Legal and Political Aspects of Public Health Agency Accreditation

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Introducing the Public Health Law Webinar Series

- A series focused on providing substantive knowledge on important issues in public health law
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- Geared toward anyone committed to public health
  - Including public health lawyers, officials, practitioners, policy-makers, advocates, and more

Webinar series partners include:
- American Society of Law, Medicine & Ethics
- Public Health Law Association
- Public Health Law Network
- Public Health Law Research Program

Next webinar is Thursday, September 22nd, “Public Reporting Laws of State Healthcare-Associated Infections”
Accreditation: The Scenic Route to the Desired Destination

Leslie M. Beitsch, M.D., J.D.
Florida State University

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When Did the PH Practice Community...

- Conceptualize the NACCHO LHD profile?
- Conceptualize the ASTHO SHD profile?
- Develop national PH practice performance standards?
- Develop a framework for accreditation?
Fifteen Years of the Committee on Administrative Practice

II. The Evolution of the Program

C. E. A. WINSLOW, Dr.P.H., F.A.P.H.A. (Life Member)
Professor of Public Health, Yale School of Medicine, Yale University,
New Haven, Conn.

THE Preacher long ago warned the people of Israel that “there is no new thing under the sun”; and the attempt to standardize health practice is no exception to the rule.

Haven Emerson, in his Sedgwick Memorial Lecture on Public Health Diagnosis traces the germ of the idea back to the Doomsday Book of William the Conqueror in 1086. Edwin Chadwick’s report on Sanitary Conditions of the Labouring Population of Great Britain (1842), Lemuel Shattuck’s Report of the Sanitary Commission of Massachusetts (1850), and the report of the Citizens’ Association of New York, Sanitary Condition of the City (1865) were more directly in our line of descent.

These early surveys were, however, primarily concerned with the sanitation of the physical environment rather than with administrative health practice. For the first real attempt to make a comprehensive evaluation of all the health aspects of community life in definite and detailed form, we must turn to the records of our own organization. At the Philadelphia meeting of the American Public Health Association in 1874, a committee of 24 was appointed “to prepare schedules for the purpose of collecting information with regard to the present condition of public hygiene in the principal towns and cities of the United States, and the laws and regulations, state and municipal, relating to the same.”

I have a photostat copy of the survey schedule prepared by John S. Billings (President of the Association in 1880) for this committee, and it is one of the most interesting documents in the history of public health. It contains 411 specific questions under the following 20 headings: Location, Population and Climate; Topography and Geology; Water Supply; Drainage and Sewerage; Streets and Public Grounds; Habitations; Gas and Lighting; Garbage and Excreta; Markets; Slaughter Houses and Abattoirs; Manufactories (and Trades); Public School Buildings; Hospitals and Public Charities; Police and Prisons; Fire Establishments, Alarms, Engines, etc.; Cemeteries and Burials; Public Health Laws, Regulations, Officials-Municipal; Registration and Statistics of Diseases; Quarantine.

The schedule for Hospitals and Public Charities is a forerunner of the studies carried on so effectively by the American Hospital Association; and
Fifteen Years of the Committee on Administrative Practice: II. The Evolution of the Program

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These early surveys were, however, primarily concerned with the sanitation of the physical environment rather than with administrative health practice. For the first time, an attempt was made to make a comprehensive evaluation of all the health aspects of community life in a comprehensive form. We must turn to the records of our own organization. At the Philadelphia meeting of the American Public Health Association in 1874, a committee of 24 was appointed “to prepare schedules for the purpose of collecting information with regard to the present condition of public hygiene in the principal towns and cities of the United States, and the laws and regulations, state and municipal, relating to the same.”

...The survey scheduled cover the constitution, personnel, salaries and powers of boards of health, number and qualifications of staff, quarantine practice, annual reports, registration of vital statistics, mortality from important diseases and at important age periods. ...

...Forty years must pass before this germinal concept came to actual fruition, under the influence of another great pioneer, Charles H. Chapman of Providence. ...In 1920, the Committee on Municipal Health Department Practice was appointed by the American Public Health Association. ...

The general objectives of the committee were stated as follows in its first annual report (1921).

