

WEST VIRGINIA

LOCAL HEALTH DEPARTMENTS (LHD) AND BUREAU FOR PUBLIC HEALTH (BPH)

Working Relationship Agreement

Dated August 6, 2002

A. Purpose and Scope

The LHD/BPH Working Relationship Agreement (WRA) serves as a written resource outlining guidelines and processes related to an effective working relationship between all West Virginia local county/regional public health departments and the West Virginia Bureau for Public Health. The WRA is a 'living and dynamic' document put in place and agreed upon by leadership representatives of both local and state levels with the sole purpose of forging a common understanding of working relationship roles and responsibilities for developing, operating, and improving the public health system in West Virginia.

Attachment 1 shows a diagram that depicts the inter-relationships of the local public health entities to the state level organization. In addition, it reflects that federal dynamics are also part of the overall interactions. The scope of the WRA rests within those areas in which there is truly an intersection of involvement between local health departments and the state public health agency. However, the overall intent is to develop effective and efficient working relationships that will afford long-term enhancement of the total public health system in West Virginia.

B. Background/Guiding Principles

The need for specific attention to a WRA has been evolving for some time. Discussions and work in this area are rooted in the Transitions initiative, the August 2001 Invitational Roundtable, the WVALHD's "Completing the Transformation" work, as well as other activities. The *Principles of Collaboration between State and Local Public Health Officials*, as adopted by the Joint Council of State and Local Health Officials (February 2000), also provides reason and reference for the WRA development.

In January 2002, the WRA Working Group, formed in late 2001 by local and state leadership, developed an initial set of guiding principles as a foundation for creating the WRA. Too, these are thought to promote sustaining an effective working relationship between local and state level public health organizations. These Foundation Guiding Principles are listed in Attachment 2.

C. Underlying Contributing Factors

A constructive working relationship can be fostered only in an atmosphere of trust and good will. The process is facilitated when all parties are sincerely pursuing a common goal in good faith. In that respect, it is helpful if the barriers to be overcome primarily represent common historical and systematic impediments, rather than the personal preferences, rigidities, or styles of the individual participants.

This is largely the situation operative in this instance. In the last century there have been enormous scientific, demographic, social, economic, and political factors that have impacted the nation's public health system. These have resulted in substantial advancements in public health capabilities and tools (e.g., epidemiological surveillance, environmental hazard abatement, vaccines, antibiotics, laboratory diagnosis). However, this situation has also resulted in a drastic change in the public health organizational and programmatic infrastructure.

Especially beginning in the 1950's, there was an exponential increase in public health centralized funding and categorical programs to address specific diseases, environmental threats, risk factors, sub-populations, and other concerns. As noted, many of these programs had a very positive impact upon the health status of the public. However, this trend also often produced fragmented service delivery, duplication in functional performance, other inefficiencies, reduced relevance, and weakening of the local public health deliberative 'prioritization' process and decreased local funding. The 'strings' accompanying categorical funding reduced local programmatic and budgetary 'flexibility' and mandated certain standardized reporting and accountability. The 'state' was often the intermediary agent for assuring compliance with these mandates.

In the 1980's public health science and the demand for new and improved services continued to grow exponentially. However, funding remained relatively stable or decreased as service costs rapidly escalated. Moreover, 'unfunded' mandates continued. State agents were still held accountable for enforcement of federal categorical programs as well as assuring compliance with state laws and performance accountability for state funded programs.

In simple terms we, especially local public health managers, were (and continue to be) asked to do more with less without appropriate accompanying increases in programmatic and funding flexibility. This has resulted in incipient rationing of public health services at the local level. The responsibility of implementing various mandates has also created tension between local and state public health representatives who are required to enforce such mandates. It is important to realize that many, if not most, of these tensions are the result of the historical and systematic factors mentioned, not the personal style or rigidity of the participants. It is imperative that we agree to jointly address the reduction of these barriers and the need for strengthening our ability to effectively address new health problems in that light.

