Program Cuts – Findings from January/February 2010 Survey)

Percentage of LHDs with Program Cuts in Calendar Year 2009
If local health departments pursue consolidation, there is the ability to pool funds and the resources from different agencies. This provides a stronger financial base to provide the necessary resources to support public health services and the needed staffing. Findings from Weisfeld and Wexler stated that consolidation puts agencies in a position where there is not a loss of funding; consolidation would protect local health departments from budget reductions resulting from their lack of competitiveness with more highly valued local services (Weisfeld & Wexler, 2009). Another possible cost savings opportunity associated with consolidation is fewer offices, thereby reducing the costs of staffing multiple locations, payment of rent, and other overhead costs such as utilities (Elsass, 2003).

**Larger Population to Better Compete for Grants**

Oftentimes, smaller organizations have a more difficult time securing grant funds compared to larger organizations (Cooper, 2007). One reason is that organizations of a small size will have limited outreach due to a smaller staff for their small population, compared to a larger entity that will encompass a larger population (Cooper, 2007). Another reason is that larger populations are thought to have more diversity. Therefore, in a consolidated health department, the increase in population size and/or diversity could help local health departments acquire grants from private and public sources, which tend to be interested in services directed to larger, rather than smaller, populations. Health departments, regardless of size, should be undertaking monitoring and evaluation of their programs, however a consolidation of smaller departments may help to generate stronger performance data that will appeal to funders and be more useful, through the added validity that a larger population base would assure (Weisfeld & Wexler, 2009).
Due to tight budgets and limited staff, local health departments are having difficulties providing the core functions and essential services of public health, and many health departments are facing program cuts (Weisfeld and Wexler, 2009). Further, a small size limits the functions a health department is able to offer and provide (Cooper, 2007). As Pierce and Blackburn wrote in a report about the transformational changes of local health departments, “We have so many individual municipal health departments that are too small to support full-time health services (Pierce & Blackburn, 2007). Consolidation has the likelihood of being able to increase capacity of services of a health department and strengthening its ability to provide the required core functions and essential services. Increasing capacity of services can take place by having more staff available, therefore increasing the potential for improved public health services to better serve a community.

In 2006, a study performed by the Massachusetts Coalition for Public Health found that more than two-thirds of local health department officials stated their staffs were too small to allow them to fulfill their responsibilities to the public on a consistent basis (Hyde & Tovar, 2006). According to the study, the second biggest problem facing local health departments, after unfunded state mandates, was the gap between the services that were being provided and the Ten Essential Public Health Services that should be provided (Hyde & Tovar, 2006). It is recommended that communities complete an assessment to identify strengths that could be shared and common gaps that could be addressed through the process of consolidation (Weisfeld & Wexler, 2009). An example of a health department comparison tool worksheet to use as an assessment can be found in Appendix A. Working toward lessening or ending department inadequacies by sharing resources and strengths is a major opportunity of consolidation.
Similarly, research shows that agencies serving large populations are able to provide more services, such as disease surveillance and health education by spreading the fixed costs of public health infrastructure over a larger number of residents. Consequently, these agencies will have a larger staff and resources to support an array of health programs and services (Mays et al., 2009) (Boulton, Hadler, Beck, Ferland & Lichtveld, 2011). Research by Mays et al. that was published in *American Journal of Preventive Medicine* found that several observational studies suggested that larger public health systems of populations up to 500,000 people perform better than smaller entities in carrying out activities related to the Ten Essential Public Health Services. Moreover, they found that the size of the local public health department and the size of its population are the strongest predictors of a local health department to be able to provide a full range of services and activities related to the core public health functions and essential services. The studies collectively indicated that small public health departments may face many challenges in performing a full range of services, suggesting that consolidation may be beneficial (Mays et al., 2009).