The need of authentic information on the practice of municipal health departments of American cities has long been recognized by all engaged in public health work. It is generally known that a great variety of procedures are in effect, that the organization of the health departments differs in different communities, and that the amount spent per capita for any branch of health service varies considerably and that, in some hospitals, few nurses are available to health officers who would plan their departments after those which predominate in American practice or achieve most satisfactory results. It was thought that the collection of data on the current practice of large municipal health departments would repay the effort and that perhaps, out of such an investigation it would be possible to discover the best procedures and to forward the movement for the simplification and standardization of health department practice in our cities.

In 1920 the committee...completed...Its first important study, a survey of health practice in the 83 largest cities of the United States...

In 1923 and 1924, the committee attacked its second major objective, the preparation of an appraisal form for the measurement of actual administrative achievement by a quantitative objective scoring procedure...

...In 1925 its name was changed from Committee on Municipal Health Department Practice to Committee on Administrative Practice to indicate its potential wider scope...

...Its first active subcommittee were organized, dealing with County Health Practice, Administrative Record Forms, and Analysis of Health Department Functions and Results...

In 1927 the committee published Community Health
100th Anniversary of AJPH: “Voices from the Past”

CEA Winslow: CAP 1935

- Summarizes 15 years of CAP work
- 1874: idea for metro PH profile
- 1920: Chapin appointed chair
- 1923: profile metro PH (83 cities)
  - Utilized as self-assessment
- 1923-1924: development of standards
- 1925: profile of smaller cities (100 cities)
- 1928: profile of 3 SHDs
CEA Winslow: CAP 1935

- 1929: standards 2.0
- 1929: Great Depression
- 1930: programatic best practices
- 1930: Evaluation Subcomm. (PHSSR)
- 1932: standards 3.0
- 1933: rural profile (337 counties)
  - more intensive study of 46
- “…securing of popular support…”
Somewhat More Recently…

- NPHPSP
  - Version 1
  - MAPP
  - Version 2
- Operational Definition of Functional LHD
- IOM Report(s)
- Exploring Accreditation Project
- PHAB
  - Incorporation (2007)
  - Development
  - Launch (9/14/11)
Framework: Domains, Standards and Measures

12 Domains (10 Essential PH services plus administration & governance)

~ Standards

~ Measures

Documentation
Domain 6: Enforce public health laws

Domain 6 focuses on the role of public health departments in the enforcement of public health related regulations, executive orders, statutes, and other types of public health laws. Public health laws are key tools for health departments as they work to promote and protect the health of the population. Health department responsibilities related to public health laws do not start or stop with enforcement. Health departments also have a role in promoting new laws or revising existing laws. Public health related laws should be science-based and protect the rights of the individual, as they also protect and promote the health of the population. Health departments have a role in educating regulated entities about the meaning, purpose, compliance requirements, and benefit of public health laws. Health departments also have a role in educating the public about laws and the importance of complying with them.

The term “laws” as used in these standards and measures refers to ALL types of statutes, regulations, rules, executive orders, ordinances, case law, and codes that are applicable to the jurisdiction of the health department. For state health departments, not all ordinances are applicable, and therefore ordinances may not need to be addressed by state health departments. Similarly, some statutes are not applicable to local health departments, and therefore some statutes may not need to be addressed by local health departments. For Tribal health departments, applicable “laws” will depend on several factors, including governance framework and interaction with external governmental entities (federal, state, and local).

Public health laws include such areas as environmental public health (food sanitation, lead inspection, drinking water treatment, clean air, waste-water disposal, and animal and vector control), communicable disease (outbreak investigation, required newborn screenings, immunizations, communicable disease reporting requirements, quarantine, tuberculosis enforcement, and STD contact tracing), chronic disease (sales of tobacco products to youth, smoke-free ordinances, and adoption of bike lanes), and injury prevention (seat belt laws, helmet laws, and speeding limits). Clearly, health departments are not responsible for the enforcement of many or most of these laws. The adoption and implementation of such laws, however, have enormous public health implications. It is important for the health department to be involved in their adoption, monitoring their enforcement, providing follow-up services and/or education, and educating the policy makers and the public about their importance and impact.

