



CASE *Study*

THE WEST CENTRAL PUBLIC HEALTH PARTNERSHIP

A Case Study in Public Health Collaboration

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- » **The Colorado Trust's Partnerships for Health initiative** was designed to help improve the coordination of health services at the community level. This effort, an expansion of The Trust's Colorado Healthy People 2010 initiative, supported community health partnerships statewide, consisting of hospitals, local health departments, community-based organizations, government agencies and community members. Each partnership identified a Healthy People 2010 focus area important to its community. Through two cycles of funding, grants were awarded to help partnerships build, strengthen and sustain the infrastructure of Colorado communities by proactively addressing public health issues. This case study is a component of the Partnerships for Health initiative.

» EXECUTIVE SUMMARY

The Project

In 2005, acknowledging the public health needs of their rural communities were great, public and environmental health officials from six counties along Colorado's Western Slope came together with a common goal of strengthening the region's public health infrastructure. With support from The Colorado Trust (The Trust), representatives embarked on a six-month strategic planning process, culminating in the establishment of the West Central Public Health Partnership (WCPHP). In the years that followed, officials enacted intergovernmental agreements outlining partnership roles and responsibilities, and participants embarked on numerous multi-jurisdictional public health campaigns and programs. As part of a larger investigation into multi-jurisdictional public health collaborations, The Trust commissioned an in-depth evaluation of the WCPHP to identify the organizational elements that contributed to the group's successes.

The Findings

The reality of forming and maintaining a regional collaboration between multiple jurisdictional public health departments is complex. Each partnering organization comes to the table with its own set of county and public health administrators and priorities, populations, political climates, economic resources and health issues. The evaluation revealed several themes relevant to the challenges and strengths involved with cross-governmental collaboration:

- **Infrastructure Change Requires Dedication.** From the beginning, the WCPHP worked to ensure that all of its members demonstrate an equal level of commitment to the success of the collaboration. Sometimes a struggle, through strong leadership and a demonstration of the

benefits of partnership (which differ for each county), the group has sustained an admirable level of internal and external support (e.g., each county continues to provide financial support to the partnership, and members share leadership responsibilities).

- **Balancing Local and Regional Priorities.** Each of the participating public health directors represent communities with different local concerns and priorities (e.g., after completing the first comprehensive health assessment, members presented the findings to local governmental officials, demonstrating the myriad of needs facing the region as well the benefits of collaboration). Smaller counties worried about losing local control to the larger ones, and larger counties questioned whether they would benefit from collaboration. By acknowledging these realities from the beginning, the founding leaders anticipated issues before they arose and strategically used the common success to build continued support and commitment.
- **Building Bonds Between People and Governments.** The WCPHP illustrates the importance of taking time to build trusting relationships among individual members. On an individual level, members described the personal and professional benefits they receive from their colleagues; on an institutional level, these relationships have led local and state officials to remark on the apparent increase in cooperation between counties and improved response during public health crises.

The following report elaborates on these themes, highlighting recommendations for other rural counties considering similar endeavors and for funders considering supporting these efforts. Although there is no single “recipe” for effective multi-jurisdictional partnerships, by identifying the “ingredients” each member brings to the table, acting with intention and good faith, actively paying attention to group processes and cultivating leadership, the WCPHP illustrates how the work that goes into creating an effective collaboration can pay off in local communities.

Note: *Most comments by WCPHP directors and members included in this case study are presented as representative perspectives shared by the partnership as a whole, and not attributed to specific individuals.*

» THE WEST CENTRAL PUBLIC HEALTH PARTNERSHIP: A STORY OF COLLABORATION

West Central Colorado is a beautiful region with seemingly endless skies. Historically identified as the counties of Gunnison, Hinsdale, Ouray, San Miguel, Montrose and Delta, the area is home to an estimated 100,190 residents spread across approximately 9,568 square miles.¹ While there are no standard definitions of “urban” and “rural,” the criteria set forth by the National Center for Health Statistics classifies all six counties as “non-metropolitan,” and only Montrose County – with a principle city of just over 19,000 residents – qualifies as “micropolitan” (a non-urban area with a town of over 10,000 residents).² With population densities ranging from less than one person per square mile to 27 persons per square mile, many residents live in largely remote areas where mountainous terrain and harsh weather conditions can make travel to places with services and businesses difficult.³

Across the United States, rural communities report higher levels of obesity and chronic diseases (including cerebrovascular disease, diabetes and hypertension), higher age-adjusted death rates, less access to primary health care, lower rates of health insurance coverage and fewer preventative screenings compared to urban counterparts...and Colorado is no exception.^{4,5} Three of the six counties in West Central Colorado have no hospital within their borders, with the closest facility ranging from 39 miles (Ouray) to 65 miles (San Miguel) from the county seat. Four counties are designated Health Professional Shortage Areas (Delta, Montrose, Ouray and San Miguel), and five have a shortage of dental health providers.³

Acknowledging that the public health needs of the region are great, public and environmental health officials from the West Central region have agreed to work together, with a common goal of strengthening the public health infrastructure. In the years since the WCPHP formed, intergovernmental agreements outlining the roles and responsibilities of the member counties have been ratified, and participants have embarked on several multi-jurisdictional public health campaigns and programs. The

» METHODS

The data for this report comes from the following sources:

- Grant proposals and progress reports submitted to The Trust
- WCPHP organizational documents
- Site visit field notes
- Online survey
- Interviews with 18 WCPHP members and partners.

All documents were reviewed by the author. Interview notes were transcribed and entered into a qualitative software program (Atlas ti) and coded using deductive and inductive methods. Key themes were then identified and explored across counties and organizational type and size.

case study which follows describes the history and process of the WCPHP, including early challenges faced by the original members, the “wins” they have had since then, and some of the critical elements that made this partnership so successful. Ideally, this document serves as a blueprint for other public health officials who are considering embarking on similar partnerships. While no two public health collaborations will have the same goals, strengths and challenges, the experiences of the WCPHP provides insight into the types of decisions and roadblocks that regional partnerships will face, and provides real-life examples of how one group successfully navigated the collaboration process.

» A BRIEF HISTORY OF INTER-JURISDICTIONAL PUBLIC HEALTH COLLABORATIONS

Historically, the degree of partnership between local public health departments, also known as local health agencies, has varied widely, from casual relationships between staff to a complete administrative merger of departments into one entity. In a 2008 review of regional public health collaborative efforts, Stoto and colleagues described a continuum of approaches to emergency preparedness partnerships, ranging from the general sharing of information to the creating of a centralized system (Figure 1).⁶ Similarly, in an examination of non-public health intergovernmental collaborations (e.g., small fire districts merging into a regional body), Kaufman identified six forms of partnerships: shared services, mutual aid, compacts, interlocal agreements, consolidation and regionalization (for a description of each, see Kaufman 2010).⁷ Aside from the term regionalization, which Libbey and Miyahara found was reserved to describe formal public sector consolidations and mergers, a common terminology defining different collaborative structures has not been developed.⁸ Thus, this document will use the terms collaborations or partnerships interchangeably, unless the discussion centers specifically on the formal merger of governmental entities.

