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Financial and Legal Characteristics of Cross-Jurisdictional Shared Service Agreements Between Local Public Health Agencies

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Abstract

Background—Cross-jurisdictional sharing is a resource management strategy increasingly being used by local health departments to provide essential and mandated public health services. Cross-jurisdictional shared service agreements (CJSSA) are the legal documents that govern cross-jurisdictional sharing arrangements. Information on the financial and legal characteristics of CJSSA is limited.

Objective—This study described the financial and legal elements of a set of formal, written CJSSA in one state to offer guidance to practitioners on how to structure the financial and legal elements in CJSSA.

Design—CJSSA which included a written statement about the financial commitment governed by the agreement (n=63) were analyzed. Data collection occurred through two structured data extraction tools and structured telephone interviews conducted with local and tribal health department directors. Descriptive statistics of all variables and a single predictor linear regression were performed.

Results—The higher population partner to the CJSSA more often provided the public health service and received payment (n=41; 65%). Financial statements were found to vary by CJSSA characteristic. CJSSA were more likely to be legally complete when legal counsel was involved in creating them (OR=2.74, CI: 2.19, 3.29; p = 0.001). Yet, only two (3%) of the CJSSA described all the legal elements and were considered legally complete.

Conclusion—Clearly identifying and including necessary fiscal and legal elements when creating and managing CJSSA may strengthen agreements and reduce local health department legal and fiscal vulnerabilities.

Keywords

cross-jurisdictional sharing; local public health; finance; legal elements

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Introduction

Despite declining resources, it is expected that local public health departments (LHD) continue to provide services that protect and improve the health of the public.^{1, 2} Local governmental collaboration through cross-jurisdictional sharing (CJS) is a resource management strategy increasingly being used to provide foundational public health services.^{3,4,5,6} CJS is the transfer or shared division of services from one LHD to another for a fixed or permanent period of time.³ It exists across all public health program areas, service sharing, and governance structures.^{7,8} In a climate of insufficient resources, LHD are implementing alternative strategies to providing services represented by an overall national increase in CJS.^{1,4,6}

Budget restraints and financial stressors are incentives for entering a CJS agreement. The allocation of funding towards specific program areas has led to budget silos where funds cannot be appropriated to other program areas; this limits use of funding within a LHD, but creates opportunities to share services with other LHD.^{1,2} In a survey of Wisconsin local and tribal health department directors, 65% reported improving fiscal savings or generating revenue as a motivation for entering CJS agreements.⁷ Further, in this same survey, researchers assessed to what extent CJS agreements are meeting expected outcomes.⁷ If a financial statement was described in the CJS agreement, there was a higher likelihood of the agreement meeting expected outcomes (OR: 2.52; CI: 1.25, 5.06).⁷

There are several ways to manage and govern CJS sharing, ranging from an informal agreement (i.e., “handshake”) to a formal creation of a new governmental entity (i.e., regionalization).³ Cross-jurisdictional shared service agreements (CJSSA) are the legal documents that govern service related arrangements.^{3,9} It is not well known how CJSSA describe the shared governance or accountability of sharing public health services across jurisdictions.^{3,10}

Purpose

This study was conducted to describe financial and legal characteristics of formal, written CJSSA between local and tribal public health departments (from this point forward, the acronym LHD reflects local and tribal public health departments) within one state (Wisconsin) with the goal of offering guidance to practitioners on how to structure agreements to be effective in achieving their goals. Research questions were: How are financial commitments described in CJSSA; how do the financial commitments vary across CJSSA characteristics; how legally complete are the CJSSA; and, does involving legal counsel in the creation of the CJSSA improve legal completeness? This data analysis was motivated by the increase of CJS in public health and was designed to inform public administrators, practitioners, and policymakers about the role, characteristics, and delivery of the financial and legal elements described in local public health CJSSA to improve future service sharing arrangements.^{1,3,4,6}

Methods

The study was approved by the University of Wisconsin–Madison Social and Behavioral Science Institution Review Board (IRB). A study advisory team composed of seven individuals representing public health practitioners and subject matter experts provided guidance throughout the study.