*Plan and Respond to Public Health Emergencies*

Many local health departments began to establish formal and regional collaborative arrangements in 2002, in order to improve their ability to respond to public health emergencies since the effects of September 11 (NACCHO, 2010). The success of these initial efforts led to an expansion of regional activities—an expansion intended to facilitate greater sharing of services and to create a platform for receiving more outside funding (Weisfeld & Wexler, 2009). It is known and expected that disasters do not stop at regional or political borders. Further, emergency resources and funding are spread too thin for any one agency to be effective by themselves (Williams & Miyahara, 2009). In a consolidated health department, all resources are
pooled together to build a stronger department, represented by a single mission, core objectives and unified staff. Planning and coordination of activities and exercises can take place more easily. Skills and training can be shared, as well as equipment and technology. As a larger entity, preparedness measures will be enhanced through collaboration in community recovery, emergency operations coordination, public information and warning, mass care, and public health surveillance and epidemiological investigations (Center for Disease Control, 2010) (California Health Policy Forum, 2007).

Be Better Prepared for Future Public Health Service Requirements and Mandates

Over the last few years, the topic of accreditation has been part of determining the future of local public health departments. Accreditation is currently voluntary, however, it will most likely become mandatory. The goal of the National Public Health Accreditation Program is to improve and protect the health of the public by advancing the quality and performance of all health departments (Public Health Accreditation Board [PHAB], 2010). Accreditation will standardize services and increase efficiency, services, access, and protection of the public. Additionally, accreditation will impel local health departments to continuously improve the quality of the services they deliver to the community. For public health departments, accreditation means demonstrated accountability and improved quality, and serves as a way to measure performance. Nationally, public health accreditation means that people across the country can expect the same quality of public health programs and services no matter where they live. The expectation is that accreditation will strengthen public health departments and the services they provide, which will contribute to improved health outcomes in communities (PHAB, 2010).
Currently, many local health departments would not pass accreditation (Konkle, 2009). Possible reasons include lack of staffing, which in turn limits services and programs. With a consolidation, national performance standards for local health departments would be more likely met (Weisfeld & Wexler, 2009). Additionally, Weisfeld & Wexler predict that accreditation will drive future funding decisions; federal agencies and other funders will require local health departments to be accredited in order to qualify for support. Smaller health departments may find it difficult to meet accreditation standards by themselves, as smaller agencies often lack population-based services such as epidemiology, disease surveillance, and conducting community health assessments (Weisfeld & Wexler, 2009). Therefore, smaller health departments will have to build capacity in order to qualify for accreditation.

Going through the accreditation process has costs associated with the process. Local health departments may have to find resources to demonstrate compliance with complicated standards, prepare accreditation applications, conduct demonstration surveys, and submit accreditation fees (Weisfeld & Wexler, 2009). Consolidation of local health departments would allow for communities to pool funds to cover expenses when applying for accreditation.

Efficiency and Lack of Duplication of Efforts

The ability of public health systems to operate successfully within their funding environments is likely to hinge on how efficiently resources are used to produce the desired services and outcomes (Mays et al., 2009). Tighter budgets demand efficiency. The budget crisis that local health departments are experiencing should be used to work more effectively together with neighboring communities to secure a broader financial base to support public health services and staff. With consolidation, duplication of services will be reduced to appropriate levels to address the expanded population, and the results will reflect more
streamlined services with greater access to medical and social services (NALBOH, 2009). Overall, consolidation promotes maximizing of services and resources of local health departments (NACCHO, 2011).

Even though public health, in general, is understaffed, overlapping and duplication of certain positions exists. Each local health department has a health director. The health director position is one in which there is much administrative overlap among communities (Weisfeld & Wexler, 2009). For example, the duties and job functions of health directors to attend meetings, administer grants, and plan services or activities could be condensed by having one health director for more than one community. Inversely, the funds saved by reducing the number of health directors could then, in turn, be used to increase staff level positions to support the provided services.

**Concerns and Barriers with Consolidation**

While there are several reasons why exploring consolidation seems very positive, there are also potential concerns and barriers that must be addressed if a consolidation is to be successful. Some examples of potential barriers include minimal cost savings, loss of local control and autonomy, individual community needs may not be a priority, multiple locations and staffing, agreeing on a contract, personnel issues, and the general difficulty of change.