FIGURE 1. APPROACHES TO REGIONAL DISASTER PLANNING*

Networking

Interactive sharing of preparedness information and plans between individuals and/or organizations.

Coordinating

Local public health departments (LPHDs) work together to plan events, such as meetings and trainings.

Standardizing

Creating some uniformity across LPHDs through mutual adoption of plans and procedures. All functions remain under the control of individual LPHDs.

Centralizing

Bringing together resources for planning or responses under one entity, such as the creation of a regional emergency notification system.

*Stoto M. 2008

Preparing for Disaster: The Spark to Collaborate

Although local and state-level public health leaders have informally networked and responded to regional health issues on an “as needed” basis for years, the topic of formalized inter-jurisdictional planning and partnerships did not enter the professional literature with any frequency until the last decade. Spurred by the 9/11 attacks (including fears of a regional bio-terrorist strike with agents such as anthrax or smallpox) and propelled by subsequent natural disasters and pandemic outbreaks, officials have realized that “preparedness” cannot be achieved by one local public health department (LPHD) or even by multiple organizations within a single geographical jurisdiction. In the event of an epidemic or other large-scale disaster, law enforcement, first responders, health care systems, school districts businesses, and other entities have separate yet coordinated roles to play. Moreover, given the fluidity of air, water, animals and people, these systems must operate seamlessly between geopolitical jurisdictions.⁹ Unfortunately, this has not always been easy to achieve.^{10,11}

In the wake of 9/11 and the subsequent anthrax scare, federal agencies released grants to state and LPHDs to shore up sparse public health resources, and it became clear to some officials that these funds would be more effectively distributed in larger amounts to a smaller number of regions than spread thinly across a large number of individual cities and counties.^{6,12-14} Further, in recognition of the emerging focus on creating regional structures to enhance preparedness, between 2006 and 2007, the Robert Wood Johnson Foundation’s (RWJF) Changes in Health Care Financing and Organization (HCFO) initiative funded an investigation into the effects of the “regionalization” movement. Using in-depth case studies of four collaborative efforts, these evaluators observed that the development of regional partnerships had the potential to improve emergency preparedness through efficient use of resources, increased coordination and planning, capacity-building and training, and the development of professional networks.⁶ In Massachusetts, for example, 351 autonomous cities and towns had historically maintained their own public health boards or departments. Although a few municipalities had partnered on specific health issues, formal service regions did not exist until a state law finally regionalized emergency medical services (EMS) in 2000. After the 2011 threats, the state health department charged local health officials with developing a statewide regional structure for the distribution of federal emergency preparedness and – by 2003 – seven emergency preparedness regions were defined.

Researchers who evaluated the efforts in Massachusetts and elsewhere identified numerous outcomes that emerged from the formation of these regional partnerships. In addition to the benefits of cost-sharing, equipment standardization and expanded staff capacity, they noted that the increased “social capital” resulting from these regional partnerships may have been the largest benefit. Through the creation of bonds and bridges between health leaders and communities, they concluded that the ability to respond effectively in a future disaster was greatly improved.¹⁴

Beyond Preparedness

At the close of his review, Stoto concluded “there is reason to believe that the development of regional structures could improve the delivery of public health services in other areas [as well as disaster preparedness],” and in various parts of the country, leaders began to recognize the benefits of cross-jurisdictional collaboration beyond emergency response.⁶ In 2004, the North Carolina legislature allocated funds for “incubator collaboratives,” described as “teams of contiguous, autonomous, local health departments working together across county lines to address pressing public health issues on a regional level.”¹⁵ By the time funding was discontinued in 2009, six collaborations had formed, encompassing approximately 80% of counties across the state. The collaboratives took on a variety of projects, including the creation of regional campaigns to address tobacco use, obesity and other chronic conditions, joint workforce trainings, and even the collective purchasing of tools and equipment. According to the North Carolina Institute for Public Health (NCIPH), the collaboratives successfully leveraged \$15 million in additional grants for public health projects throughout the state. Across the United States, similar partnerships are experiencing similar outcomes.

In what appears to be a continuation of the HCFO initiative, the RWJF recently commissioned an “environmental scan” aimed at gaining “a better understanding of the issues involved in creating formal collaborative relationships between local health departments in different communities.”⁸ In a summary

of their findings, Libbey and Miyahara observed that the movement toward cross-jurisdictional partnerships appears to be increasing due to a number of factors, including the desire for smaller and cash-strapped departments to achieve financial savings that result from economies of scale; the continued attention to key programmatic areas like disaster preparedness; and the movement toward the creation of public health performance standards that may be difficult for smaller communities to achieve on their own.⁸

» PUBLIC HEALTH IN THE WEST CENTRAL REGION

Prior to the passage of the Public Health Improvement Act (PHIA) in 2008, the size and scope of local public health agencies across Colorado varied greatly from county to county. Generally, the state health department had little authority over these jurisdictions, and while some counties maintained “organized public health departments” (with oversight over a broad scope of health-related arenas), others chose to limit the focus of public health to priorities that could be fulfilled by public health nurses.¹⁶ In the West Central region, Delta County was the only jurisdiction with an organized public health department; the remainder maintained “nursing services” with a few nurses providing a limited scope of public health programs.

In many of the counties along the Western Slope, environmental health concerns have traditionally been handled outside of public health, generally as part of community development or planning offices, with an emphasis on wastewater management issues. Although the overlap between communicable and chronic diseases and environmental problems is clear, many counties continue to lack the resources, time, initiative and political will to institute coordinated public/environmental health projects.

» EARLY COLLABORATIVE EFFORTS IN WEST CENTRAL COLORADO

Long before the formation of the WCPHP, officials from the six West Central counties partnered together on numerous projects that impacted the area as a whole. The Region 10 League for Economic Assistance & Planning was formed in 1972 “to provide its members with a vehicle for regional cooperation,” especially in the area of economic development, and as the Western Region of the Colorado Division of Emergency Management, officials from all six counties worked jointly to develop emergency preparedness resources and training.