All Wisconsin local health departments (n=88) and three tribal health departments were invited to participate in the study. LHD were eligible to participate if they reported having a written CJSSA with at least one other health department which was in place on or after January 1, 2011, and that met the following definition: a written document that describes, defines, or governs sharing of resources across jurisdictions on an ongoing or as needed basis. Three LHD declined to participate, 13 were not eligible because they did not have a written CJSSA, and 12 did not respond to the study invitation. A total of 81 CJSSA were collected that met study criteria. For this analysis, CJSSA were included in the sample if they included a written statement about the financial commitment governed by the agreement. A financial commitment was defined as a statement which specifies an intended payment for the activities defined by the CJSSA. A total of 63 CJSSA (77.8% of the 81 agreements collected) met this study's inclusion criteria.

Data Collection

Two structured data extraction tools were created to extract relevant information from the CJSSA. The first tool was applied to all 81 CJSSA and retrieved information relevant to the general organization and structure of the agreements. Sources used to identify relevant features included prior research on CJSSA, factors associated with successful collaboration identified through the Center for Sharing Public Health Services³, and through consultation with a legal expert.¹⁰ The tool was reviewed by the study advisory team, piloted, and revised to achieve its final form. Two researchers independently extracted data from each CJSSA, then reviewed and resolved discrepancies by discussion. Variables from this extraction included in this analysis were whether a financial commitment existed in the agreement, the primary nature of sharing, the program area, and the extent of legal completeness of the agreement. Legal completeness included documentation of the presence (or absence) of six features: decision-making process is clear, all parties involved in decision-making, dispute resolution process is identified, renewal process is identified, communication processes are clear, and expected outcomes are clear.¹⁰ The legal completeness measure was then summed with equal weighting of each of the six items.

The second structured extraction tool was developed by the research team to retrieve more specific data about the financial variables that are important for practitioners to consider when creating CJSSA. The final form of the financial data extraction tool was achieved after it was piloted, revised and reviewed by the study advisory team. Two researchers independently extracted data for each CJSSA, then reviewed and resolved discrepancies by discussion. Variables on the financial extraction tool included: direction of payment, financial payment, process of the financial exchange, funding source, cost apportionment strategy⁹, consequence for non-payment, financial commitment upon termination or withdrawal, and provision to increase or change fees.

Data were also collected through structured telephone interviews conducted with LHD directors. All participating directors and directors' partners listed on the CJSSA represented in the full study were invited to participate in the interview (n=77). They were recruited through personalized mailed recruitment letters and follow up telephone calls. A total of 43 participated in interviews; 34 did not respond to the invitation. The interview guide was designed by the research team to verify data extracted from the documents and to explore motivations and perceptions related to the collaboration. Two researchers administered the structured interview with one taking notes while the other conducted the interview. The interviews were not audio recorded. After the interview, the two researchers reviewed notes and resolved discrepancies by discussion. Variables included in this analysis drawn from the structured telephone interviews were whether a template and legal counsel was used in creating the CJSSA.

County population size and LHD structure were drawn from the 2013 Wisconsin Local Health Department Survey.¹¹ See Table 1ⁱ for a list of variables used in this analysis.

Data Analysis

Data analysis was completed using Stata v. 14.¹² Descriptive statistics were generated for all variables. A single predictor linear regression analysis with legal completeness as the dependent variable was run to determine whether having legal counsel involved in the creation of the CJSSA increased legal completeness.

Results

CJSSA Characteristics

Table 2ⁱⁱ displays CJSSA characteristics by program area addressed, primary nature of the sharing, population size served by all CJSSA LHD partners, the LHD region, and whether the CJSSA came from a template. The highest proportion of CJSSA primary program area was environmental health (n=24; 38%), primary nature of sharing was for service provision (n=44; 70%), and CJSSA occurred most frequently in LHD serving populations of 100 000 to 249 999 (n=25; 40%). Templates were used to create 40 (63%) agreements. The CJSSA were received from LHD in all regions across the state. Of the LHD represented in this CJSSA sample (n=70), most were categorized as a county health department (n= 51; 73%) and LHD population was 50 000 (n=48; 69%).

CJSSA Financial Characteristics

Table 3ⁱⁱⁱ displays the characteristics of the financial commitments. Direction of payment went from a lower population county to a higher population county in 42 (67%) of the CJSSA. In five (8%), the direction of payment was multi-lateral. Four of these agreements were related to the program area of public health emergency preparedness and the fifth was an environmental health agreement. Geographical clustering among similar types of CJSSA was noted. For example, the direction of payment in 32 (51%) of the CJSSA, was toward just seven different LHD, which in most cases was the higher population county (n=26, 81%).