**Minimal Cost Savings**

One of the leading misconceptions agencies have about mergers is that there will be a cost savings (Price, 2003). According to a study done by the University of Wisconsin Extension Local Government Center, merging services does not always save money; there is no guarantee
that consolidations help communities cope with cuts in state or federal aid, or strict limits on property taxes (Elsass, 2003). Most consolidations require a financial investment— that might include supplies, equipment, and personnel costs. Start-up costs, such as ordering new stationary, and accommodating possible wage increases for employees, if one jurisdiction is paying more than the other, are added expenditures. Most likely, cost savings will not be acquired for at least three to five years (Elsass, 2003). A survey conducted by the Wisconsin Department of Revenue found that municipalities that shared services with their neighbors did not always yield significant savings to taxpayers (Price, 2003). If local health departments consolidate, their funding in grant dollars from the State health departments will most likely be reduced (Weisfeld & Wexler, 2009). Specifically, if three local health departments consolidated into one agency, the consolidated department would now only receive one funding base instead of three. According to a report from Weisfeld and Wexler, written on NACCHO’s behalf, “Consolidating will not always save money, in the sense of reducing overall expenditures. There isn’t a lot of waste now in local public health to produce savings… cost savings often fail to meet original expectations” (Weisfeld & Wexler, 2009).

Loss or Reduction of Local Power, Control and Autonomy

Loss of local control and autonomy can be major adversities of consolidation. Local public health departments are a governmental entity, each reporting to either a governing or an advisory board of health, as well as to the elected officials who make up a county, village or city board (Turnock, 1994). Because local tax dollars support local health departments, elected officials and boards of health have authority on how their health department functions. As local health departments merge, power within the jurisdiction will be reduced, as the majority of the control will lie within the fiscal agent of the consolidated health department. Thus, the political
landscape of who the health department will be reporting to will change as health departments come together to be one entity. Each separate government entity will still be contributing funds to the health department, yet the control of the health department will most likely fall under only one jurisdiction. Therefore, self-governance and independence are fully reduced in a consolidation (Konkle, 2009).

Additionally, many states have statutes regarding the board of health composition and the number of members. Most boards of health are required to include doctors, dentists, nurses, citizens at large, and elected officials (NALBOH, 2010). As health departments consolidate, it is possible that all communities comprising the health department may not have equal representation on the board of health. Configuring a board of health in compliance with various community requirements that oversees a consolidated health department could be difficult.

Relative to loss of autonomy, many health departments have spent years making local connections and networking, and a consolidation could weaken carefully nurtured local partnerships and impair the department's ability to marshal local resources (Weisfeld & Wexler, 2009). In a consolidation, dedicated time may not be able to be spent re-establishing and maintaining those relationships within a community.

*Individual Community Needs May Not be a Priority*

If local health departments pursue consolidation, it is important to note that individual community needs may not be a priority for the new, integrated organization. Alternatively, health services, programs, and interventions most likely will focus on what the communities need as a whole. Therefore, services and programs will be more generalized instead of reaching out to specific community needs. Health problems or priorities that are present in one
community are now the responsibility of all of the communities comprised of that health department, but given limited staffing, individual community health needs may not be addressed (Konkle, 2009). If the consolidated communities do not have similar community health assessments or similar health concerns, it may be difficult for staff to determine where to prioritize their efforts and outreach, and community-specific health issues may be overlooked.

Since health departments have been part of communities for years, public health professionals may have developed personal relationships with their clients and families. As a stand-alone health department within a specific community, the delivery of services, especially health education services, could be adjusted to people’s circumstances. In a consolidated department, this freedom of adjustment may be complicated and personal relationships with clients may grow distant (Weisfeld & Wexler, 2009). This would be an unfortunate outcome due to consolidation of local health departments.

