Promoting Health in All Policies: An Assessment of Cross-Sector Collaboration Among State Health Agencies

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Introduction

Good health is a universally shared value, so many view addressing the determinants of health as a shared responsibility. Interactions between humans and the environment are complex, and the resulting issues often fall under the purview of multiple agencies or organizations. Population health and equity cannot be improved without working collaboratively with the sectors that shape social and environmental policies.

Since human health is inextricably linked to the environments in which we live, state and territorial health agencies are key players in promoting environmental health. As such, ASTHO promotes and highlights collaboration between health agencies and other partners to help individuals be healthy at every stage of life. Since health status is determined by a multitude of factors beyond healthcare and traditional public health activities, collaboration is key to improving community health.

Public health practitioners have a unique role to play in raising awareness about how health is created, discussing which policies and programs impact health outcomes, and working with partners in other sectors to identify opportunities to both advance their goals and improve public health. To this end, ASTHO promotes the use of a Health in All Policies (HiAP) approach to decisionmaking.[1,2] ASTHO defines HiAP as a collaborative approach that integrates and articulates health considerations into policymaking across sectors, and at all levels, to improve the health of all communities and people.[3] Relationships are the building block to any collaborative effort and HiAP is, by definition, a process of building relationships with other sectors.

This assessment is a follow up to an earlier report describing the partners and types of collaboration happening between state health agencies (SHAs)[i] and other groups.[4] This updated assessment is based on the most recent data reported in the ASTHO Profile of State and Territorial Public Health, Vol. 4 (Profile Survey) that describes the current level of collaboration between SHAs and partners. Results indicate that SHAs are collaborating with many partners in their communities and across governmental sectors at the local, state, federal, and tribal levels, as well as with many non-governmental agencies such as hospitals, schools, faith communities, and businesses. This collaboration can occur through many different activities, such as information sharing, formal agreements like memorandums of understanding (MOUs), and even funding mechanisms. This report summarizes the breadth of activities that are instrumental for HiAP approaches.

Methods and Data Sources

In 2007, ASTHO launched its first Profile Survey to collect data that would provide a complete and accurate picture of state and territorial public health. The Profile Survey is the only comprehensive source of information about state, territorial, and freely-associated state public health agency activities, structure, and resources. The survey defines the scope of state and territorial public health services, identifies variations in practice among state and territorial public health agencies, and contributes to the development of best practices in governmental public health. The Profile Survey drives improvement at SHAs, educates policymakers, enables the sharing of best practices among SHAs, and is a resource to the field of public health systems and services research.

[i] Note: This report is focused on state-level collaboration and based on SHA responses only. Data specific to territorial health agencies is available in Chapter 7 of the ASTHO Profile Survey.

Data for this updated "cross-collaboration" report is based on the latest survey findings in a series of ASTHO publications on this topic, and funded by the Robert Wood Johnson Foundation and CDC.[5] Prior to 2016, SHAs completed similar surveys in 2007, 2010, and 2012 with response rates of over 90 percent for the 50 states and Washington, D.C. The previous "cross-collaboration" report, released in 2012, was based on data from the 2007 and 2010 surveys.

In April 2016, ASTHO launched the fourth iteration of the Profile Survey, sending a link to the 129-question, web-based survey instrument to senior deputies from the 50 states, Washington, D.C., and eight territories and freely-associated states. At the close of survey administration, the Profile Survey response rate was 98 percent among the 50 states and Washington, D.C., and 97 percent among all U.S. states, territories, and freely-associated states. ASTHO conducted extensive follow up with the states, territories, and freely-associated states through the remainder of 2016 to verify responses.

Data for this collaboration report is based on a few different survey questions related to the nature of SHA collaborative activities, including how SHAs collaborate and with whom. In addition, ASTHO included questions related to health impact assessments since they are collaborative processes. On relevant questions, SHAs provided information on whether they had an MOU with other agencies within state government, or if they engaged in collaborative activities with other agencies or organizations by exchanging information, working together on activities or projects, or providing financial resources. ASTHO staff examined the results of the 2016 Profile Survey in winter and spring of 2017, and compared results with similar questions from previous versions of the Profile Survey to look for trends.