According to members of the WCPHP, networking between public health agencies along the Western Slope had been ongoing for years. A coalition of public health departments met two or three times each year to discuss common interests, and a network formed among the county nursing service directors in the West Central region. As a way of breaking the isolation that came with being the only “public health official” in the county, these nurses met quarterly to discuss the projects they were working on and provide professional and personal support. In 2000, they designed and received funding for a regional “Nurse-Family Partnership” program, with branches in all six of the West Central counties.

» 2005 – FACING RURAL CHALLENGES TOGETHER: THE BEGINNING OF THE WCPHP

In 2005, The Colorado Trust (The Trust), a Denver-based foundation dedicated to advancing the health and well-being of the people of Colorado, launched the Partnerships for Health initiative supporting community health partnerships across the state. The initiative offered the potential for five and one-half years of funding in the form of one six-month planning grant (designed to help counties build the infrastructure needed for regional collaboration) and two additional implementation grants, the first of which could be applied for at the conclusion of the six-month planning phase. At the time, Carol Dawson, the then-Director of Public Health in Gunnison County had been working closely with

her county's environmental health specialist to develop coordinated strategies to address several overlapping health problems in the county. Concurrently, Dawson had been sharing stories with her colleagues across jurisdictional lines, and realized that many of them faced similar challenges, including a sense of isolation, the lack of environmental health support, and the need to complete state-mandated local health assessments and disaster-preparedness plans. With a vision of a "regional public health/environmental health collaboration" and the possibility of seed funding on the table, Dawson sprang into action, speaking with the public health staff and/or county managers in all six counties, and asking if they would be interested in preparing a joint application for The Trust's six-month "planning grant" to enable them to form a regional public health collaboration. Once the representatives from each county's health department agreed to come to the table, she submitted the proposal to The Trust.

After The Trust awarded the group the initial planning grant, the real work started. One provision of the grant was that the group had to work with an external facilitator who could lead the partners through the strategic planning process. Noelle Hagan of Noelle Hagan & Associates helped the collaboration formalize their vision and identify the goals and objectives necessary to realize that vision. Throughout this planning phase, Hagan saw her primary task as keeping the group focused, making sure they made measurable progress at the conclusion of each meeting and identified the issues that needed to be addressed before the next gathering.

In January 2006, Gunnison County kicked-off the planning phase by hosting a four-hour meeting with all the major stakeholders up to that point: public health and staff, environmental health directors and staff, county commissioners, county managers and representatives from the Colorado Department of Public Health and Environment (CDPHE). The focus of the initial meeting was to lay the foundational pieces for the partnership, including reviewing the requirements and expectations of The Trust planning grant and engaging all the stakeholders in the process of identifying the existing resources, potential benefits and possible pitfalls of engaging in a regional collaboration. After a decision was made to move forward with planning the partnership, a smaller working group was charged with developing a strategic plan that would be submitted to the larger group for approval. Over the next six months, four additional strategic planning sessions were held, culminating in the creation of a strategic plan, statements of vision, mission and values, and a request to The Trust for the next phase of implementation support.

Despite the potential for additional funding from The Trust, the skills of a professional facilitator (Hagan), and the drive of Dawson and several others, the planning process was not always smooth. Each county representative came to the table with different levels of support for the concept of "regional collaboration." Even when public health directors or environmental health managers were enthusiastic, some county commissioners (who generally served as a county's board of health) were lukewarm about the idea of participating. Fears that this could be the first step to the "regionalization" of public health services surfaced, and some of the smaller counties were concerned that local control over public health would erode, and that their departments would be taken over by the partnership. Likewise, officials in the larger counties were concerned that – rather than benefitting from the collaboration – they would be directing resources away from their own residents. When asked what finally solidified the initial buy-in necessary to submit the first implementation proposal to The Trust, Dawson said, "It got to the point where people didn't want to be left out!" As it became clear that some form of a partnership was going to happen, the fear of missing out on something outweighed the initial apprehension.

It was clear from talking with the early members of the WCPHP that Dawson supplied the early vision, the momentum and the coordination necessary to get the partnership off the ground. "She just kind of pulled us together," remarked one member. "Just knowing Carol, you know something is going to happen." She rallied initial support from her manager and the county commissioners, securing her county's agreement to serve as the fiscal agent for the group, and preparing the application for The Trust's planning grant. One of the commissioners whom Dawson had approached early on admitted that, along with the potential to increase the efficiency of their public health resources, Dawson's expertise and reputation helped to solidify the decision to support the planning process. During this phase, she traveled from county to county, meeting one-on-one with key officials as often as

necessary to garner support. If she sensed that one of the partners was hesitant to voice an opinion in a meeting, she contacted them individually to sort out the issue. In hindsight, Dawson remarked, “I really felt that I went out of my way to keep people informed”...a task that was time-consuming in the moment, but appears to have been a necessity in the long run.

» WORKING TOGETHER: IMPLEMENTING THE STRATEGIC PLAN (2006-2009)

In June 2006, the newly minted West Central Public Health Partnership submitted its strategic plan and implementation grant to The Trust. In it, they described their mission to “build and strengthen public health and environmental infrastructure” through collaborative projects that would benefit all member counties, and identified key criteria for those projects (see Figure 2). Finally, they described four primary goals, complete with objectives, indicators and measures of success (see Figure 3).

Over the next three years, the group worked assiduously on these goals. State guidelines require that counties submit a written assessment of the public health needs for their area every five years; these assessments can be completed by each county, or can be submitted on behalf of a multi-county region. One of the motivating factors for many directors in participating in the partnership was the ability to pool resources and complete a regional assessment, rather than individually gathering and analyzing data county by county. With epidemiological support from CDPHE (whose representative became a regular participant in the WCPHP), technical assistance and facilitation supplied by The Trust and the addition of a graduate student who could help with data collection (whose stipend was paid through The Trust grant), the health assessment was completed by the end of 2007. Along side the examination of public health needs in the region, one of the partnership directors (who has a background in health services fiscal management) facilitated the completion of a “capacity assessment” for the region, describing the financial infrastructure of the region as a whole. The completion of those assessments was a milestone and helped to ease any uncertainty some directors had in their participation.

FIGURE 2. CRITERIA FOR WCPHP PROJECTS

All WCPHP projects must:

- Have some degree of benefit to all six counties;
- Be measurable;
- Be demonstrated “best practice” and/or “evidence-based”;
- Not ultimately add to the current workload of the individual counties;
- Be realistic and attainable.

FIGURE 3. 2006 WCPHP GOALS

- Formalization of the regional partnership;
- Conduct a regional health assessment;
- Prevent and decrease the incidence of food borne illness;
- Maximize public health resources for pandemic planning.