Multiple Locations

Another complication of health departments consolidating is deciding where the health department should be located or if multiple locations need to exist. If the physical area of the communities is large or if a health department’s location presents access difficulties, then multiple locations for the consolidated entity may be necessary (Konkle, 2009). If this is the case, financing multiple offices takes away from the potential cost savings and leads to other considerations such as the placement or the rotation of a supervisor, the hours of operation and services provided by location. In addition, the cost of staffing various offices is burdensome. However, the availability of space to hold all staff at one location may be an insurmountable problem (Weisfeld & Wexler, 2009).
Agreeing on a Contract

When a decision is made to consolidate local health departments, writing a contract or the terms of the agreement can be a difficult and time consuming process. The contract must specify: the authority and governance structure; the composition of the board of health and its role; all health services that will be provided; operations; personnel; fiscal agent responsibilities; financing; and term in relation to the existence and validity of the contract (Elsass, 2003). One of the more difficult areas of negotiation is developing a formula to determine how much each agency will pay to support the infrastructure, staff, and programs (Weisfeld & Wexler, 2009). When negotiating a contract, there will need to be compromises among the different jurisdictions, which can be challenging.

As part of the contract agreement, it should be decided on how to incorporate each community’s local ordinances. Each jurisdiction has adopted its own standards and will bring a separate set of local laws or ordinances, many of which fall into the responsibility of the health department. Ordinances on human health hazards, nuisances, and inspections may all be different. If regulations differ from community to community, this may be confusing for public health officials to enforce (Weisfeld & Wexler, 2009).

Personnel Issues

In a merged department, the combining of personnel can be a complicated issue. There is the possibility of reducing staff or having lay-offs. Most likely, the reduction in staffing would be from the elimination of the health officer or director positions, since there would only need to be one health director (Weisfeld & Wexler, 2009). Additionally, administrative assistants may lose their positions if certain offices are closed. Other personnel complications may involve the consolidation of unionized and non-unionized employees, and require working with unions on
the labor changes. Further staff issues to manage include seniority, adjusting for different wages, and other human resources requirements, such as civil service rules, titles, and pay levels (Weisfeld & Wexler, 2009). With the many changes taking place in the working environment, employee morale may be affected, since transformation often brings feelings of doubt, mistrust, and insecurity (Cocowitch, 2010).

Change can be Difficult

As local health departments undergo consolidation, many changes will take place. Often times, change can be hard for all who are involved. Whether those affected by the changes are personnel or community members who utilize the health department, living up to people’s expectations is difficult as well as getting over “how things used to be”. The Madison/Dane County Health Department in Wisconsin consolidated over three years ago, and the organization is still adjusting to the many changes (D. Caes, personal communication, March 18, 2011). Some may find it hard to accept the concept of unity, along with much uncertainty. There may be a sense of newness and innovation, as the new consolidated department seeks to establish its identity (Shortell & Kaluzny, 2006). Consolidation is considered a transformational change that may alter the core business and introduce new strategies, therefore allowing doubt and hesitations among those experiencing the changes (Cocowitch, 2010).

When Consolidation May be Successful

Consolidation of local health departments may not work for all communities or in all situations. There are certain characteristics that make it more likely for a consolidation to be successful for the communities involved. Some of these characteristics include communities
who are smaller in size, share similarities within their populations, and have strong leadership to guide the organization and the communities through the changes.

**Size and Location of Communities**

Consolidations of local health departments seem to work best within smaller regions. Research shows that a region needs to have a population size of approximately 50,000 people in order for the consolidation to be cost effective (Konkle, 2009). According to NACCHO’s 2008 Profile of Local Health Departments Study, 64 percent of the nation’s local health department’s serve populations of less than 50,000 persons. Many small health departments across the country do not have the capacity to meet national accreditation standards on their own (NACCHO, 2011). This population size is adequate for looking at health trends, and is also significant when applying for federal grant money. A health department servicing a population of only 8,000 people may have a difficult time making a case to receive grant money, while a region of 50,000 people may look more attractive to funders (Williams and Miyahara, 2009). However, research shows that the advantages of size start to diminish once public health systems reach a threshold of 500,000 residents (May, Smith, Ingram, et.al, 2009).

Another characteristic to consider is that the communities should be neighbors of one another and preferably in the same county. If regions become too large, programs lose their effectiveness, as staff will have to travel further to deliver services (Konkle, 2009). Even worse, accessibility of the health department becomes a problem for residents.

