**Justin Marlowe**

**jmarlowe@uw.edu**

**Endowed Professor of Public Finance and Civic Engagement**

**University of Washington**

**Intent to Propose for Robert Wood Johnson Foundation’s “DIRECTIVE” Program**

The Robert Wood Johnson Foundation (RWJF) has issued a request for proposals for research focused on the implementation of evidence-based practices in public health (the program is called “Dissemination and Implementation Research to Improve Value”, or DIRECTIVE). This program is designed to bridge this gap in the implementation and dissemination of evidence-based practice, especially in areas like health protection, promotion, and disease prevention.

We intend to submit a proposal for this program organized around the following research question: Can cross-jurisdictional partnerships advance evidence-based public health practices? We will focus our investigation on the communicable disease control domain, with specific emphasis on immunizations, STIs, and enteric diseases. We would like to enlist local partners in Washington, Oregon, Wisconsin, and New York to participate in this research.

Evidence-based practices are expensive. They typically demand new resources, skills, assets, and in some cases, risk-taking. Many public health practitioners, especially those in small jurisdictions, don’t have the requisite time or resources to pursue these practices.

In concept, cross-jurisdictional sharing can drive down some of those costs. In this context “cross-jurisdictional” means partnerships between and among local public health jurisdictions. For example, two county public health departments might agree to share the costs of television advertising for a new health promotion campaign, to jointly develop a community health needs assessment, or to share “back office” functions like accounting and purchasing. Much cross-jurisdictional sharing also happens in multi-jurisdictional or regional cooperatives that sometimes involve dozens of jurisdictions. Conventional wisdom says these partnerships can improve cost and quality because they allow local health jurisdictions to share fixed costs, leverage economies of scale, and afford greater flexibility for when and how a service is deployed.

However, partnerships are not cost-free. To enter into a partnership a local health jurisdiction must incur new coordination and transaction costs and must address difficult technical challenges such as how to assign the costs for the service across the involved agencies, how to write appropriate contracts, and so forth. And perhaps most important, local policymakers are often reluctant to give up the autonomy to make their own decisions about service delivery in favor of shared decision-making through a partnership. Conventional wisdom says this is why public health practitioners have not fully realized the potential for sharing to improve cost, quality and reach.

Therefore, this research will have four main objectives:

1. Document the extent of cross-jurisdictional sharing around health protection and disease prevention at both the state and national level. We will do this through an original survey of local health jurisdictions in four states, a review of state-level administrative data on inter-local agreements and other formal sharing agreements four states, and analysis of data from the national NAACHO survey questions on partnerships.
2. Identify instances where cross-jurisdictional sharing made possible the implementation of evidence-based practices. We will focus on the barriers to implementation without sharing, how sharing helps to address those barriers, and how to address the challenges that sharing requires. We will examine this mostly through interviews and case studies of selected four to six selected partnerships.
3. Determine how sharing affects the unit costs and measurable quality of public health services. For a sample of local health jurisdictions we will combine three data sources: 1) MPROVE measures of communicable disease control services, 2) financial/budget data from individual local health jurisdictions, and 3) primary data on the scope and intensity of cross-jurisdictional sharing. This will produce jurisdiction-level indicators of how quality and unit cost vary according to the type and intensity of jurisdiction-level partnerships.
4. Where possible, examine the claim that cross-jurisdictional sharing provides most or all of the same benefits for cost, quality, and reach of public health services as mergers and consolidations. Policymakers in many states are considering regionalizing or even eliminating many local public health jurisdictions as a cost-saving measure. This assumes consolidation saves money, and it assumes the same benefits can’t be achieved through methods that afford the same benefits while preserving local autonomy, such as cross-jurisdictional-sharing. We will test this claim, to the extent possible.

Local practitioners will be involved in the project several ways:

1. Participate in a study advisory body that will review the work throughout, test pilot the survey, and comment on the findings and implications.
2. Respond to the survey on cross-jurisdictional sharing.
3. Where necessary, share locally-housed data relevant to the construction of the MPROVE measures and the requisite financial datasets.
4. Identify noteworthy cases of successful and – perhaps more important – unsuccessful cross-jurisdictional sharing.

RWJF requires that proposals for this grant program consist of an interdisciplinary research team that engages public health practitioners across multiple states. I would serve as principal investigator and would hire an Evans School Ph.D. or MPA student as project manager. Betty Bekemeier, a well-established public health systems researcher in the UW School of Nursing, would serve as co-investigator. Professor Bekemeier and I are currently working together on a separate RWFJ-funded research project on the costs of public health services. We have enlisted practice partners from the practice-based research networks in in Washington, Wisconsin, and New York. Oregon does not have a PBRN, but the staff at its association of local health officials has expressed strong interest in participating in this project.

Each state partner brings something different to the project. The Washington PBRN has collected both the MPROVE measures and financial data, but to date has not documented cross-jurisdictional sharing throughout the state. The same is true for New York. Researchers in Wisconsin, by contrast, are leaders in studying cross-jurisdictional sharing. We would model our survey on cross-jurisdictional sharing after their efforts so far. However, to date their PBRN has not collected either the MPROVE measures or any significant financial data. Their main task for this project would be to complete that data collection effort. Oregon has collected none of these data but is eager to participate.