One of the most salient outcomes of the health assessment is that it represented the first time that environmental health indicators were included in the regional public health assessment, marking the start of a movement towards greater collaboration between the two disciplines in the region. Another indication of the growing integration between public and environmental health can be seen in prioritization of regional food safety as a key goal for the partnership. At the time the plan was written, few of the counties offered any formal “food safety” classes for food service professionals, and restaurant inspections were inconsistent – some counties contracted with CDPHE or other counties, and others handled them internally. Seeing this as an area where the infusion of Trust resources could have an immediate impact, the partnership contracted with the Colorado State University Extension Service to provide “Food Safety Works”

classes in each county. Additionally, the partnership hired an environmental health staff person to oversee consumer protection and environmental health needs in three of the six counties, and serve as a regional coordinator between all the counties and CDPHE. In retrospect, the members saw this as an important accomplishment on numerous levels: it solidified the new partnership between environmental and public health, and it provided an “early win” for the group.

In many respects, the way the WCPHP chose to implement these activities is indicative of how important the idea of “partnership” has been to the group. From the start, different counties took the lead on different projects, including hiring and overseeing any additional staff. For example, the new environmental health expert was shared with Montrose County, enabling them to hire a full-time person who was responsible for providing services to the other counties on a part-time basis. Likewise, Delta County took the lead in working with CSU to establish the food safety classes, Hinsdale coordinated the pandemic planning process, and Gunnison served as the fiscal agent for The Trust grant and oversaw the hiring of a paid staff person to coordinate the activities of the WCPHP (see below).

Given this emphasis on shared responsibility, it is not surprising that one of the first goals the group prioritized involved continuing to build and strengthen the infrastructure of the partnership itself. The support from The Trust allowed the group to continue contracting with Hagan, who “held their feet to the fire” when it came to the work of organizational development. As many multi-agency collaborations have discovered, without the structure imposed by becoming a separate legal entity, the partners needed to wrestle with organizational questions such as “who is a member?” and “how will we make decisions?” and “how do we choose our leaders?” The initial step in solidifying the structure for the partnership was to adopt an Intergovernmental Agreement (IGA) between all the participating counties. The IGA was drafted with the assistance of one of the county managers, reviewed by attorneys representing each county and ultimately approved by each county’s Board of Commissioners. In later years, an official “operating agreement” was drafted and adopted by all member counties. This agreement spelled out who was a “member” of the partnership, what membership entailed (attending meetings, maintaining communication), and specifically addressed how the group would handle issues when consensus could not be reached, or when a county elected to not participate in a particular project.

The other critical decision the group made to support itself was to have a paid staff person serve as coordinator. It was apparent from the beginning that the number of hours needed to facilitate communication between meetings, prepare reports and presentations, and oversee the various projects in conjunction with the lead counties would be more than any member of the partnership could absorb into her/his current position. Coincidentally, Dawson had just retired from her role with the public health department in Gunnison County and agreed to continue her work with the WCPHP as Partnership Coordinator. Thus, not only did the group gain a dedicated staff person, but Dawson’s considerable expertise, skills, and connections would continue to benefit the group for the next several years.

It was clear from the conversations with long-time participants that maintaining support from county managers and commissioners was (and is) an ongoing process. In February 2009, the partnership again invited the county commissioners and managers to attend their quarterly meeting, and used the opportunity to showcase their numerous accomplishments. They presented data from the health and capacity assessments to buttress support for the WCPHP and to emphasize the importance of public health in the region. The members of the partnership generally agreed that holding these meetings with the public officials (both the initial meeting during the planning phase and this second one) was key to gaining the buy-in from the county managers and commissioners. Along with serving as opportunities to provide information to and solicit input from the community leaders, these meetings also provided occasions for elected officials and administrators to highlight the work that was happening in their individual counties. As one director said, referring to her own commissioners, that opportunity “made them strong advocates for this model and for why you do public health in this way.”

» THE PUBLIC HEALTH IMPROVEMENT PLAN OF 2008 AND ONWARD

In 2008, the Colorado State Legislature passed SB-194 (also referred to as the “Public Health Improvement Act” or PHIA) as a step toward strengthening the public health infrastructure across the state. CDPHE was charged with preparing an implementation plan based on the provisions of the PHIA, which included requirements that significantly affected local health departments and nursing services across the state. Among the new stipulations, the responsibilities of many local boards of health and directors were increased, and all county or district health agencies were instructed to provide a scope of “core services” to the community (Figure 4); if they were unable to do so, counties

could contract with another county or agency to provide those services to their residents. Additionally, the act incorporated environmental health issues under the umbrella of public health, emphasizing the need for health department directors to take a more comprehensive approach to health promotion and disease prevention.¹⁶

In many respects, the timing of the PHIA could not have been better. Not only did it validate the need to strengthen the public health infrastructure in the region, but it brought the issues of public health to the attention of the county commissioners and administrators. As one director put it, the act “was the match to the firework that we were working toward.” Suddenly, all counties became responsible for providing certain essential services that were clearly laid out; local officials could no longer claim they were simply unable to do so. Moreover, not only were counties required to complete health assessments, but they had to use those data when creating strategic plans. According to several of the directors, PHIA made it easier to gain the support they needed from their county government to participate in the regional partnership. They could point to the existing collaborative structure to demonstrate how they were ahead of the curve, having already started working together on shared services and health assessments.

As it happened, not only could the directors use the PHIA to justify the time and resources dedicated to the WCPHP, but by involving CDPHE in the partnership from the beginning, the group was poised to serve as a model for the rest of the state. In 2010, the partnership was asked to serve as a pilot site for regional assessment and planning, and received a CDPHE grant to support the staff time needed to complete an updated regional health assessment and public health improvement plan. As of this writing, the group is working to complete the strategic improvement plan, which is intended to serve as templates for other regions of the state that are not as well-versed in collaboration, assessment and planning as the West Central region.

At the end of 2008, the WCPHP submitted its third grant request to The Trust. This marked the final phase of The Trust initiative, and meant that the partnership would need to begin to address issues of future sustainability. For the most part, the broad goals the partnership set forth did not shift substantially, continuing to focus on strengthening the regional partnership (including the development of a sustainability plan), improving regional environmental health services and assessing public health needs. Because the emergency preparedness goal was time limited, it had been completed shortly after the partnership’s formation; thus, a new goal of using the regional collaboration to promote healthy behavior was developed. The partnership continued to rely on Trust funding to cover the costs of the outside facilitator, the coordinator, and a half-time regional environmental health staff person based in Montrose, as well as expenses associated with providing food safety classes through CSU Extension.