**Similarities in Populations**

Another area that may contribute to a successful consolidation is that the communities that are joining together have similarities. For example, the public health problems and priorities
of the communities should be analogous; community health assessment data or community health improvement plans should be targeting matching public health concerns in all communities (Wisconsin Department of Public Health, 2003). This enables services and programs to be tailored to the entire population more easily, especially with limited resources and staffing. Similarities of a combined population could also include characteristics such as comparable backgrounds, habits, ways of living, traditions or ethnicities (Wisconsin Department of Public Health, 2003). Another characteristic of the consolidated communities is to be similar in per capita wealth in order for a more equal distribution of services and resources among the communities (Elsass, 2003).

**Strong Leadership**

Overall, for a consolidation of local health departments to be successful, strong leadership must be present. Strong local leadership is vital to win political backing, public acceptance, and staff support (Elsass, 2003). The leader of the consolidation must be highly respected in all communities in order to gain trust, assistance and support. The leader must have a vision, goals and a strategic plan in mind, as this person will be a key component and channel behind the consolidation efforts. Possessing a mission and a vision allows the consolidated health department to have purpose, meaning, and convey what this entity aspires to accomplish; the vision will focus on the future and will serve as a guide for linking values to activities (Sollecito, 2010). Leadership will help put the vision into action, as leaders are change agents who are concerned with moving their agencies forward (Rowitz, 2009). According to W. Edwards Deming’s philosophy on successful transformations of organizations and management, a strong leader should make constant improvements to services; drive out fear, create trust, and create a climate for innovation; and optimize toward the aims and purposes of the organization,
and the efforts made by teams and staff (Sollecito, 2010). A strong leader will be able to enhance the ability of all of those who are a part of the consolidation to create and build a forward-thinking health department to better meet community needs (Weisfeld & Wexler, 2009).

**Decision to Pursue Consolidation**

As noted, consolidation has many potential opportunities for local health departments, yet there are concerns as well. The decision whether to pursue consolidation is one that requires much research, gathering of information, community engagement, and careful planning. As part of the decision making process, the feasibility should be studied and there should be a great deal of support from the community, elected officials, and boards of health. Additionally current staff should have input in the process.

**Feasibility**

In order to determine what is best for an organization as well as to remain focused on the role of local health departments – improve community health – a feasibility study should be completed. The benefit of conducting a feasibility study of a possible consolidation of health districts would be to provide information that will assist the boards of health, elected officials, and the community in making decisions concerning the most economical way to provide necessary and effective public health services (NALBOH, 2009). A feasibility study can be undertaken to provide information on:

- Public health services provided in the community and identifying unmet needs utilizing the Core Functions, Essential Public Health Services, and the voluntary Public Health Accreditation Standards.
- Revenues and expenditures allocated for public health services.
• Personnel costs including an examination of each benefit package offered and the identification of duplicative costs.
• Space allocation and related costs.
• Identification of alternate governing structures permitted by state statutes.

Above all, the intent of a feasibility study is to identify the options for effectively and efficiently delivering public health services to the citizens of the area to be served (NALBOH, 2010).

A feasibility study should address the major aspects of a consolidation. According to the National and Local Board of Health’s guide for determining the feasibility of a consolidation, major focus areas to include are governance and organizational structure; capacity assessment; facilities and space considerations; funding, resources, and cost projections; analyzing legal issues and considerations; and proposed timetables and target dates (NALBOH, 2010). The following table summarizes each major focus area.
Table 1: Focus Areas in a Feasibility Study. Source: National Association of Local Boards of Health (2009).