The financial payment measure was described in 60 (95%) of the CJSSA. Financial payments varied across all CJSSA but were most often made to compensate staff providing the services. The majority of the CJSSA specified an actual dollar amount (n=45; 75%) to be paid under the agreement. For example, “[LHD–Receiver] shall pay \$200.00 per day to [LHD–Provider] to cover expenses incurred by the [WIC] Registered Dietician...program meets on [specified days],” where LHD–Receiver represents the jurisdiction receiving the services and LHD-Provider represents the jurisdiction providing the services. Of the CJSSA which specified an actual dollar amount, the amount varied by rate and agreement period. Thirteen agreements specified an hourly rate ranging from \$35 to \$100, five specified a day rate ranging from \$200 to \$440, two specified a monthly rate ranging from \$600 to \$800, three specified a 6-month rate ranging from \$517 to \$1 000, four specified an 8-month rate ranging from \$1 800 to \$2 264, 16 specified a yearly rate ranging from \$500 to \$40 000, and two agreements had other specific payment and agreement period rates. All (100%) of the maternal and child health, communicable disease, and chronic disease prevention program area types specified a payment dollar amount to be paid compared to 50% (n=6) of the public health emergency preparedness, 67% (n=16) of the environmental health and none (0%) of administration program areas. Specific dollar amounts were identified in 88% (n=38) of CJSSA designed to manage the sharing of services followed by shared staffing (n=4; 67%); shared administration (n=2; 22%), and shared technical assistance (n=1; 50%).

In eight (13%) of the CJSSA, financial payment was specified as a percentage. An example of payment specified as a percentage is, “Member agencies agree to contribute 25 percent of their local public health agency allocation for [program area] for the budget period.” Financial payment as a percentage was noted in CJSSA with a focus on public health emergency preparedness (n=5; 42%), environmental health (n=2; 8%), and administration (n=1; 100%). The nature of sharing described in agreements with percentage payments included administration services (n=4; 44%), service provision sharing (n=2; 5%), sharing staffing (n=1; 17%) and sharing technical assistance (n=1; 50%).

Other types of payments were specified in 29 (48%) of the CJSSA and include: mileage (n=17; 59%), administration or legal fees (n=9; 31%), cost of materials or supplies (n=8; 28%), extra service fees (n=8; 28%), and workers’ compensation (n=4; 14%).

Payment was dependent on whether the CJSSA was activated and costs accrued in the three agreements that did not specify a method of payment. These agreements were all in the public health emergency preparedness program area; and, the primary nature of sharing was staffing in two of the agreements and service in the other.

The process for the financial exchange measure was described in 53 (84%) of the CJSSA. The process for the financial exchange varied across all program areas and nature of sharing. Of the CJSSA that specified a dollar amount, 38 (84%) described a process for the financial exchange and all (n=8) of the CJSSA that specified a percentage described a process for the financial exchange. Of the CJSSA that specified a dollar amount, the most frequent processes for the financial exchange were described as billed or invoiced (n=16; 42%), a payment that went directly from the funding source to the LHD which was providing the service (n=11; 29%), and initial payment upon activation of the CJSSA with multiple

recurring payments (n=7; 18%). Of the CJSSA that specified a percentage, the process for the financial exchange was described as reimbursement as billed/invoiced and payment mechanism through public health emergency preparedness funds, (n=4; 50%).

The source of funding for the payments was mentioned in 36 (57%) of the CJSSA. The funding sources most frequently mentioned were state or federal grants (n=32; 89%). All (100%) CJSSA of the chronic disease prevention and communicable disease program types specified a funding source compared to 66% (n=10) of public health emergency preparedness, 42% (n=10) of environmental health, 36% (n=4) of maternal and child health. None of the CJSSA with administration as the program area specified a funding source. A large proportion of the CJSSA in the environmental health program area (n=40; 80%) specified user fees. Examples of user fees detailed included food license, inspection fees, and temporary event fees.