**DOMAIN 6 INCLUDES THREE STANDARDS:**

<table>
<thead>
<tr>
<th>Standard 6.1</th>
<th>Review Existing Laws and Work with Governing Entities and Elected/Appointed Officials to Update as Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 6.2</td>
<td>Educate Individuals and Organizations on the Meaning, Purpose, and Benefit of Public Health Laws and How to Comply</td>
</tr>
<tr>
<td>Standard 6.3</td>
<td>Conduct and Monitor Public Health Enforcement Activities and Coordinate Notification of Violations among Appropriate Agencies</td>
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</tbody>
</table>
**Standard 6.1:** Review existing laws and work with governing entities and elected/appointed officials to update as needed.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Purpose</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1.1 A</td>
<td>Review laws to determine the need for revisions</td>
<td>The purpose of this measure is to assess the health department’s analysis of public health laws and other laws that have public health implications to ensure that they are consistent with evidence-based public health and newly emerging public health issues and information. The assessment of laws should consider individual or community cost, inconvenience, and regulatory alternatives and sanctions, in addition to the public health benefits of the law.</td>
</tr>
</tbody>
</table>

Health Accreditation Board • Standards & Measures
Standard 6.2: Educate individuals and organizations on the meaning, purpose, and benefit of public health laws and how to comply.

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</thead>
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<tr>
<td>6.2.1 A</td>
<td>Maintain agency knowledge and apply public health laws in a consistent manner.</td>
<td>The purpose of this measure is to assess the health department's knowledge of how laws support public health practice and their efforts to ensure that these measures are applied consistently.</td>
</tr>
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</table>
Standard 6.3: Conduct and monitor public health enforcement activities and coordinate notification of violations among appropriate agencies.

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</thead>
<tbody>
<tr>
<td>6.3.1 A Maintain current written procedures and protocols for conducting enforcement actions</td>
<td>The purpose of this measure is to assess the health department’s standard and consistent enforcement actions.</td>
<td>Enforcement actions should be conducted using standard steps, criteria, and actions. When public health enforcement is conducted by other agencies or entities, the health department should have working relationships with those entities to share information. The health department may be able to provide advice concerning enforcement. Additionally, the health department should be informed of noncompliance. For example, if a toxic substance is being emitted by a plant or a restaurant inspection identifies a risk of a food borne illness, the health department should be involved to provide public health follow-up on any related illnesses or to deliver community information and education.</td>
</tr>
</tbody>
</table>

**Required Documentation**

1. Documentation of authority to conduct enforcement activities

**Guidance**

1. The health department must provide the documentation of authority to conduct enforcement activities. Two examples are required. The health department may select the areas or programs. This authority may be located in a state or local code, MOU, letter of agreement, contract, legislative action, executive order, ordinance, or rules/regulations. In some cases, the health department may have little or no authority to conduct enforcement actions. In those cases, the department should be coordinating and sharing information with agencies that do have public health related enforcement authority. In those cases, the health department must provide documentation of the authority of the other entity that conducts enforcement.
<table>
<thead>
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<th>Purpose</th>
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</thead>
<tbody>
<tr>
<td><strong>6.3.2 A</strong> Conduct and monitor inspection activities of regulated entities according to mandated frequency and/or a risk analysis method that guides the frequency and scheduling of inspections of regulated entities</td>
<td>The purpose of this measure is to assess the health department's adherence to guidelines on the frequency of inspection activities. Where the inspections are conducted by other agencies, the health department should be notified of inspections, protocols, and status. This enables the health department to provide follow-up education and communication, where appropriate, to safeguard the public's health.</td>
<td>When the law specifies inspection frequency, the health department should be following the defined schedule. When there is no mandated schedule, the health department should have a method to define an appropriate schedule and should adhere to the schedule.</td>
</tr>
</tbody>
</table>

**Required Documentation**

1. Protocol/algorithm for scheduling inspections of regulated entities

**Guidance**

1. The health department must provide the schedule for inspections for two programs. The health department may select the areas or programs. The selected schedules should be, but may not be, in programs where the health department has authority to conduct an inspection of the regulated entity.