<table>
<thead>
<tr>
<th>Governance &amp; Organizational Structure</th>
<th>Capacity Assessment</th>
<th>Facilities &amp; Space Considerations</th>
<th>Funding, Resources, &amp; Cost Projections</th>
<th>Analyzing Legal Issues &amp; Considerations</th>
<th>Proposed Timetables &amp; Target Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size, composition; appointment of board members</td>
<td>Mandated vs. non-mandated services</td>
<td>Identify space options for new department</td>
<td>Identify direct and indirect costs</td>
<td>Labor relations and collective bargaining agreements</td>
<td>Develop phased approach</td>
</tr>
<tr>
<td>Terms of office</td>
<td>Program evaluation</td>
<td>Current space analysis</td>
<td>Determine per capita costs</td>
<td>Commitments to retirement benefits</td>
<td>Allow time for transition</td>
</tr>
<tr>
<td>Statutory vs. non-mandated functions</td>
<td>Grant supported services</td>
<td>Furnishings and equipment available</td>
<td>Determine total expenditure and revenue</td>
<td>Accumulated sick and vacation leave</td>
<td>Joint board of health created</td>
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<tr>
<td>Bylaws, consideration and adoption</td>
<td>Comparison of services matrix creation</td>
<td>Utilities and related infrastructure costs</td>
<td>Determine financial options</td>
<td>Transfers and bumping rights</td>
<td>Determine a final date for the operation of new health department</td>
</tr>
<tr>
<td>Selection and evaluation process for a Public Health Director</td>
<td>Development of program summaries, goals, objectives</td>
<td>In-kind and financial commitments for current and future space</td>
<td>Identify costs from standard workweeks and equalization</td>
<td>Liability insurance issues</td>
<td></td>
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<tr>
<td>Qualifications for the Director</td>
<td>Cost/benefit analysis</td>
<td>Maintenance of facility</td>
<td>Identify funding gaps and needs</td>
<td>Examine current sources of funding (fees, state/federal grants, general revenue)</td>
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<tr>
<td>New organizational structure to include new Director of the consolidated department</td>
<td>3 year services comparison</td>
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<tr>
<td>Designation of board officers</td>
<td>Personnel assessment</td>
<td></td>
<td>Compare salaries and benefits and identify disparities</td>
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<tr>
<td>Frequency of meetings</td>
<td>Personnel recordkeeping</td>
<td></td>
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<tr>
<td>Policies and Procedures</td>
<td>Collective bargaining issues</td>
<td></td>
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<tr>
<td>Board committee structure</td>
<td>New personnel system to include classification, reviews and benefit analysis</td>
<td></td>
<td></td>
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<tr>
<td>Budget formulation and oversight</td>
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</table>
Support

Early on in the process of deciding whether to consolidate, it is necessary to gain support from all who may be affected by the change. These groups of people include elected officials, the board of health, residents, and staff members (Quade, 2010). The reading by Weisfeld and Wexler made a strong point that the only way consolidation will happen is to get public support and a very broad-based constituency (Weisfeld & Wexler, 2009). Elected officials have the ultimate authority to make decisions about the direction and the future of the health department, if the board of health is advisory instead of governing. When deciding to pursue consolidation, both groups of the elected officials and the board of health should be in agreement that consolidating would be the best thing to improve communities’ health, because without united support, a consolidation is unlikely to move forward or be a successful solution to meet the health needs of the local communities.

Obtaining community engagement and support is necessary when considering consolidating with other communities. Meeting with different focus groups, as well as holding public listening sessions or forums should be conducted to solicit feedback from the public and obtain their input (Wisconsin Department of Public Health, 2003). Possible focus groups to obtain information from could include those who utilize the health department on a regular basis, school nurses and health aides, seniors, healthcare professionals, or other community partners. Additionally, conducting surveys will provide feedback on thoughts and feelings regarding consolidation. Listening to what residents want and need, and then using that information to decide whether to consolidate is a necessary step.

Staff input and support is invaluable when considering consolidation. Since it is staff’s responsibility to provide the services and perform the day-to-day functions, they may offer
insight that is not apparent to health directors, elected officials, board of health members, or residents of why consolidation may or may not work. While staff is most likely to view consolidation as a negative change, because of fear of the unknown, it is important to communicate with them and work through the changes together (Wisconsin Department of Public Health, 2003).