Using the Center for Sharing Public Health Services cost-apportion strategy⁹, most of the CJSSA were classified as fee-for-service arrangements (n=57; 90%) and weighted formula (n=10; 16%). Five (8%) included aspects that were classified as both fee-for-service and weighted formula. One agreement was classified as equal share and one as proportional share. None of the CJSSA were classified as per capita sharing, cost plus fixed fee, ability to pay, ability to generate revenue or prevalence.

Legal Completeness of the CJSSA

Figure 1^{iv} displays the frequency of the legal items in the CJSSA. Legal completeness scores ranged from 1 to 6 with a mean of 3.57 (SD: 1.44). Only two (3%) CJSSA were considered legally complete, with all 6 items included. Legal counsel assisted in the creation of 35 (56%) of the CJSSA. However, for 13 (21%), it was unknown whether a legal counsel assisted in the creation of the CJSSA. The odds of CJSSA being more legally complete were higher when legal counsel was reported to have been involved in their creation (OR=2.74, CI: 2.19, 3.29; p = 0.001).

Consequences of non-payment were described in 6 (10%) of the CJSSA. An example of such a clause describing a consequence for non-payment is, "If [LHD–Receiver] fails to make payment when due and such failure continues for thirty days after written notice, [LHD–Provider] may terminate this Agreement. [LHD–Provider] also may pursue any other remedies available to it resulting from such failure by [LHD–Receiver]." A slightly higher number of agreements (n=11; 17%) specified a financial commitment upon termination. An example of such a financial termination clause is, "If either party finds it necessary to revise or terminate the contract prior to the expiration date for reasons other than nonperformance, actual cost incurred by [LHD] may be reimbursed for an amount determined by mutual agreement of both parties." A small proportion of the agreements (n=14; 22%) included a provision for changing payments. An example of a provision to increase fees is: "[LHD–Receiver] can conduct an annual review of program expenses and, if necessary, increase the annual and per diem fees charged to [LHD–Provider] to cover its program expenses. If a fee increase is deemed necessary, [LHD–Receiver] shall provide [LHD–Provider] with written notice of the fee increase at least sixty days prior to any increase being implemented." Provisions for financial audits were included in a small minority of agreements (n=5; 8%).

An example of a provision for a financial audit statement is, “The books, records, documents and accounting procedures and practices of the [LHD–Provider] and its employees, agents, or subcontractors relevant to this contract shall be made available and subject to examination by the [LHD–Receiver], including the contracting Agency/Division, legislative auditor, and State Auditor for a minimum period of seven years from the end of this contract.”

Discussion

Results show CJSSA examined in this study were generally incomplete from a legal perspective. Only two CJSSA had all the legal elements recommended by a legal consultant to the project.¹⁰ Further, a small proportion of the sample identified the consequences of non-payment, the financial commitment upon termination, provisions for changing payments, or provisions for financial audits. These gaps raise questions of legal and fiscal vulnerabilities for LHD. Having legal counsel assist with the creation of the CJSSA was associated with higher legal completeness of the document. The results demonstrate needs for improved availability of legal counsel when creating CJSSA and increased professional development for managers regarding contracts including CJSSA.¹⁰

Results revealed considerable variation in style and content of the CJSSA financial elements based on the program area and nature of sharing. It is possible that the type of program or nature of sharing influences what financial elements should be included in a CJSSA. Previous research describes some program areas may be well suited for cross-jurisdictional sharing (CJS) due to the easy fee-for-service to cost-sharing calculation.¹³ Practitioners should assess what financial description best supports the quality and efficiency of that work.

Consistent with national studies, this study found larger population LHD supporting the services of smaller population LHD.⁶ Further, the finding of geographical CJSSA clusters suggests that some counties are perhaps serving as regional hubs for the provision of several services. For example, one LHD was the fiscal agent and provided a service through nine different CJSSA. This regional approach could increase trust between LHD that may extend into services beyond the terms in the CJSSA. Previous studies show prior and more collaborative partnerships increases implementation and performance of CJSSA and may be essential for preparing for, responding to, and recovering from public health disasters.^{5,7}

Another important finding from this study was that most of the CJSSA were categorized as a fee-for-service. This runs counter to trends in healthcare delivery services which have moved from a fee-for-service model to a pay-for-performance model following the passage of the Affordable Care Act.¹⁴ This finding implies that for public health to be consistent with other health services, the payment model may need to assess outcome or quality measures linked with CJS. Also, administrators may want to consider how to assess quality as they create CJSSA because to achieve national accreditation a health department must demonstrate quality improvement efforts.¹⁵