The fact that the support from The Trust would conclude at the end of 2011 was not far from their minds, and they began rallying support from the individual counties to contribute to the expenses of the partnership. By the end of 2010, the partnership had secured a small amount of financial support from all the participating counties to help cover general collaboration expenses (including the coordinator’s salary), and the three counties provided additional support for the regional environmental health position. With the understanding that they would not be able to continue contracting with CSU to provide food safety classes directly, they used some of the grant to leverage additional in-kind services from CSU for the production of a food safety DVD, which could be provided to regional

FIGURE 4. ESSENTIAL PUBLIC HEALTH SERVICES

1. Monitor health status to identify and solve community health problems.
2. Investigate and diagnose health problems and health hazards in the community.
3. Inform, educate and empower individuals about health issues.
4. Mobilize public and private collaboration and action to identify and solve health problems.
5. Develop policies, plans and programs that support individual and community health efforts.
6. Enforce laws and regulations that protect health and promote safety.
7. Link people to needed personal health services and assure the provision of health care.
8. Encourage a competent public health workforce.
9. Evaluate effectiveness, accessibility and quality of personal and population-based health services.
10. Contribute to research into insightful and innovative solutions to health problems.

restaurants and would serve as a substitute for in-person classes. Finally, the partnership again leveraged some unused Trust funding to secure the regional planning grant (referred to above) from CDPHE.

As successful as the partnership has been in moving forward with big ideas using small amounts of resources, not every plan has come to fruition. Through conversations with members and a review of the progress reports, it appears that several people pushed for the creation of a regional health education position. To fund the position, they proposed asking all the counties to “chip in” (much like they did to cover other collaboration-related expenses); unfortunately, due to the dire economic situation most counties were facing, only two jurisdictions were willing to contribute funding. Moreover, some of the counties already had health education positions, and the directors in those departments ran the risk of losing support for the local position in favor of the regional one.

» THE GOOD, THE BAD, THE UGLY: SOME SIGNIFICANT CHALLENGES AND KEY SUCCESSSES

Through telling the story of the WCPHP, the previous section describes some of the milestones in the lifespan of the partnership, illustrating several ways in which a regional partnership can benefit the public health systems of less-urbanized, underserved jurisdictions. However, this hardly tells the whole story. Through conversations with the members and friends of the partnership, both new and old, the following primary themes emerged, capturing the reality of forming and maintaining a regional collaboration between six separate jurisdictional public health departments, each with its own set of county administrators to answer to and different populations, political climates, economic resources, health issues and internal priorities. The universal nature of these sentiments was astounding; all were raised by multiple interviewees, and most were voiced by the majority of participants.

Commitment

One of the most common challenges (and successes) cited by the interviewees involved gaining and maintaining commitment from both individual participants and the county governments who control public health purse strings. While nearly everyone agreed that individual, organizational and county commitment was ultimately responsible for the accomplishments of the partnership, participants voiced equal levels of frustration with members whom they perceived as having less buy-in than others. Although there was no consensus over why some counties appeared more reserved in their support for the collaboration, one or two jurisdictions were frequently singled out as demonstrating an occasional (or continuing) lack of involvement. On the flip side, one county appeared willing not only to participate, but also agreed to serve as the fiscal agent for the partnership; without this commitment of administrative time and resources, no amount of support from other jurisdictions would have made any difference.

As coordinator and champion, Dawson reached out to participants whose dedication appeared to be waning.

“*In the beginning, pulling people together, having them come to the meetings and having them participate in the email dialogue discussions...several counties were just absent. And Carol Dawson would call those people and set up appointments and had face-to-face interactions about what is it they would want from the partnership...and that was really persuasive.*”

From the beginning, participation at quarterly meetings was expected, and a stipulation in the organization agreements states that if a county fails to send a representative to two consecutive meetings, the leaders of the partnership have the right to approach the county administrators to verify that county’s continuing interest in the WCPHP. To date, that provision has only been enacted once, and most members felt that the level of commitment and engagement has evened out as the benefits of participation became more apparent. That said, it was clear that maintaining those levels of commitment among all of the partnering counties remained a concern.

County-level Priorities and Politics

Another universal theme was the challenge of gaining and maintaining local governmental support from six different jurisdictions. Most participants indicated this was a critically important part of the start-up phase; without it, the partnership would not have succeeded. Even now, while the administrative leadership in all six counties continue to sign the IGAs, some directors need to spend more time garnering that support than others. Several people suggested that the long-standing commitment to “local control” over resources was, at times, a significant barrier, but when push came to shove, the bottom-line appears to be money: what will it cost and what will they get? As one member put it, “[County commissioners] don’t do anything just because it’s a great idea.”

“It’s all prevention and health promotion and the outcomes and measures are years down the line, and they like to see things now rather than five years from now.”

Given the array of political climates, county-level priorities, local health codes and fiscal strength, each director faced her own unique set of circumstances. For some, the stumbling blocks take the form of competition for attention and funding; as one director summarized, “Our commissioners have

always been supportive of public health, but when oil and gas are screaming for their attention, or the budget of human services is three times that of public health, those things take their attention more.” A county commissioner built on that sentiment, explaining that in their positions, they review so many aspects of county government that they are unable to learn about any single issue in-depth. Finally, the very nature of public health makes funding a challenge in any jurisdiction.

Some commissioners and directors seemed concerned about the greater implications of participating in a regional collaboration. Participants alluded to the territorial nature of county leaders, and most directors had to convince their commissioners that the benefits would be worth the investment. For example, one director described the completion of the emergency preparedness plans as much “harder” to complete than the other early projects, primarily because each county was asked to contribute a portion of the “bioterrorism” grants distributed by the state and federal governments. “Once a county is allotted money, they want to hold onto it, they want to keep it for their staff. That’s the hardest thing about a partnership.” Leaders in the smaller counties also feared they would not be treated as equal partners and that the resources they invested would be diverted to the larger population centers. Likewise, commissioners in the larger jurisdictions needed to be convinced that they would be compensated for the programs they provided in the other counties. Regardless of the specific details, the argument was generally the same: convince me that if we invest, we will benefit without losing our identity or control over resources.

When asked how they secured support for the WCPHP, two main responses emerged: 1) the early members were extremely strategic about when and how they approached county leaders, and 2) the more the partnership accomplished, the easier it was to illustrate the benefits of collaborating. When Dawson and others invited the county leaders to the early strategy meeting, those leaders became involved in determining the initial focus of the partnership, resulting in a level of buy-in that may not have been there otherwise. “The timing of the organizational development was really good,” said one director, because the partnership was not asking for approval for something already done, yet enough work had gone into developing the vision that there was something to approve.