D. Expected Behaviors for Working Together

In addition to the WRA Foundation Guiding Principles (Attachment 2), all parties will demonstrate in words and actions the following as expected behaviors for working together both as individuals and in group settings:

1. Our primary focus in our work and decision making will be the public.
2. Doing things in the most effective and efficient ways is vital.
3. Openly state what we desire from the other person (I statements) and let them decide how.
4. When working together, all members will be prepared and all will participate.
5. Both local and state will be open in sharing information with each other.
6. Honor local and state relationships and partnerships that might happen together or individually.
7. We must be inclusive in getting input from the broadest group involved in the issue/discussion both within local and state public health.
8. We will invite those we serve and those we work with to assist in our work.
9. We will have a way for everyone in the system to voice issues/problems in a respectful way.
10. We will address conflict directly and with respect so as to understand issues and give private opportunity to resolve differences or reach appropriate resolution.
11. Decisions will be based on data wherever possible and not on rumor or hearsay.

E. Respect Lines of Authority/Organizational Dichotomy

The WRA does not supplant the natural and legal dichotomies existing between local and state levels. Issues should be properly defined, formulated, and addressed at the lowest level and careful deliberation undertaken before solutions are implemented broadly across the total system.

All entities will ensure that the appropriate level working relationships exist when addressing issues or carrying out responsibilities between staff members (e.g., procedures, performance, processes, etc.). In case of perceived or actual differences there will be respect for the line relationships/authority structure within each organization. To help reduce these occurrences, all staff will be sensitive to how possible actions may be viewed differently by local and state levels and be proactive in ensuring agreement will prevail. In some cases, certain issues may require elevation to a higher level for resolution.

All parties recognize the requirement for some issues to be more fully explored and decided at the respective local or state levels through established processes. Both the local and state representatives involved in the WRA development or practice agree to clearly state when issues need referred back to the respective organizations they represent for final authorization, further discussion, or final decision making.

As delineated separately in this WRA, both local and state levels will provide clear and concise information that reflect how each supports the other through organizational structure and links to staff and resources. All parties consider that the effectiveness of the working relationships will be advanced best by strong visible commitment of infrastructure support of each other.

F. WRA Oversight Group

All parties agree it is critical to have a 'high level' group of local and state representatives to oversee the WRA and to advance the working relationships, especially related to a shared common vision for West Virginia public health. A WRA Oversight Group will be named and charged with the following:

1. Ensure the WRA is sustained and practiced by all parties.
2. Serve as the highest-level state/local health department forum regarding major issues affecting the public health system in West Virginia.
3. Address specific issues that are determined inconsistent with the spirit of the WRA.
4. Conduct regular meetings to identify priority issues and address concerns regarding the public health system in West Virginia, including the annual planning event outlined in the WRA.
5. Support actively the value of the present WRA and its underlying principles, and look for ways to enhance the on-going working relationships.
6. Assess the effective implementation and on-going performance of the working relationships.
7. For specific projects/topics, recommend the best methods to support and sustain a collaborative approach.

The WRA Oversight Group will work collectively on issues and attempt to reach agreement on recommendations that it would take back to the respective organizations. The Oversight Group members are encouraged to support recommendations agreed upon by the full group and assist in presenting the recommendations in a supportive manner to the respective organizations. This group should be a role model team using teaming principles and practices.

The membership shall be composed of the following:

From BPH the positions of

- Commissioner
- Deputy Commissioner
- Director, Office of Community and Rural Health Services
- Director, Office of Epidemiology and Health Promotion
- Director, Office of Maternal, Child and Family Health
- State Epidemiologist, Division of Surveillance and Disease Control
- Director, Division of Public Health Sanitation
- Director, Division of Public Health Nursing and Administration
- Turning Point Director, Division of Public Health Nursing and Administration
- Executive Director, Public Health Threat Preparedness, Bureau for Public Health

From the local level the positions of

- Six elected officers of the West Virginia Association of Local Health Departments (WVALHD).
- The two full-time local public health officers.
- Two at large representatives appointed by the WVALHD.