Limitations

There were several limitations to this study. The recruitment method potentially introduced bias as those LHD directors who were interested in the topic may have been more likely to submit CJSSA and participate in the interview portion of the study. In addition to non-participation, there was incomplete interview data due to LHD staff turnover as new staff did not always know the background of the CJSSA. This particularly affected the legal counsel measure as many LHD directors were unsure of the CJSSA creation process. Finally, cross-sectional design of one state and one type of agency (public health) limits the ability to generalize in other states or to other interagency agreements.

Implications for Researchers

While the body of evidence about CJS is growing, many questions remain unanswered. More understanding of how partners find each other and the factors that drive their decisions to partner might help LHD choose their partners for success. Future researchers could explore whether CJS is balancing effectiveness, efficiency, and meeting public health outcomes and community needs. Such research could focus on the perspectives of the myriad of stakeholders on the CJSSA including programmatic staff, LHD directors, policy makers, and the public affected by the CJS; and, include a longitudinal study to assess public health impact and benefits and consequence of CJS. Research should also assess whether CJS in one program area is affecting other program areas; whether smaller LHD are trying to improve services available to their communities through CJS or if they are using CJS to provide their essential or mandated public health services⁴; and, whether LHD that provide services for multiple counties through multiple agreements are maintaining the capacity to provide services for their own county. For example, is CJS of sexually transmitted disease services affecting the resources available for other communicable disease services? Finally, future research should explore the implications of the legal gaps of CJSSA.

Implications for Public Health Practitioners and Policy Makers

Cross-jurisdictional sharing is accomplished only when the capacity for planning, coordination, budgeting, management, and evaluation exist. While jurisdictions may have different processes for creating CJSSA, LHD should consult with a legal counsel when creating CJSSA. Further, LHD should carefully consider cost-sharing and incorporate expected direct and indirect costs.⁹ A checklist of key considerations that include legal and fiscal elements to incorporate or consider should be used when developing CJSSA.¹⁶ Finally, LHD which have experience with CJS could share resources or best practices through a sustained community of practice.³

Conclusion

Cross-jurisdictional sharing is a resource-sharing strategy that is increasingly being used to provide local public health services.⁴ Understanding and strengthening the financial and legal elements of CJSSA must be a priority for all stakeholders involved in the creation and management of these documents. The findings from this study demonstrate that the financial and legal characteristics of CJSSA vary considerably. Engaging key stakeholders and carefully considering the planning, management, and cost-sharing when creating written

agreements, could improve the success, quality and efficiency of cross-jurisdiction sharing in local public health.