In some cases, these schedules are mandated. In other cases, the department may provide a protocol or an algorithm for scheduling inspections. For example, rules requiring restaurant inspections on a specified schedule or a schedule for return inspections after a violation may be submitted. These may be documents provided by another agency that has enforcement responsibilities.
<table>
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<th>Purpose</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.3.3 A Follow procedures and protocols for both routine and emergency situations requiring enforcement activities and complaint follow-up</td>
<td>The purpose of this measure is to assess the health department's implementation of procedures and protocols for routine and emergency enforcement activities and for follow up of complaints.</td>
<td>Scheduled investigations, emergency situations, complaint follow-up should be conducted according to standard procedures and protocols to ensure that they are conducted appropriately.</td>
</tr>
</tbody>
</table>

**Required Documentation**

1. Data base or log of actions with analysis and standards for follow-up at each level
2. Communications with regulated entities regarding a complaint or compliance plan

**Guidance**

1. The health department must document actions taken through investigations or follow up of complaints, as well as analysis of the situation and standards for follow up. Documentation must be provided for two programs. The health department may select the areas or programs. The standards for follow-up may be within the procedure and protocols and does not have to be a part of the log. If separate, the standards must be included with the database or log for the documentation.
2. The health department must provide documentation of hearings, meetings or other official communications with regulated entities regarding a complaint and any resulting compliance.
The goal of the voluntary national accreditation program is to improve and protect the health of the public by advancing the quality and performance of state, local, tribal and territorial public health departments.
Results of Accreditation Leads to QI Focus

The process of preparing for and achieving accreditation yields information about the agency that can be used to identify areas for improvement. These areas cut across agency silos (programs).
Realizing Public Health Transformation Through Accreditation and QI

- Ensures transparent accountability
  - Key for elected officials

- Accredited agencies perform better on what accreditation measures
  - Need to ensure PHAB adjusts metrics as data develops (PHSSR)

- Sets focus on a vital few priorities
Transformation Through Accreditation and QI

- Create a sense of urgency for measurable results and a culture of quality
- Engage every employee
- Build QI time into daily workload
- Adopt fact/data-based decision making
American Society of Law, Medicine & Ethics

Public Health Law Association

Public Health Law Network

Public Health Law Research Program

Relationship of Accreditation and Shared Service Delivery

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Accreditation Law Research: Methods

- Mapping study of 23 states to determine type of program (accreditation, certification, other, none) and legal framework
- Case studies in 10 states to identify legal issues and lessons learned as states prepare for the national voluntary accreditation program

Data collection:
- Semi-structured interviews (3-5 per state)
- Legal and policy documents
Because the national program is voluntary, no states anticipate significant legal barriers that will hinder participation in the national accreditation program.

Wide variation exists among jurisdictions in the level of legal expertise that has been focused on accreditation (and shared service delivery).

No states are planning to create new state-based accreditation programs.

All case study states are planning to encourage participation in the national accreditation program.
Benefits of Accreditation

- “We’re working toward accreditation, but for me that is not the goal, it’s kind of a side benefit. The goal is to operate more efficiently.” - Local public health administrator

- “We’ve seen some agencies that got recognition [for being accredited] from their local government structure that meant more money for them, or better access to the mayor’s office.” - Director of a nonprofit public health institute
Accreditation and Shared Service Delivery

- In 2 case study states, the use of shared service delivery to meet accreditation requirements was viewed positively.
  - Interviewees reported that shared service delivery works best when LHDs can choose their own partners and arrangements (e.g., inter-local agreements where LHDs retain autonomy).

- In other states, LHDs fear that shared service delivery will lead to regional consolidation of LHDs and loss of local autonomy and resources.
Regional Partnerships: Contrasting Views

- “There’s no way we could have moved forward...if the locals weren’t on board.”
  -- State public health institute leader

- “If you are a home rule state, don’t pretend that a need to share services doesn’t exist. As we look at accreditation...it’s the elephant in the room.”
  -- Health official from a home rule state
Regional Partnerships: Contrasting Views

- “It’s the region that enables the counties to do what they need to do, not the other way around.”
  --Public health attorney from a rural state

- “Regionalization is a dirty word.”
  --County health officer
Cross-Jurisdictional LHD Collaboration (Horizontal Regional Arrangements)