At the initial meeting of this group, team processes will be established to include roles, meeting frequency, committee structure, alternative or back-up membership guidelines, process agreement, etc. The group will also formulate the targeted goals for the first year. The WRA Oversight Group should use a subcommittee structure to carry out some of its work. It is suggested that the WRA Oversight Group establish focused subcommittees in the following areas:

- ◆ Policy Development
- ◆ Funding/Resource Allocation
- ◆ Legislative Agenda
- ◆ Communication (Common Message)
- ◆ Planning/Performance

The WRA Oversight Group can charter special WRA Task Teams to address specific topics. The WRA Oversight Group will determine the scope of work, membership, timeframe, budget, and other considerations.

The WRA Oversight Group, as appropriate and warranted, may call upon resource people, groups, or organizations for expertise on topics or issues needing addressed.

An official roster will be maintained of current membership names and contact information. Attachment 3 reflects the current WRA Oversight Group membership.

G. State Level Organizational Support and Staffing Infrastructure

As a significant partner and major customer of the state level public health organization, BPH is committed to integrating a strong presence at the Commissioner's level regarding support of local public health.

The BPH fully endorses the WRA Oversight Group and will commit to working with it on issues as outlined in this agreement. Further, it supports the proposed five subcommittees that can work to refine the support and staffing infrastructure over time. BPH agrees to fully adhere to and fully support the principles outlined in this WRA.

On an ongoing basis, BPH leadership will continue to review internal organizational structures and processes to best support the effective functioning of the WRA.

H. Local Level Organizational Support and Staffing Infrastructure

The WVALHD Association provides a primary channel between local health departments and state level public health. On an ongoing basis, WVALDH leadership will continue to review organizational structures and processes to best support the effective functioning of the WRA. WVALHD, on behalf of all local health departments, agrees to fully adhere to and fully support the principles outlined in this WRA.

I. Support for Public Health Advisory Council

The WRA supports the development of a statewide, broad based Public Health Advisory Council to provide guidance to the WV Bureau for Public Health and to assist in overall improvement of the state public health system.

J. Selection of Collaborative Work Groups

From time to time, and as more collaborative work occurs, there is a need to populate work groups, steering committees, and other type involvement opportunities (e.g., panels, workshops, attend conferences, etc.) related to public health system matters. The WRA recognizes the value of involving a wide range of individuals from throughout both local and state levels. There must be consideration to the needed expertise and the wise use of human resources. As stated in the driving principles, everyone should be afforded the opportunity to participate.

Both LHD and BPH will develop and monitor a 'pool' of individuals most appropriate and willing to serve on a work group. There should be an effort to spread the resources and not rely on a few number of often-tapped individuals. This would include looking at new employees as well as those who have been working within the system for longer periods.

When requesting individuals to be involved in collaborative work of any nature, both local and state will practice the following process.

1. Have a clearly defined charter (purpose) for the work group, task team, etc.
2. Define the number of people, type of individuals, skills, etc. needed.
3. Provide information regarding expected time commitment and any other resource requirements (e.g., person has to pay for travel, etc.).
4. Provide suggested names, if warranted.
5. Submit the request to the WRA Oversight Group who may assume responsibility for selecting members or refer the task to others.

K. WRA Decision Making

In matters of the WRA and directly related issues, the WRA Oversight Group will use the consensus decision-making method on final decisions deemed appropriate for their consideration. Any member may indicate 'up front' when issues being considered will require consideration under different decision-making methods or should not be considered by the group. The group will strive to use and

reach consensus on as many decisions as they can. Attachment 4 contains basic information regarding consensus decision-making as discussed during development of the WRA.

L. Funding/Resources

Securing adequate and timely resources for public health must be a joint responsibility between state and local health levels and balance the needs of state and local service providers.

Based on principles embraced by NACCHO and ASTHO, there is a need to have a focus on working together related to planning and allocating resources, especially those from federal and state public health sources. Resources should be allocated and services delivered as close to the location in need as possible, while considering other factors including economy of scale, accountability, and specific expertise. Further, there should be given priority consideration to local and state infrastructure needs wherever possible to assure that essential capacities are in place.

As part of this WRA, local and state agree to the following related to funding and the allocation of resources.