Findings

Cross-Sector Collaboration

SHAs are collaborative in nature and share resources, such as staff, funding, and equipment with other state, local, and tribal health agencies. About a quarter of SHAs report that they share resources with other states on a continuous, recurring (non-emergency) basis, and almost three quarters of SHAs report facilitating the sharing of resources among local health departments on similar intervals. In addition, SHAs collaborate with other states, local health departments, and tribes, as well as other types of governmental and nongovernmental agencies in different ways. Similar to what is outlined in ASTHO's Health in All Policies Framework, collaboration can take shape across a spectrum of activities.[6] Such activities include exchanging information, working together on projects, providing financial resources to another agency, and providing leadership to another agency. SHA collaborative activities with agencies and organizations are displayed in **Tables 1** and **2**.

Collaboration with Public Health and Healthcare Entities

In general, SHAs report being highly collaborative with local public health agencies, hospitals, and many other entities in the healthcare field. At least 90 percent of SHAs report exchanging information with hospitals, physician practices/medical groups, community health centers, health insurers, and emergency responders. The percentage of SHAs that report working together on projects with these organizations is also very high. There is a large variation in whether SHAs provide financial resources to these organizations and whether they assume the leader role within that particular partnership. However, SHAs are most likely (>75%) to provide financial resources to local public health agencies, hospitals, and community health centers. One notable increase in collaboration between 2012 and 2016 is the percentage of SHAs that reported exchanging information with health insurers (72% in 2012 and 92% in 2016).

Table 1. SHA collaborative activities, public health and healthcare entities, 2016 (N=43-49)

	Collaborative Activity (by type)											
	Exchange Information		Work Together on Projects		State Health Agency Provides Financial Resources		State Health Agency has Leadership Role in the Partnership		No Relationship Yet		Organization Does Not Exist in Jurisdiction	
Agency Name	N	%	N	%	N	%	N	%	N	%	N	%
Local public health agencies	43	88%	43	88%	42	86%	32	65%	0	0%	6	12%
Hospitals	49	100%	49	100%	39	80%	26	53%	0	0%	0	0%
Physician practices/medical groups	44	92%	45	94%	23	48%	19	40%	1	2%	0	0%
Community health centers	43	94%	45	98%	38	83%	19	41%	0	0%	0	0%
Other healthcare providers	41	89%	39	85%	23	50%	18	39%	1	2%	2	4%
Health insurers	44	92%	43	90%	10	21%	9	19%	0	0%	1	2%
Emergency responders	48	98%	47	96%	31	63%	27	55%	0	0%	0	0%
State boards of health	30	63%	31	65%	12	25%	9	19%	0	0%	16	33%
Local boards of health	33	69%	25	52%	17	35%	13	27%	1	2%	13	27%

Collaboration with Non-Public Health Agencies and Organizations

When asked about collaboration with non-public health partners, SHAs report (at least 90% of them) that exchanging information is the most common method, including with primary/secondary schools, community-based organizations, higher education, media, continuing education (e.g., pharmacy, medical, nursing), and law enforcement. Over half of SHAs report providing financial resources to community-based organizations (90%), higher education (63%), primary/secondary schools (58%), and faith communities (51%). In addition, SHAs are most likely to have a leadership role in the partnership with community-based organizations. When asked about organizations with which SHAs do not yet have relationships, over a third noted utility companies/agencies (39%) and energy agencies (35%).

Table 2. SHA collaborative activities, non-public health agencies and organizations, 2016 (N=43-49)

	Collaborative Activity (by type)											
	Exchange Information		Work Together on Projects		State Health Agency Provides Financial Resources		State Health Agency has Leadership Role Within the Partnership		No Relationship Yet		Organization Does Not Exist in Jurisdiction	
Agency Name	N	%	N	%	N	%	N	%	N	%	N	%
Land use/planning agencies	28	65%	27	63%	4	9%	3	7%	6	14%	3	7%
Economic and community development agencies	32	71%	30	67%	6	13%	4	9%	7	16%	3	7%
Housing agencies	29	63%	36	78%	15	33%	6	13%	6	13%	2	4%
Utility companies /agencies	21	48%	18	41%	4	9%	2	5%	17	39%	5	11%
Environmental and conservation agencies	32	73%	34	77%	7	16%	6	14%	8	18%	0	0%
Cooperative extensions	33	72%	34	74%	14	30%	6	13%	8	17%	2	4%
Primary/ secondary schools	44	92%	47	98%	28	58%	14	29%	0	0%	0	0%
Parks and recreation	37	80%	36	78%	10	22%	5	11%	4	9%	1	2%
Transportation	40	85%	41	87%	10	21%	7	15%	3	6%	0	0%
Community-based organizations	46	96%	48	100 %	43	90%	31	65%	0	0%	0	0%
Faith communities	38	81%	44	94%	24	51%	12	26%	3	6%	0	0%
Other voluntary or nonprofit organizations (e.g., libraries)	38	86%	38	86%	19	43%	13	30%	4	9%	0	0%
Higher education (e.g., universities, medical schools, community colleges)	48	98%	49	100 %	31	63%	24	49%	0	0%	0	0%
Business	35	81%	38	88%	12	28%	9	21%	2	5%	0	0%
Media	42	96%	30	68%	11	25%	5	11%	0	0%	0	0%