SPECTRUM

Informal Arrangements ↔ Service Contracts ↔ Inter-local Agreements ↔ Full Regional PH Mergers

Adapted from: Ruggini, J. (2006); Holdsworth, A (2006); and The Strategic Vision Group; from Kaufman, N. J. Regionalization of Government Services: Lessons
Local Human Service Agency Consolidation (County “Umbrella Agency” Mergers)

- Concern about loss of “public health” identity especially in local emergency workforce situations
- Retains close working relationships with local sister-agencies

Social Services + LHD + Medicaid + WIC + Child Protection + Etc. → Single Local HHS Agency
Evolving Organizational Changes Faced by Public Health Agencies

1. Local Health and Human Services Agency Consolidations
2. Cross-Jurisdictional LHD collaborations
3. LQHC and LHD Partnerships
4. Nonprofit Hospitals and LHD collaborations [community health assessments]
5. Quasi-independent public health authority structures
Thoughts for the Public Health Community

- Historical analogy to annual military readiness
- Accreditation is transparent; hence political
- Despite the current economic environment, PHAB accreditation is maintaining momentum
- External economic and political pressures are driving PH to become more measurable and more performance-oriented. **Accreditation does that!**
Thoughts for Legal & Political “Wonks”

- Accreditation is part of the evolving discussion now taking place about the purpose, legal structure, governance and funding of local health departments.
- This discussion touches upon politically sensitive views about the autonomy and funding of local governments.
- Accreditation can impact the direction and availability of future funding streams.
- The transparency of accreditation can attract media attention, which can have positive or negative consequences.
Regional Collaboration Among Local Health Departments in Kansas

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Welcome to the Sunflower State

Kansas Demographics

- **County Population**
  - 0-5K
  - 5K - 20K
  - 20K – 50K
  - 50K – 100K
  - 100K – 600K

105 Counties
Less than 10% with population > 50K

Kansas Public Health Structure

- 100 Local Health Departments
  - 98 single county jurisdiction
  - 2 multi-county departments

State Departments of Health and Environment, Agriculture, Aging, and Social and Rehabilitation Services
Kansas Political Landscape

- **Home Rule**
  - Use the unit of government closest to the community for all public functions it can handle.

- **Cooperation**
  - Leverage limited resources by employing interlocal cooperative agreements.
Kansas Interlocal Cooperation Act

- Problems with “handshake” deals between public agencies
- KICA provides method by which agencies can establish ground rules for working together to achieve common goal
- Does not expand agency’s authority or excuse any existing legal obligation
KICA Required Elements

- Purpose and duration
- If create separate legal entity, its nature, composition and powers
- If no separate entity, identify person/entity responsible for administration, and manner for acquiring, holding and disposing of property
- Finance/budget
- Termination
- Disposal of property
- Other necessary and proper matters
ICA Approval

- Signed by person with proper authority to bind each agency
- Approval by Kansas Attorney General
- Approval by any other state agency with subject matter jurisdiction
- File with Kansas Secretary of State
- File with register of deeds for each county in which participants are located
Functional Regionalization

2002 Emergency Preparedness Grants

- Collaborative Development
  - KS Association of Counties
  - KS Association of Local Health Departments
  - KS Department of Health & Environment

- Rules of Engagement
  - At least three contiguous counties
  - Pick your own partners
  - Equal voice/governance

- ICAs
  - Not consolidation
  - Define rules of engagement
  - Specific authority
Emergency Preparedness to Public Health Accreditation

Can we apply the model used for building preparedness capacity for accreditation?
Regionalization Project
Public Health Accreditation Preparation

- NACCHO receives grant from RWJ to examine regional approaches to developing public health capacity
- Kansas and Massachusetts invited to participate in project
- Both states given the flexibility to develop unique approaches
<table>
<thead>
<tr>
<th>Region</th>
<th>North Central</th>
<th>NE Corner</th>
<th>Massachusetts</th>
</tr>
</thead>
<tbody>
<tr>
<td># gov’t units</td>
<td>13</td>
<td>8</td>
<td>326</td>
</tr>
<tr>
<td>Population</td>
<td>87,430</td>
<td>262,197</td>
<td>6,437,193</td>
</tr>
<tr>
<td>Land area (sq. mi.)</td>
<td>10,260</td>
<td>4,757</td>
<td>7,840</td>
</tr>
<tr>
<td>Population Density</td>
<td>8.52</td>
<td>55.1</td>
<td>810</td>
</tr>
</tbody>
</table>
What additional public health capacity is needed for accreditation?