1. Where possible, funding should be distributed to the locale(s) where the function is performed (sample functions may include service delivery, support, training, etc.)
2. Issues of efficiency, economy of scale, and delivery effectiveness should be involved in funding deliberations.
3. Fiscal and performance accountability is critical at all levels. Where possible, methods of assuring accountability should be developed collaboratively or when dictated by funding sources, shared openly.
4. Although funding source expectations may exceed current perceived or actual capacity, acceptance of funds implies a willingness to set standards high and seriously work towards the delineated intent or outcome.
5. Fiscal stewardship should be practiced by all.
6. Recognizing that capacity varies widely at both the state and at local level, efforts will be made to support continued advancement and development at each level while also working to strengthen the capacity of the system as a whole.
7. All parties recognize that resources/issues beyond fiscal ones must often be addressed for system progress to be made. If such issues will significantly impede appropriate use of funds, individual or collective efforts to resolve these will be undertaken prior to fund acceptance.
8. When documents or discussions include potentially sensitive fiscal data (e.g., personnel salaries, etc.), those working with the information will handle it discretely, responsibly, confidentially, and with respect to all involved.

During the first year of this agreement, the WRA Oversight Group should form the Funding Committee to take a serious look at the present processes and make recommendations for consideration by the full group.

M. Policy Development

The more local and state policies related to public health align, the more effective the entire system. Both local and state levels will continue to create, change, or remove policies that relate to the public health system. As part of this, the WRA Oversight Group will identify and address policy issues that affect local health departments and the state level organization. When the WRA Oversight Group agrees on policy requiring higher level approval, they will collectively develop the best strategies for advancing the policy to the most appropriate individuals or entities.

N. Legislative Agenda/Advocacy

Although most likely both local and state will have individual issues or focus areas for consideration as to their legislative agenda, there is merit in forging a common agenda for mutually agreed issues or requirements. Each year a special meeting will be held early enough to review pending legislative agendas for both local and state. Efforts will be made to develop common agendas that will be actively supported together.

In some cases, there may be issues or items that cannot be mutually supported or where agreement can not be reached. In such instances state and local entities will accept the situation without damaging the underlying principles of the WRA.

O. Performance Management

Both local and state levels recognize and will support the need for on-going quality improvement processes. The full development and use of performance standards and peer assessment will also be supported as part of this WRA.

P. Tools for Facilitating Planning, Communications and Effective Discussion

As evidenced throughout the WRA and in the stated intentions of all parties, on-going productive communication is paramount to advance an effective working relationship and to improve the overall public health system. Both local and state leadership will continue to foster a culture in all public health organizations that is proactive in working with each other.

Both state and local value planning for themselves as well as planning together. Finding ways to build common agendas and a shared vision for goal setting will be most beneficial to an effective and efficient public health system. As part of WRA sustainability and to set priority on issues needing addressed that relate to the on-going working relationship, the WRA Oversight Group will coordinate and fulfill the following on an annual basis:

1. Conduct regular meetings of the WRA Oversight Group and designated subcommittees.
2. Hold an annual Invitational Roundtable with board participation from local and state levels. The format will be to review progress over the past year related to the WRA, public health system operational improvements, and assessment of the delivery of public health services to the public. This Roundtable will also serve to collect priority issues needing addressed in the next year.
3. Set annual key goals based on the work of the WRA Oversight Group and the outcomes of the annual Invitational Roundtable. This goal setting will be part of the WRA for the following year. An action plan will be developed to support the goals and strategies as developed.
4. Share information both with respective organizations and within agencies (offices, individual LHDs, etc.).

Q. Common Voice

The more both local and state levels can speak with a common voice related to public health issues, system needs, and expectations, the more effective its overall operations and ultimately image. This applies both to those within the public health system as well as the general public and partners served. As part of the WRA, the WRA Oversight Group will assist in developing communication plans that will help improve getting a common voice in the future.