Tribal government agencies or other tribal community	31	67%	31	67%	22	48%	14	30%	2	4%	12	26%
Continuing education (e.g., pharmacy, medical, nursing)	41	91%	39	87%	17	38%	12	27%	1	2%	1	2%
Food banks	37	82%	35	78%	11	24%	6	13%	5	11%	0	0%
Energy agencies	22	51%	22	51%	0	0%	2	5%	15	35%	3	7%
Law enforcement	45	96%	45	96%	9	19%	8	17%	1	2%	0	0%
Justice system	37	80%	36	78%	4	9%	10	22%	4	9%	0	0%

Nature of Collaboration

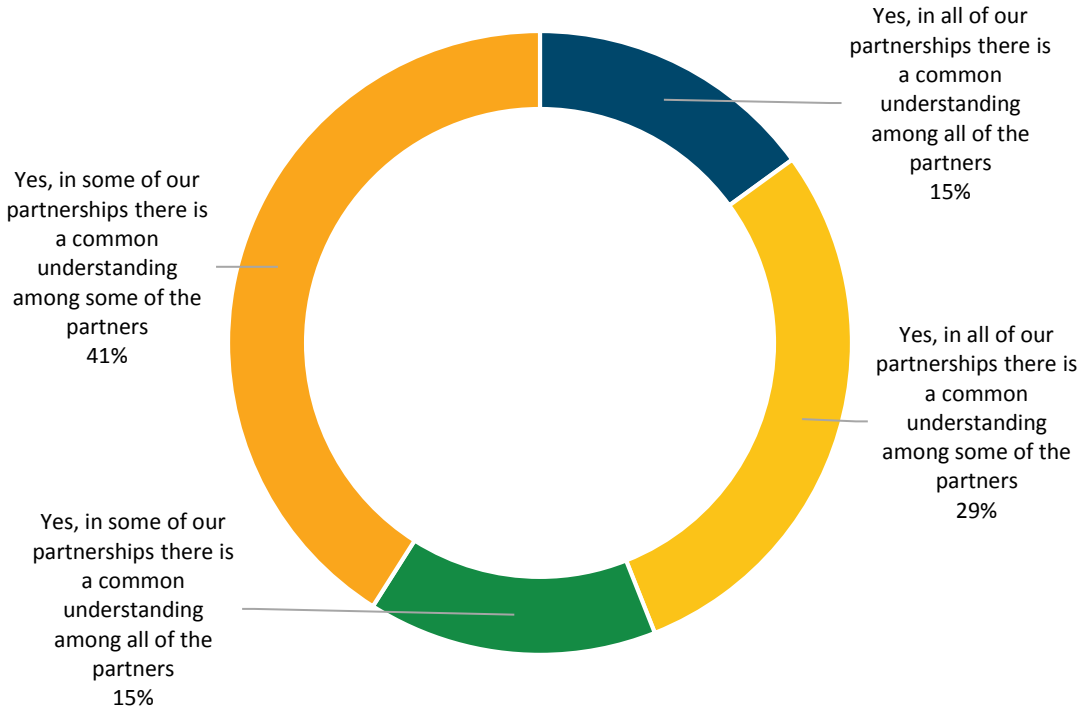
In 2016, ASTHO asked respondents a new series of follow-up questions about the nature of the collaborations in which they participate. These questions were based on a review of elements key to successful collaborations, including: MOUs; a designated body with a charter; a common understanding of population health concepts, definitions, and principles across the partners in the formal partnerships; and specified health objectives and targets.[7]

Respondents were asked to indicate whether any of the collaborations that they listed were formal partnerships. This was defined as partnerships governed by an MOU or other written agreement involving more than one sector outside of public health (e.g., a partnership among the SHA, education, and business groups). A majority of state health agencies (84%) reported being part of one or more formal partnerships. When asked how many of these formal partnerships had adopted a statement of mission and goals, 38 percent of SHAs reported that most or all partnerships had done so; 37 percent reported that some had done so; 19 percent reported that few had done so; and 5 percent of states were unsure.