As time went on, the benefits of the partnership became clear. The commissioners appreciated the assessment data, and they “saw that [the public health directors] were collaborating on things and not trying to get money out of the budget and were trying to find solutions,” which garnered respect and support. The smaller counties, in particular, were able to show that by working collaboratively,

“We get so ingrained in our own little communities, our own little political jurisdictions that we lose a picture of the greater good for the citizens of a region. Air pollution, water pollution, people in our transient society moving back and forth don’t know county boundaries so much, they don’t know jurisdictional boundaries...I think we need to keep a regional perspective.”

they gained resources without losing control over local resources. More than one person felt additional respect and recognition because she was part of the partnership: “It changed us from The County Nurse title to Public Health Director and validated our expertise.”

Smaller vs. Bigger: Maintaining Local Control While Working for the Greater Good

A theme alluded to throughout this report is the challenges involved when counties of different sizes invest collaboratively in projects. Due to their larger population base and greater funding levels, the two larger counties (Montrose and Delta) provided a number of public health programs that the smaller counties could not. As an “Organized Public Health Department,” Delta County was particularly unique, operating under different state statutes from the “Nursing Services” and maintaining an infrastructure that included the integration of environmental and public health under one roof.

Because of the resources available to these larger departments, a certain inequity was felt, especially by the smaller jurisdictions. Some members thought that the larger counties were less committed to the success of the partnership because they had less incentive to join or stay, especially since they already had many of the programs the smaller counties needed. Others thought the larger counties were more

invested because they were less concerned about losing their identities or being swallowed by the larger group. When asked about the benefits their counties reaped from the partnership, representatives from the larger departments did not waver in the least: they saw the creation of a stronger regional public health infrastructure as benefitting their own counties, too.

Another member described the collaboration as working to create a “public health blanket” for the whole region.

“It has truly made it better for our residents, and for our staff, and for our Board of Health.”

The smaller jurisdictions had other concerns: they were fearful of being swallowed by the larger departments and losing local control over public health programs. “Small little places can feel threatened by ‘Big Brother’s going to come take over,’” described one director. There had been rumors of state-initiated regionalized health departments, and some feared this collaboration could be the first step towards a structure that would eliminate any local authority over public health, particularly in smaller counties. In the long run, however, the benefits of working together outweighed the fears: the public health staff in the smaller departments completed tasks they could not have done on their own, and additional programs started to flourish in their jurisdictions. Eventually, as one director said, they “put away any idea that...this was going to threaten our existing individual county public health departments.”

A Stronger Regional Infrastructure

Communicable diseases and water pollution do not stop at the jurisdictional boundary, and one of the original goals of the partnership was to strengthen the public health infrastructure across the region. Interviewees described the benefits of getting to know their counterparts and the issues surfacing in the adjoining counties. Several felt that the ability to work together in times of crisis was vastly improved through establishing these personal relationships. “We know these people, and are partners,” observed one of the environmental health managers. “They know us and we know what to expect and how to deal with them. We are not isolated jurisdictions.”

The improved multi-jurisdictional cooperation was apparent not only to the partners themselves, but to others across the state, and the CDPHE liaison to the partnership has held up the group as a model at regional and international meetings. She described the mobilization effort when a raw milk dairy in one of the counties experienced a disease outbreak, and teams of workers

“It pulled together very fast and very effectively. Every county had people assigned to the outbreak to assist, and we connected with the state health department very fast...I don’t know that we could have done that in the past. I think a lot of it has to do with this group meeting regularly and trusting one another.”

“ I am a public health nurse. I am an R.N. It [environmental health] was not my area of expertise. ”

were dispatched across the region to interview approximately 270 households who may have been exposed to the tainted milk.

As further evidence of the strengthened public health infrastructure, many people pointed to the successful relationships being created among public health nurses/directors and environmental health specialists. Part of the initial focus of the partnership was to bring the public health and environmental health workers together

and expand environmental health programs across the region. After working in tandem for the past seven years, members from both disciplines acknowledge a greater acceptance and awareness on the part of “public health people” about what environmental health is and how it fits in with the mission of public health. Having no background in environmental health, one director described being skeptical of the benefits at first, but admitting that she “saw the light” after they hired and started working with the environmental health consultant.

Although work in this area remains to be done, the evidence of improved cooperation can be seen beyond the meeting room. In addition to the increase in environmental health and food safety programs, when the raw milk pathogen was identified, both sets of workers joined together to investigate the outbreak. In the past, communicable disease interviewing had been reserved for traditional public health workers; but this time, environmental health workers were also trained and sent out as interviewers.

Breaking the Isolation and Finding Support

Given the numerous challenges that face this group, something must keep them going. As pleased as the interviewees were about the new programs, data and “toys” they added to their arsenal, the most valuable benefit seems to be the professional and personal support they get from one another. As public and environmental health professionals in rural and often remote counties, their experiences of isolation and frustrations are frequently shared. As partners, they exchange ideas, successes and failures, gaining a “broader perspective of public health on the Western Slope.” For some, speaking with a common voice has provided additional professional credibility within their own jurisdictions; they are no longer the only person advocating for this or that.

For the newer directors, being part of this network was especially important. Having a built-in group of people with similar experiences who could serve as sounding boards and mentors clearly made the transition to their new role smoother. One member described the partnership as her “home base” and explained how it reduced some of the stress of taking on her new position: “Knowing that there would be a built in support system...There are a number of things that are shared, issues and concerns, the isolation, rural, whatever. There are also the issues around being a director and how you feel like you’re going in a thousand different directions, and the support makes it bearable.”

“ It’s a whole lot easier to have a conversation and model the process as opposed to starting from scratch. ”

Even directors who had been in their role for years spoke of feeling mentored, and others described the rewards they got from watching the newer directors flourish.

Finally, it is clear from the interviews that the group has provided beyond regular professional support and guidance; for many it has become something much greater: “The bond is more than just public health. I think I could call any of those [core directors] and say, ‘Tara, I need you to die in a ditch.’ And she would say, ‘Give me the address, face-up or face-down, and what should I wear?’ And that would be it, there would be no querying, no wanting to negotiate, no quibbling...because she would know that if I asked, it was a real need. It’s almost like we function as extended family for one another...that’s the beauty of this.”

The exact nature of the experience was often difficult to put into words, and as one member said, “You have this factual description of the partnership, but when you say what the project is, you can’t get the full appreciation of how important it is and what [we’re] doing. Although it’s a broader organizational concept, it can have deep positive influence on individuals doing their work.”