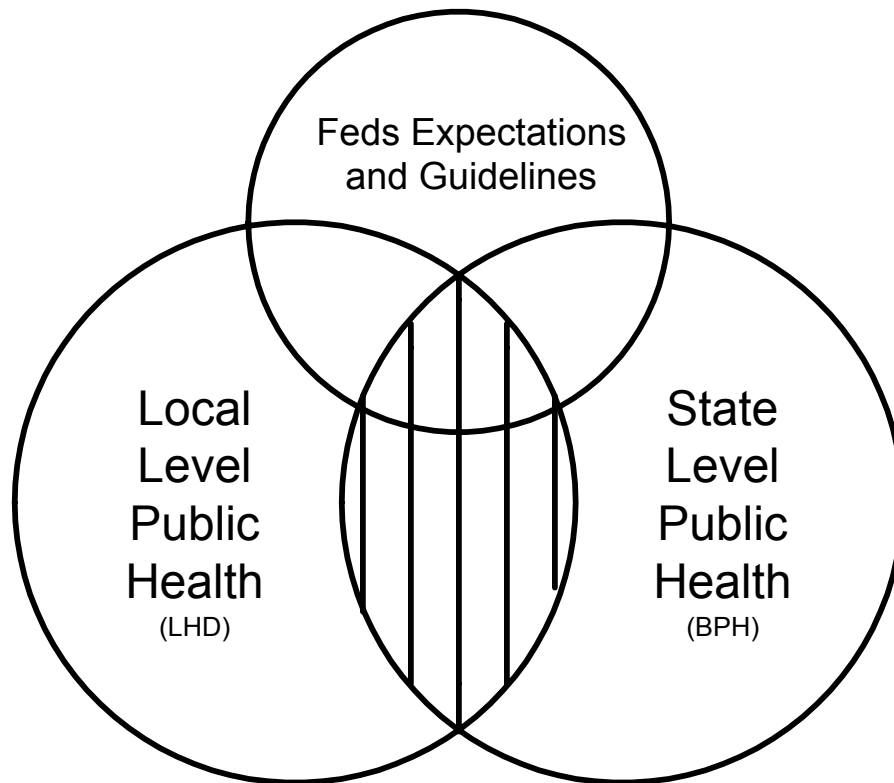
R. Resolution of Issues

The WRA Oversight Group will develop a mechanism to receive and process any issue that surfaces related to a 'failure' in the WRA. If the WRA Oversight Group cannot successfully reach a resolution on any given issue, it will seek external assistance to work with it.

S. WRA Evaluation

On an annual basis, the WRA Oversight Group will conduct an assessment related to how well the WRA is working from a variety of perspectives (e.g., leadership, staff, customers). This assessment will be completed prior to the annual Invitational Roundtable session. The WRA Oversight Group will select an independent team to develop and administer the assessment.

Attachment 1
Understanding the Working Relationships and Entity Responsibilities



This diagram depicts how three clearly separate entities (Federal, local health departments – individually and collective and the state) interact related to the ‘total’ public health system in West Virginia. The working relationship agreement formation is rooted in understanding the dynamics of roles, responsibilities, and actions related to programs, funding, customer base, performance requirements, management, collaboration, etc. The striped section indicates where the working relationships are most critical between local and state level public health organizations and operations.

Attachment 2

WRA Foundation Guiding Principles for Shared Understanding

The following guiding principles were agreed upon by the WRA group as the shared understanding/vision for developing and implementing the working relationship agreement between local health and the state health going forward.

Together, we will. . .

1. Respect other's positions, circumstances, authorities, and responsibilities.
2. Show a willingness to change, compromise, and give everyone the benefit of the doubt.
3. Arrive at a solution that is done with mutual respect.
4. Surprise in private - praise in public.
5. Commit time and effort by the key people to get this done.
6. Support and honor decisions made by consensus.
7. Strive to get all viewpoints on the table when moving toward consensus.
8. Recognize that the success of the working relationship agreement is greater than any one issue.
9. Encourage thinking outside of the box - everything is on the table.
10. Accept the need to develop a shared vision for the WV Public Health system.
11. Establish a framework and guidelines on our roles and how we communicate in both directions.
12. Foster system thinking - understanding the connections between parts and adapting based on new data.
13. Accept the principle that central coordination and local control is ideal.
14. Agree that some efforts may be most effective/beneficial at multi-state, statewide or regional, etc. (These should be jointly determined.)
15. Concurrently (simultaneously) looking at all public health system components in the community for efficiency and effectiveness would be ideal.
16. Start off with a clean piece of paper as to the roles, communication responsibilities, etc.
17. Be willing to make structural changes to maximize resources.
18. Use data from assessments and public informing sessions to help guide what happens: structure, programs, and resource allocation.
19. Operate in a 'planful' mode.
20. Get and use input from the other party when change related to WRA covered issues is needed (consult all parties prior).