- Each local health department completes a capacity assessment
- Results compiled into regional reports
- Common strengths...common gaps
- Regions select a common gap to explore regional approaches to filling gap
2010 Kansas Regional Accreditation Project

- Examine PHAB documents to explore the multi-jurisdictional applicant option
- Engage 2 regions from the NACCHO Regionalization Project in three workshops
- Review standards, measures, and required documentation to look at implications for multi-jurisdictional application
- Review governance issues of Kansas’ regional approach in light of accreditation documents
## Regional/Local Functions by Accreditation Domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Administration &amp; Governance</th>
<th>Monitor Health Status</th>
<th>Diagnose &amp; Investigate</th>
<th>Inform &amp; Educate</th>
<th>Mobilize Community Partnerships</th>
<th>Develop Policies &amp; Plans</th>
<th>Enforce Laws</th>
<th>Link People to Services</th>
<th>Assure Competent Workforce</th>
<th>Evaluate Services &amp; QI</th>
<th>Contribute &amp; Apply Evidence-Based Practices</th>
</tr>
</thead>
</table>
Collaborative Accreditation

- Develop module to insert into application
- Each agency responsible for demonstrating module implementation in its jurisdiction
- Example: Ensure competent workforce
  - Collaborative training programs
  - Module includes course descriptions
  - Each agency submits personnel attendance records
Multi-Jurisdictional Accreditation

Regional Function
Regional Function
Regional Function

Local Function
Local Function
Local Function
Local Function
Local Function
Local Function

Economy of Scale
Community Considerations

LHD Accredited
LHD Accredited
LHD Accredited
LHD Accredited
LHD Accredited
Model Interlocal Agreement

- Which C word?
  - Communicate
  - Coordinate
  - Cooperate (2002)
  - **Collaborate**
  - Consolidate

- Build a governance structure (*form*) to facilitate collaboration (*function*)
Creating a Collaborative

- Board of Directors: who makes decisions
  - Bylaws: how decisions are made
- Strategic plans
  - Identify specific functions to be “regionalized”
- Operational plans
  - Task list for “regionalizing”
- Financial matters
  - Operating account
  - Agency contributions
    - Basis for assessments?
  - Financial reports
Creating a Collaborative

- Personnel
- Real and personal property
- Limitation of liability
- Indemnification
- Dispute resolution
- Termination
  - Triggers
  - Winding up
Part of a Bigger Trend

- Accountable care organizations
- Readmissions/never-events
- Value-based purchasing
- Bundled payments
Question & Answer

Type your question in through the Q and A panel
A New Initiative in Development to Assist Public Health Agencies

“Evolving Legal Issues Initiative”
Responding to a Changing Public Health Infrastructure

Evolving Organizational Changes Faced by Public Health Agencies

1. Local Health and Human Services Agency Consolidations
2. Cross-Jurisdictional LHD collaborations
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4. Nonprofit Hospitals and LHD collaborations [community health assessments]
5. Quasi-independent public health authority structures
Public Health Law Network

• **National Coordinating Center/Northern Region**
  - Public Health Law Center at William Mitchell College of Law

• **Eastern Region**
  - University of Maryland School of Law working with the John Hopkins Bloomberg School of Public Health

• **Mid-Southeastern Region**
  - University of Michigan School of Public Health

• **Southeastern Region**
  - UNC Gillings School of Global Public Health working with the National Health Law Program

• **Western Region**
  - Sandra Day O’Connor College of Law at Arizona State University working with the University of New Mexico School of Law
References

1. Two Page Summary of Emerging Legal Issues Project

2. Full Report: Accreditation Legal Structures Report: Key findings and lessons Learned from 10 State Case Study

3. Executive Summary: Accreditation Legal Structures Report