» A FEW LESSONS FROM THE TRAILBLAZERS

Although the WCPHP is hardly the first successful model of its kind, it is unique in Colorado for the level of commitment on behalf of the partnering agencies, and for the plethora of successes it has to show. The members of the collaboration are justifiably proud of their accomplishments, and few are nearly evangelical in their belief that other rural areas need to band together as they have. What follows is a summary of the few of the most important lessons about collaboration that members of the partnership shared.

“We are really blazing a trail here!”

LESSON #1: Strong Leadership is Essential: “You MUST have a champion!”

One of the most commonly expressed sentiments was that without Carol Dawson, the WCPHP would not exist. As the participants in the partnership made clear (and as the literature supports), having a strong leader with the skills to pull the group together, the vision of what the group can accomplish, and the passion to energize others is one of the most critical factors in creating and sustaining a productive collaboration. In all respects, Dawson was the embodiment of those qualities.

- **She knew her colleagues and had their respect.** Dawson worked in public health within the region for years, and had long-standing relationships with her cross-jurisdictional counterparts. She was respected as a professional, and several people commented that because she asked them to participate, they did.
- **She knew her community and what the issues would be.** She didn’t go in blind, with good intentions that could never fly. From the start, she realized that some departments would be concerned about being taken over by “the big guys,” and that some directors would have difficulty with their county governments. “It was really good that Dawson, who was one of us...knew the ins and outs of the day-in day-out, 24/7 work that we do was writing grants...she knew exactly what we were up to.”
- **She had political clout and respect.** A champion is only as effective as her or his reputation. Dawson was not merely well-connected (both in her own county and beyond), but also well-respected. She was able to gain the initial commitment from her county’s health department to serve as the administrative body for the partnership; without this support, the partnership’s efforts would have stalled.
- **She understood the importance of nurturing relationships and listening.** This strength cannot be overstated. “Carol brought the great skill about very respectfully and politely playing the devil’s advocate or challenging ideas or keeping it an open atmosphere where people could verbalize potentially unpopular positions.” She met with members in person, logging hours of “windshield time” when she was concerned that a member was not fully on board or didn’t feel heard.
- **She knew it couldn’t be all about her.** Although the initial vision for the partnership had been hers, she knew if they were to succeed, everyone had to feel included. “We all saw Carol as the leader, but she didn’t want to be the leader because she wanted more buy-in from all of us, which really strengthens the collaborative.” From the start, Dawson knew that she would be stepping down eventually, and that there needed to be room for new leadership to grow.
- **She built a “shared vision.”** While having a champion is important, if that person is unable to share and build on the initial vision with others, the group will go nowhere. With the help of the external facilitator, Dawson and the others took the time to identify the needs and desires of all the member counties in the partnership. Moreover, they realized that this vision had to be shared by not only the individuals involved in the day-to-day events of the partnership, but that elected officials and county leaders also needed to be on the same page of the playbook.

“Unless you have the blind trust that you could appear naked on stage in front of one another and know you were safe, it won’t happen...you can’t short-cut the process.”

LESSON #2: Building on Bonds

One of the essential qualities necessary for a strong collaboration is embodied by the WCPHP: the solid relationships among members.

- **Prior relationships are good.** When asked what they would recommend to new collaborations, several spoke about the importance of making sure the group could function well together. Even before Dawson called them to the table, most of the participants had worked together in the past. “I think it’s the long term relationships that have a lot to do with it,” remarked one director.
- **Build the trust, share the power.** In a collaboration where the partners are expected to share resources and responsibilities, even longstanding friendships can be strained. Early in the process, the members agreed to focus on issues that were priorities for all the counties, and to share both power and responsibilities among them. While one county agreed to serve as the fiscal agent for The Trust grant, other departments stepped up to the plate and took the lead on other projects. The smaller agencies began to see that the larger ones were not trying to take them over, and the more strides they made forward, the more that trust deepened.
- **Focus on relationships.** While few collaborations experience the depth of personal and professional friendships that many members of the WCPHP described, time spent nurturing personal connections is not wasted. When group members are invested in the people in the room as well as the projects, a need to not “let down” the others can serve as an extra motivation for follow-through and commitment. When one participant pulled back from the partnership, he said he realized he was letting down friends and colleagues, and “stepped back up” to the plate. The stronger the relationship between individuals, the deeper the trust as professionals.

FIGURE 5. VISION AND MISSION STATEMENTS

“Laying this foundation helps group members to identify a sense of commitment to the group and ownership in their group process, and community organizing work and results, which are the keys to retaining engaged and involved group members in the collaborative partnership.”

Kansas City Coalition Against Sexual and Domestic Violence, Community Organizing Toolkit.
<http://www.kcsdv.org/toolkit/VisionandMissionStatements.pdf>

LESSON #3: There are NO Short-cuts in the Process

All too often, new groups – especially those whose members have existing relationships – want to jump right into accomplishing goals and projects and skip the organizational development steps, such as developing a mission and vision, identifying shared values, and determining operating procedures. However, this is a dangerous step to skip (Figure 5).

- **The process itself is critical.** Even participants who found the process development “very tedious” commented on its importance. It forced the group to develop the shared vision groups need to succeed, and to learn to work together and communicate from the very start. It also gave them a roadmap to follow that they all had a stake in creating. “You have to have a direction go in,” recalled one member. “We had to determine a purpose and agree upon it...that was important.” The creation of these shared visionary statements forces a group be intentional about who they are and how they want to be together.
- **Agree on how to operate.** This is particularly critical for groups with no formal legal standing. Whereas the incorporation process often requires these agreements be drafted, collaborations whose glue boils down to good intentions often believe an informal agreement to strive for consensus is enough structure. Like many collaborations, the WCPHP members were more

interested in making decisions than deciding how to make them; however, the facilitator gently pushed them to define membership, the responsibilities of membership, how decisions would be made and how leadership is selected (among other provisions). They also agreed that it was fine for partners to not agree with or participate in all projects, but those counties needed to abstain from criticism after a decision had been reached.

- **Invite a professional facilitator to the party.** WCPHP members agreed unanimously that having an external, skilled facilitator lead them through the stages of development was essential for their success. “Until we each settled into...the role that we were going to play in this family, we had [the facilitator] to keep neck-raining us back to center, because I think we could really drill down into the minutia and end up so far off in the trail and lost in the weeds that we would never get our way back. I think that was real critical for the first...probably five years [to] have somebody who kept bringing us back and instilling in us the discipline of having an agenda, having a timeline and developing that culture of being accountable to each other.”