WRA OVERSIGHT GROUP MEMBERSHIP 2/2004

Bureau for Public Health Members

Amy Atkins, Turning Points Project Coordinator, Division of Public Health
Nursing and Administration

Nancye Bazzle, Director, Office of Community and Rural Health Services

Chris Curtis, Acting Commissioner, Bureau for Public Health

Ron Forren, Acting Deputy Commissioner, Bureau for Public Health

Loretta Haddy, State Epidemiologist, Division of Surveillance and Disease
Control

Pat Moss, Director, Office of Maternal, Child and Family Health

Kay Shamblin, Director, Division of Public Health Nursing and Administration

Joe Barker, Director, Office of Epidemiology and Health Promotion

Cathy Slemp, Executive Director, Public Health Threat Preparedness and Acting
Health Officer

Joe Wyatt, Acting Director, Public Health Sanitation

Local Health Departments Members

Karen Dawson, President Elect, WVLHA, Clay County Health Department

Kerry Gateley, Physician/Director, Kanawha-Charleston Health Department

Candy Hurd, Member at Large, Director of Nursing, Beckley/Raliegh County
Health Department

Bill Kearns, Member at Large Executive Committee, WVLHA, Morgan County
Health Department

Julia Kerns, Past President, WVLHA, Grant County Health Department

Stanley Mills, Member at Large, WVLHA, Cabell-Huntington Health
Department

Mickey Plymale, President, WVLHA, Wayne County Health Department

Linda Sanders, Treasurer, WVLHA, Randolph-Elkins Health Department

Omayma Touma, Physician/Director, Cabell-Huntington Health Department

Mike Vickers, Member at Large, WVLHA, Boone County Health Department

Mike Nestor, Member at Large Executive Committee, WVLHA, Grafton Taylor
Health Department

Attachment 4

Consensus Decision-Making Overview

A larger handout regarding decision making was provided during the WRA development. This attachment provides an excerpt from that document. Copies of the full document are available through the WRA Oversight Group.

Consensus is based on the principle that every voice is worth hearing, every concern is justified. A team must reach consensus on its decision process, not on every decision. The team may develop different decision-making methods for different types of required decisions.

GUIDELINES THAT FACILITATE CONSENSUS DECISION MAKING:

The following guidelines may help individuals or teams make decisions by consensus.

1. Team members should present their position as understandably and logically as possible, but consider seriously the reactions of the group in any subsequent presentations of the same point.
2. Treat differences of opinion as indicative of incomplete knowledge of relevant information on someone's part and press for additional sharing, either about the positions (tasks) or their emotional content, where it seems in order.
3. View differences of opinion as both natural and helpful, rather than as a hindrance to the decision-making process.
4. View initial agreement as suspect. Explore the reasons underlying apparent agreements; make sure that all team members have arrived at similar solutions for either the same basic reasons or for complementary reasons before incorporating such solutions in the team's consensus decision.
5. Strive for enlightened flexibility; avoid outright concession.
6. When impasses or stalemates occur, look for the next most acceptable alternative for the customer.
7. Withstand pressures to yield that have no objective or logical foundation.
8. Avoid **arguing** for one's own position.
9. Avoid changing one's mind **only** in order to avoid conflict and to reach agreement and harmony.
10. Avoid conflict-reducing techniques such as the majority vote, averaging, bargaining, coin flipping, and so on.
11. Avoid "**win-lose**" stalemates in the discussion of positions. Discard the notion that someone must win and someone must lose.

Note: Generally, the more ideas expressed, the greater the likelihood of conflict, but also the richer the array of resources.