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Reference

1. Bekemeier, B., Zahner, S.J., Kulok, P., Merrill, J., Kub, J. [November 13, 2016] Assuring a strong foundation for our nation's public health systems: A commentary.. Nursing Outlook. 2016. <http://dx.doi.org/10.1016/j.outlook.2016.05.013>.
2. Bekemeier B, Chen AL, Kawakyu N, Yang Y. Local public health resource allocation: Limited choices and strategic decisions. American Journal of Preventative Medicine. 2013; 45(6):769–775. [November 13, 2016] <http://dx.doi.org/10.1016/j.amepre.2013.08.009>.
3. What we do. Center for Sharing Public Health Services; <http://phsharing.org/what-we-do/>. Published 2016. [November 13, 2016]
4. Madamala K, Zahner S, Brown R. Sharing local public health services across jurisdictions: Comparing practice in 2012 and 2014. Frontiers. 2016; 5(2):19–25. [November 13, 2016] <http://uknowledge.uky.edu/frontiersinphsrr/vol5/iss2/4/>. [PubMed: 28154790]
5. Shah GH, Badana ANS, Robb C, Livingood WC. Cross-jurisdictional Resource sharing in changing public health landscape: Contributory factors and theoretical explanations. Journal of Public Health Management and Practice. 2016; 22(2):110–119. [November 13, 2016] 10.1097/PHH.0000000000000368. [PubMed: 26808685]
6. National Association of County and City Health Officials. 2013 profile of local health departments. Washington, DC: 2014. <http://archived.naccho.org/topics/infrastructure/profile/upload/2013-National-Profile-of-Local-Health-Departments-report.pdf>. [November 13, 2016]
7. Zahner, S., Watts, T., Mrochek, T., Madamala, K. Factors associated with performance of cross-jurisdictional shared services in local public health.. Poster presented at: Academy Health; Boston, MA. June 25, 2016;
8. Madamala K, Young N, Young D, Giese L, Brandenerg T, Zahner S. Current and planned shared service arrangements in Wisconsin local and tribal health departments. Journal of Public Health Management and Practice. 2014; 20(6):640–646. [November 13, 2016] <https://dx.doi.org/10.1097/PHH.0000000000000029>. [PubMed: 24399279]
9. Center for Sharing Public Health Services. Determining and distributing costs of shared public health services. Topeka, KS: 2015. www.phsharing.org/costs. [November 13, 2016]
10. Network for Public Health Law. Legal completeness and effectiveness in cross jurisdictional shared service agreements in Wisconsin. St. Paul, MN: 2016. https://www.networkforphl.org/_asset/bp8z56/Legal-Completeness-and-Effectiveness-in-CJSSA-in-Wisconsin_Additional-Information.pdf. [November 13, 2016]
11. Wisconsin Department of Health Services: Division of Public Health: Office of Health Informatics: Health Analytics Section. Wisconsin local health department survey, 2013. Madison, WI: 2014. <https://www.dhs.wisconsin.gov/publications/p4/p45704-13.pdf>. [November 13, 2016]

12. Stata statistical software: Release 14. StataCorp LP; College Station, TX: 2015.
13. Pezzino G, Corso LC, Blake RG, Libbey P. Sharing environmental health services across jurisdictional boundaries. *Journal of Environmental Health*. 2015; 77(8):8–36. [November 13, 2016] <https://www.cdc.gov/nceh/ehs/docs/jeh/2015/april-eh-jurisdiction-boundaries.pdf>.
14. Centers for Medicare & Medicaid Services. [November 13, 2016] HCAPHPS fact sheet. 2015. http://www.hcaphsonline.org/Files/HCAHPS_Fact_Sheet_June_2015.pdf.
15. Public Health Accreditation Board. Standards and Measures: V.1.5. Alexandria, VA: 2013. http://www.phaboard.org/wp-content/uploads/PHABSM_WEB_LR1.pdf. [November 13, 2016]
16. Center for Sharing Public Health Services. CJS Roadmap. Topeka, KS: 2015. <http://phsharing.org/roadmap/>. [November 13, 2016]

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Figure 1.
Legal items in the CJSSA

Table 1

Study measures, definition, code, and source

Measure	Definition	Code	Source
Direction of Payment	Direction of payment between LHD on the agreement. Multi-lateral means the direction could differ depending on the circumstances under which the agreement was activated	<ul style="list-style-type: none"> • Payment from LHD • Payment to LHD • Multi-lateral 	Financial extraction tool
Financial Payment *	Type of financial payment specified	<ul style="list-style-type: none"> • Dollar amount • Percentage • Other[†] 	Financial extraction tool
Process of Financial Exchange *	The process of the financial exchange	<ul style="list-style-type: none"> • Lump sum payment • Payments as billed or invoiced • Payment if CJSSA is activated and costs incurred • Initial payment with CJSSA activation followed by multiple additional payments • Budget • Other[†] 	Financial extraction tool
Funding Source *	Whether the CJSSA described the funding source for the cross-jurisdictional sharing	<ul style="list-style-type: none"> • Health department funds • Grants • Third party funds • Fees • Other 	Financial extraction tool
Cost Apportionment Strategy *	Center for Sharing Public Health Service Cost Apportionment Categories ⁵	<ul style="list-style-type: none"> • Equal share • Per capita sharing • Cost plus fixed fee • Ability to pay • Ability to generate revenue • Prevalence • Weighted formula • Fee for service • Other[†] 	Financial extraction tool
Consequence for Non-payment	Whether the CJSSA had a statement describing the consequence for non-payment	<ul style="list-style-type: none"> • Yes • No 	Financial extraction tool
Financial Commitment upon Termination or Withdrawal	Whether the CJSSA had a statement describing a financial commitment upon termination	<ul style="list-style-type: none"> • Yes • No 	Financial extraction tool
Provision to Increase or Change Fees	Whether the CJSSA had a statement describing a provision to increase or change fees	<ul style="list-style-type: none"> • Yes • No 	Financial extraction tool
Program Areas	Primary program area of the CJSSA	<ul style="list-style-type: none"> • Public Health Emergency Preparedness • Maternal and Child Health • Communicable Disease • Environmental Health • Chronic Disease Prevention • Administrative/Other 	Original extraction tool
Primary Nature of Sharing	Primary nature of sharing of the CJSSA	<ul style="list-style-type: none"> • Staffing • Service • Technical assistance • Administrative 	Original extraction tool
Legal Completeness	Additive score from 0 to 6 representing six different variables that if included in the CJSSA would represent a more legally complete document	Six variables: <ul style="list-style-type: none"> • Decision-making process is clear • All parties involved in decision-making • Dispute resolution process is identified • Renewal process is identified 	Original extraction tool