When asked how many of their partnerships had a designated body with a charter, fewer reported that most or all did (17%). However, 38 percent reported that some did, 30 percent reported that few did, and one state reported that none had a designated body and charter. Twelve percent of respondents were unsure if any of their partnerships had a designated body and charter.

When asked if there was a common understanding of population health concepts, definitions, and principles across the partners in the formal partnerships, results varied (see **Figure 1**). Medium (19%) and large states (21%) were more likely than small states (0%) to report a common understanding in all partnerships.

Figure 1. Formal partnerships with a common understanding of population health concepts, definitions, and principles across partners, 2016 (N=41)



Approximately three-quarters (73%) of SHAs with formal partnerships reported that, in some formal partnerships, both their health objectives and targets have been specified. Approximately one-quarter (27%) reported that health objectives and targets had been specified in all partnerships. States in the Mid-Atlantic and Great Lakes (38%) and the South (39%) were more likely to report that the health objectives and targets had been specified in all formal partnerships than were states in the other three geographic regions (values in other regions ranged from 13-17%).

Similarly, when asked if the tools they will use to track and monitor progress have been specified, 71 percent reported that they had in some partnerships, while 27 percent reported that they had in all partnerships; two states were unsure. States in the Mid-Atlantic and Great Lakes (50%) were more likely to report that the tools had been specified in all partnerships than were states in the other four regions (values ranged from 17-25%).

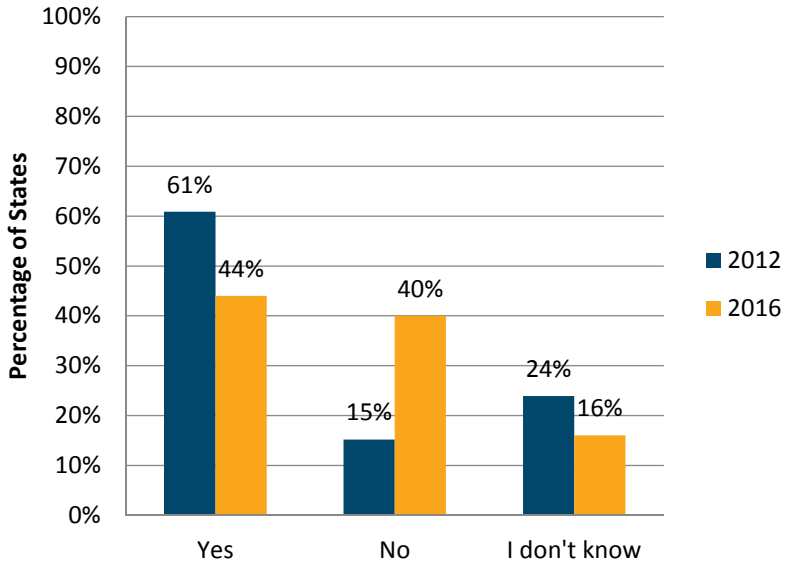
Health Impact Assessments

A health impact assessment (HIA) is a systematic process to evaluate the potential health impacts of a project, program, or policy.[8] In 2012 and 2016, the Profile Survey asked SHAs if anyone in the agency had

attended an HIA training in the past two years. The number of states health agencies that reported participation in HIA training decreased between 2012 (61%) and 2016 (44%) **(Figure 2).**

By 2016, the number of agencies that had participated in training was almost equal to the number of agencies that had not participated. Individuals from Western states were most likely to have participated in an HIA training (67%), while individuals from states in the Mountain and Midwest region were least likely to have done so (20%).