Like most skilled facilitators, Hagan knew that her job was to help the group accomplish something. “People in governmental agencies spend way too much time in meetings that don’t have any results.” As someone external to the group, she was able to help balance the power differentials that all groups have, whether from age, experience, or (in this situation) size of the county. “Having a facilitator hopefully ensures that every voice is in the room, that we are not leaving somebody out inadvertently, and also that no super-strong personality takes over.” Her presence also allowed Dawson to participate as a full member of the partnership without either exerting undue influence or having to silence herself because she was facilitating.

In the long run, most partnership members concurred that the process of intentionally designing the collaboration strengthened it and that those steps cannot be short-changed. “The agony in the beginning is worth it in the end,” commented one semi-reluctant participant. “I see how much it paid off!”

LESSON #4: The Difference Was the Support

Although no single factor is responsible for the accomplishments of the WCPHP, the partners themselves are not shy in crediting The Trust with providing the resources and support to succeed. In structuring the initiative with both planning and implementation phases, they enabled the partnership to do the groundwork that was necessary to build the collaboration, not just implement the goals. A few of the most critical aspects of the grant included:

- Providing the time and resources to build the collaboration before requiring them to provide a strategic plan
- Requiring an external facilitator
- Providing additional technical assistance with planning and assessment
- Providing training and the opportunity for a few grantees to meet their counterparts
- Providing support for enough of an extended period that they could accomplish longer-term goals than a one-year infusion of money allows.

The other aspect to the type of support that The Trust offered was that it enabled the group to experience several “early wins” that would not have been possible otherwise. By having the resources to contract with CSU Extension Services and to hire an environmental health specialist to conduct restaurant inspections, the partnership saw how successful they could be, with the right resources and motivation. Additionally, without the resources to hire a paid coordinator, most doubt they would have gotten very far, if anywhere. Given the daily workload that public health and environmental health directors face, it is unlikely that other members of the partnership could have prepared the community health assessment or assisted with meeting planning and preparation or facilitated essential communications between meetings. Those early wins were critical in keeping up the morale of partnership members and keeping them at the table.

» WALKING THE TALK: SHARED LEADERSHIP

Had the WCPHP not gone through the steps of discussing the importance of shared power and intentionally incorporating that value into the operating agreements, it is unlikely they would have implemented a leadership schedule in which every county's representative takes a turn at chairing the group for a one-year period. To make this even more fair, they determined the chair position would rotate alphabetically by county.

» CONCLUSION

In the long run, the most serious concern facing the WCPHP is sustainability. While there is unanimous agreement about the importance of staying together and not giving up, the long-term sustainability of the specific accomplishments is concerning. Some members expressed the belief that the individual counties would continue to "chip in" to support the shared work of the collaboration; others thought that without the influx of additional external grant funding, maintaining the group would be challenging. The general consensus was one of "cautious optimism," accompanied by a commitment to continue to work together as partners, even if support for the staff role is eliminated.

For regional public health partnerships like the WCPHP to ultimately thrive, incentives to collaborate need to be forthcoming. Public health departments, particularly in rural and resource-poor areas, receive the bulk of their revenue from state and federal grants, which traditionally go directly to individual health departments and are spent within those department's jurisdictional boundaries. As the experiences of the WCPHP show, numerous barriers to "sharing the wealth" exist, and although the six counties in the West Central region of Colorado have been able work around those barriers, other geographical areas may not support the types of existing relationships and trust between individuals and departments that made all the difference to the WCPHP. If counties and health departments in other locations are to truly begin to work smarter with less, some form of financial incentive may be necessary.

This does not mean that individual health departments should be collapsed into a large regional organization. As several interviewees argued, not every essential public health service should or can be done well at a regional level. But for those projects where collaboration makes sense – where partnering with other jurisdictions can increase the efficiency and lower the costs of programs – regions need reasons to work together. The WCPHP is an excellent example of what can happen when people with the vision, passion and incentive to come together with the determination of improving the public health infrastructure for all.

“ You need a growing period, and thanks to The Colorado Trust, we were allowed that. ”

» ENDNOTES

- 1 US Bureau of Census. State and Country QuickFacts. Available at: <http://quickfacts.census.gov/qfd/index.html>. Accessed June 18, 2012.
- 2 Ingram D, SJ F. *NCHS urban-rural classification scheme for counties*: National Center for Health Statistics; 2012.
- 3 Colorado Rural Health Center. CRHC Library. Available at: <http://www.coruralhealth.org/resources/library.htm>. Accessed June 18, 2012.
- 4 Bennett KJ, Olatosi BO, Probst JC. *Health Disparities: A Rural-Urban Chartbook*. Columbia, SC: South Carolina Rural Health Research Center; 2008.
- 5 Colorado Rural Health Center. Key Issues Facing Rural Colorado. Available at: <http://www.coruralhealth.org/resources/documents/2011snapshot.pdf>. Accessed June 18, 2012.
- 6 Stoto MA. Regionalization in local public health systems: variation in rationale, implementation, and impact on public health preparedness. *Public Health Rep*. 2008;123:441-449.
- 7 Kaufman NJ. *Regionalization of Government Services: Lessons Learned & Application for Public Health Service Delivery*. Princeton, NJ: Robert Wood Johnson Foundation; 2010.
- 8 Libbey P, Miyahara B. *Cross-Jurisdictional Relationships in Local Public Health*. Princeton, NJ: Robert Wood Johnson Foundation; 2011.
- 9 Bashir Z, Lafronza V, Fraser MR, Brown CK, Cope JR. Local and state collaboration for effective preparedness planning. *J Public Health Man*. 2003;9(5):344-351.
- 10 Bullard CH, Hogan RD, Penn MS, et al. Improving cross-sectoral and cross-jurisdictional coordination for public health emergency legal preparedness. *J Law Med Ethics*. 2008;36(suppl):57-63.
- 11 Mays GP, Smith SA, Ingram RC, Racster LJ, Lamberth CD, Lovely ES. Public health delivery systems: evidence, uncertainty, and emerging research needs. *Am J Prev Med*. 2009; 36(3):256-265.
- 12 Bekemeier B. Personal Communication; 2012.
- 13 Grieb J, Clark M. Regional public health emergency preparedness: the experience of Massachusetts region 4b. *Publ Health Rep*. 2008;123:450-460.
- 14 Koh HK, Elqura LJ, Judge CM, Stoto MA. Regionalization of local public health systems in the era of preparedness. *Annu Rev Publ Health*. 2008;29:205-218.
- 15 Nowell B, Harrison LM. Leading change through collaborative partnerships: a profile of leadership and capacity among local public health departments. *J Prev Interv Community*. 2010;39(1):19-34.
- 16 *Colorado's Public Health Improvement Plan: From Act to Action*. Denver, CO: Colorado Department of Public Health and Environment; 2009.

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