Questions to Consider

According to the 2003 Wisconsin Department of Public Health’s handbook, Multi-Jurisdictional Health Departments: Guidance for Local Boards of Health, the following questions should be asked by a health department when they are considering merging services with another jurisdiction:

- Have you contacted the State Division of Public Health for guidance with this process?
- Is the type of merger you are considering possible under current State Statutes?
- What are you hoping to achieve? Fiscal savings? Better services for the money?
- Do you have a champion? Do you have the political will?
- Are you willing to enter into a process of evaluating services?
- If the local public health departments are designated at different levels, have you discussed the options for the final level?
- What would your organizational chart look like?
- Have you considered the many issues of governance?
- How will your board of health be organized?
- How would budgets be developed and approved?
- How would you resolve differences in equalized valuation?
• How will you take into account working with school districts? Some health departments use county levy to provide services to schools while others contract directly with school districts.

• How would you organize local service delivery to preserve public health in individual jurisdictions?

• How will you address fair and equitable job security for your staff? Who would employees work for? What labor contracts would be involved?

• Where would the health department be located and how would work spaces be determined?

• What time constraints are you under to research and implement a plan?

• Who will keep people informed and make sure they are receiving consistent information?

• Will your current data management systems work together or will they require major adjustments?

• Will liability insurance adjustments need to be made?

• How would you resolve differences in local ordinances?

• Who will appoint, confirm, and supervise the health officer?

• Is the geographic area reasonable for delivery of efficient public health services by a merged department?

• Is a strategic or community plan in place that will be supported by a merger?

• Instead of merging departments, would jointly providing services improve delivery and accessibility?

Answering these questions provides a basis for health departments to thoroughly think about the consolidation process. The questions also serve as a checklist to ensure that the many different areas and topics have been considered before taking additional steps toward consolidation together (Wisconsin Department of Public Health, 2003). Consolidation may not be successful if communities are unable to agree on answers to the questions or have different expectations.
Possible Organizational Options

There are many different organizational options for health departments considering consolidation. The 2009 report, *A Guide for Local Boards of Health Considering the Feasibility of a Consolidation of Independent Local Public Health Jurisdictions*, written by the National Association of Local Boards of Health outlines five options, along with many advantages and disadvantages for each organizational structure option. One option is for local health departments to remain separate departments. Possible advantages of remaining stand-alone health departments are to have known costs of operation, status quo programming, and a defined organizational structure. Possible disadvantages include duplicated administrative and supervisory positions, maintaining multiple facilities, competition for grant funding, application of programs and services may not be uniform, and achieving accreditation may be more difficult. Another possible organizational structure could be one local health department contracting with another health department. Likely advantages are that the cost of services and the regular reporting of services will be spelled out in a contract, one department will provide the services, and the contracting health department has no responsibility for personnel and related services, or for providing facilities. Disadvantages to the organizational structure of one health department contracting with another health department are that there may be lost input and decision-making on contracted services, the contractor assumes responsibility for additional personnel and management, the contractor needs to provide additional office space, services could be terminated by the contractee or the contractor, and there is the necessity of having a contingency plan. A third organizational structure option is to have one or more health districts contract with neighboring health departments. Benefits to using this structure are the same as mentioned above for a health department contracting with another health department - that the cost of
services and the regular reporting of services will be spelled out in a contract, one department will provide the services, and the contracting health department has no responsibility for personnel and related services, or for providing facilities. Difficulties with this structure include losing governance and decision-making for contracted services, services could be terminated by a contractee or the contractor, and there is the necessity of having a contingency plan. Another option for the organizational structure is to remand the public health programs back to the State. The only advantage mentioned is that there would be no responsibility for maintaining services and facilities. The drawbacks to this option include that the State could mandate a new board of health and health commissioner, service costs could be assessed back to the community, and there may be loss of local control. A last possible organizational structure option is for a combined health district. Probable benefits with this structure include using one facility and access point, uniform regulation and services throughout the district, a single governing body, full-time public health leadership, cooperative efforts among political entities, a realignment of positions for a stronger workforce, accreditation may be better achieved, and the adjustment in staff hours could result in more available staff time. Possible shortcomings to this option are that a larger facility may be needed, adjustment of work hours and salaries may result in increased costs, the need to develop new personnel policies and benefits, and the potential for elimination of staff positions.