Measure	Definition	Code	Source
		<ul style="list-style-type: none"> • Communication processes are clear • Expected outcomes are clear 	
Template	Whether the CJSSA came from a template	<ul style="list-style-type: none"> • Yes • No • Unknown 	Phone interview
Legal Counsel	Whether legal counsel of any partner on the CJSSA was involved in the creation or review of the CJSSA	<ul style="list-style-type: none"> • Yes • No • Unknown 	Phone interview
CJSSA Population Size	Additive variable of the population size of all of the LHD which were partners on the agreement	<ul style="list-style-type: none"> • 50 000 • 50 001-99 999 • 100 000-249 999 • 250 000-499 999 • 500 000+ 	2013 Wisconsin Local Health Department Survey
LHD Structure	Type of LHD	<ul style="list-style-type: none"> • County • City/Town • City-County • Tribal 	2013 Wisconsin Local Health Department Survey

* Each CJSSA could be coded as more than one type.

[†] Other was coded further to additional categories.

Table 2

Characteristics of the CJSSA (n=63)

Program Area	
Environmental health	24 (38%)
Emergency preparedness	15 (24%)
Maternal and child health	11 (17%)
Chronic disease prevention	11 (17%)
Communicable disease	1 (2%)
Administrative/other	1 (2%)
Primary Nature of Sharing	
Service	44 (70%)
Administration	9 (14%)
Staffing	8 (13%)
Technical assistance	2 (3%)
CJSSA Population Served	
50 000	7 (11%)
50 001-99 999	22 (35%)
100 000-249 999	25 (40%)
250 000-499 999	8 (13%)
500 000+	1 (2%)
Wisconsin Region	
West	19 (30%)
Northeast	13 (21%)
North	11 (17%)
South	11 (17%)
Southeast	9 (14%)
CJSSA came from a template	
Yes	40 (63%)
No	5 (8%)
Unknown	18 (29%)

Table 3

Characteristics of the financial commitments

Direction of payment from low population county to high population county	
Yes	42 (67%)
No	16 (25%)
Multi-lateral	5 (8%)
Payment Specified (n=60; 95%) *	
Dollar amount	45 (75%)
Percentage	8 (13%)
Other types of payments (n=29)	
Mileage	17 (59%)
Administrative or legal fees	9 (31%)
Material charges	8 (28%)
Extra service fees	8 (28%)
Worker's compensation	4 (14%)
Mechanism of Financial Exchange (n=53; 84%) *	
Reimbursement as billed or invoiced	24 (45%)
Payment direct from funding source to provider county	11 (21%)
Initial payment followed by multiple payments	7 (13%)
Reimbursement through PHEP funds	4 (8%)
Lump sum payment	3 (6%)
Payment if CJSSA is activated and service provided	3 (6%)
Budget	2 (4%)
Other	4 (8%)
Funding Source for Payment Mentioned (n=36; 57%) *	
Grant	32 (89%)
Fees	5 (14%)
Health Department	4 (11%)
Other	4 (11%)
Center for Sharing Public Health Services cost-apportionment strategy^{*3}	
Fee for Service	57 (90%)
Weighted Formula	10 (16%)
Equal Share	1 (2%)
Proportional Share	1 (2%)

* CJSSA may be coded as more than one type.