**Conclusion**

Local health departments, as well as other government departments, are expected to deliver efficient and cost-effective services. The forces of today’s marketplace are creating an imbalance between citizens’ expectations and demands, and the local government resources that
are available (Konkle, 2009). This imbalance is unlikely to be resolved by future increases in local tax revenues, increases in state or federal revenues, or by working harder or faster at doing the same things in a similar manner. Consequently, local governments will be compelled to consider further changes such as consolidation (Konkle, 2009). The need for readjustment in public health programs has been recognized and in recent years has been the subject of extensive studies by governmental agencies and private groups. These efforts aid public health professionals as we try to determine where we are going in public health and how to meet the demands; in public health, the demands are broader than the capabilities (Baxter, 1998).

Reconfiguring the organization and financing of public health systems in some communities through consolidation may hold promise for improving the performance of essential services and work toward building capacity (Mays et al., 2006). However, we must understand the implications of consolidation. It is not feasible or possible to provide the health programs with the required personnel and facilities necessary to meet all of the diverse and rapidly growing demands for public health guidance and service, while facing the increased pressures to “do more with less” (Price, 2003). While consolidation promotes intergovernmental coordination, at the same time, it may introduce conflicting governmental authority, cumbersome administrative rules, and complex reporting relationships that pose barriers to effective public health action (Mays et al., 2009). Deciding whether to consolidate is a difficult decision, one that requires much research and one that must have strong support from community members, elected officials, as well as staff. For optimal development and provision of our health services, we need more adequate funds and trained personnel, as well as competent public health leadership in implementing an all-inclusive program to improve the health of communities through assessment, policy development and assurance.
REFERENCES


APPENDIX A

Health Department Comparison Tool

Instructions: The following is a list of services and functions that may be performed by staff in a local health department. Each jurisdiction contemplating participating in a multi-jurisdictional health department should use the tool to compare services, staffing, budgets or functions provided by the health department. This is the first step in identifying similarities and differences between public health services in the jurisdictions.

<table>
<thead>
<tr>
<th>Local Health Department: ___________________________</th>
<th>Date: ________</th>
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<table>
<thead>
<tr>
<th>Health departments level classification (Level - I, 2, 3)</th>
<th>Health Department A</th>
<th>Health Department B</th>
<th>Health Department C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population served (#)</td>
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<td></td>
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<tr>
<td>Geographical area (Sq. Miles)</td>
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<tr>
<td>Budget information (S)</td>
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<tr>
<td>A. Local Tax</td>
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<tr>
<td>B. Block grant</td>
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<td></td>
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<tr>
<td>C. Fee for service</td>
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<tr>
<td>D. Categorical funding</td>
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<tr>
<td>E. Donations</td>
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<tr>
<td>F. Contracts/subcontracts</td>
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<tr>
<td>Total PH budget (A-F)</td>
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<td>&gt; Cost per capfin</td>
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<td>&gt; Tax Levy per $1000</td>
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<td>Annual Report (Y/N)</td>
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<td>Agency Newsletter (Y/N)</td>
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<tr>
<td>Health Implementation Plan</td>
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<td>(year developed)</td>
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</table>

| Staffing                                                  |                     |                     |                     |
| > Union/Non-union                                        | # U                 | # U                 | # U                 |
|                                                          | # NU                | # NU                | # NU                |

| Public Health Staff (FTE)                                 |                     |                     |                     |
| > Supervisor(s)                                           |                     |                     |                     |
| > PH Nursing                                              |                     |                     |                     |
| > PH Nutrition                                            |                     |                     |                     |
| > PH Sanitarian                                           |                     |                     |                     |
| > PH Education                                            |                     |                     |                     |
| > Laboratory                                              |                     |                     |                     |
| > Support                                                 |                     |                     |                     |
| Home Health Staff (FTE)                                   |                     |                     |                     |
| > Supervisor(s)                                           |                     |                     |                     |
| > Nursing                                                 |                     |                     |                     |
| > Aids                                                    |                     |                     |                     |
| > Support                                                 |                     |                     |                     |