Figure 2: Participation in HIA training in past two years by anyone in SHA, 2012-2016 (N=46-48)

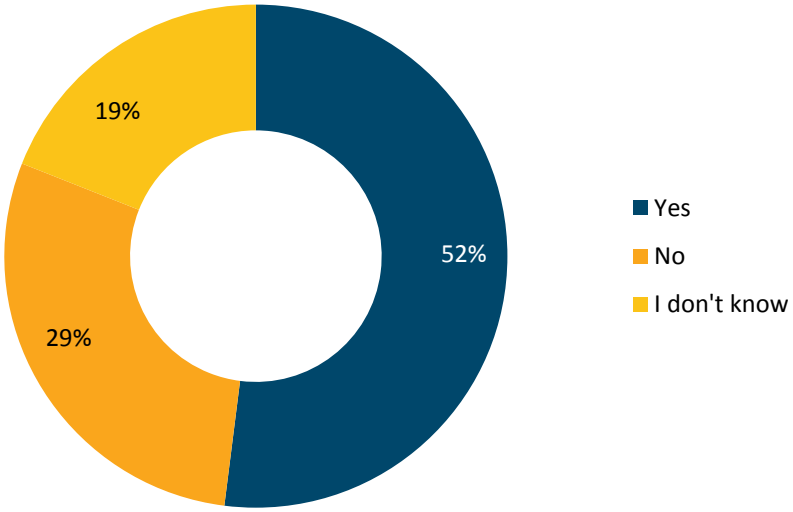


The survey also asked states if their SHA had participated in an HIA in the past two years (see **Table 3**). In both 2012 and 2016, fewer than half of SHAs had participated, though the average number of HIAs increased slightly during this time (three in 2012 to four in 2016). States in the Mid-Atlantic and Great Lakes region conducted the fewest HIAs (mean=2), while Western states conducted the most (mean=5). Small states conducted fewer HIAs (mean=2) than medium and large states (mean=4 for both). Of those states in which a staff member participated in HIA training, half also reported SHA participation in an HIA advisory committee in 2016 (see **Figure 3**). All Western states participated in an HIA advisory committee (0-57% in other regions.

Table 3. Number of HIAs conducted by SHAs, 2012-2016 (N=17-21)

	2012				2016			
	Mean	Median	Minimum	Maximum	Mean	Median	Minimum	Maximum
Number of HIAs	3	2	1	13	4	2	0	16

Figure 3. SHA participation in an HIA advisory committee, 2016



Reflections on the Data

Collaboration

Coordinating efforts across sectors is a way to improve the efficiency of government processes and services. Public health and other sectors can work together to identify mutual goals, and integrate health considerations upfront into their own work and values. When building a foundation for HiAP initiatives, it is helpful to have several key resources in place, such as relationships, information, funding, and staff. Relationships are crucial to getting started, while funding and personnel can help sustain an initiative. It is not surprising that SHAs are very likely to exchange information with their other public health and healthcare partners, since relationships are usually the first step in a collaborative process. While not as common, over 75 percent of SHAs are likely to take the next step and work on projects with a variety of their public health and healthcare partners. This may even take the shape of providing financial resources or assuming a leadership role in the partnership. Since this embodies an even more formal partnership structure and is more resource intensive, it is not unexpected that these two mechanisms of collaboration are less common. However, these types of relationships are more likely to be sustainable. The pattern found here follows the spectrum of foundational activities for HiAP outlined in Box 5 of ASTHO's HiAP Framework and implementation activities for HiAP adapted from the Policy Consensus Initiative model.[9]

In looking at the same types of collaboration with non-public health partners, over 90 percent of SHAs reported exchanging information with over six different agencies and 80 percent reported exchanging information with at least 12 other agencies and organizations. In terms of working on projects, all SHAs reported working together on projects with community-based organizations and higher education. Collaboration is also very common (over 80%) with primary/secondary schools, transportation, faith communities, other voluntary or nonprofit organizations, business, continuing education, and law enforcement.

When SHAs were asked whether any of the collaborations that they listed were formal partnerships, such as those governed by an MOU or other written agreement involving more than one sector outside of public health, a majority of SHAs (84%) reported being part of one or more formal partnerships. This is a very promising trend, given that formal partnerships are more likely to withstand changes in personnel and dedication of resources. Of those formal partnerships reported by SHAs, almost three-quarters reported that, in some cases, both their health objectives and targets have been specified and over 70 percent reported that the tools they will use to track and monitor progress with the partnership have been specified. This is also key to successful partnerships since they are outlining an evaluation plan for their collaboration.

HIAs

When asked about participation in an HIA training over the past two years, the percentage decreased between 2012 and 2016. This observation in the data may be due to a couple factors. One explanation could be that SHA staff who work on HIAs (if any) had already been trained and thus didn't require follow-up training. It is often said that the best way to understand an HIA is to do one, and SHAs reported a slight increase in the average number of HIAs in which they participated between 2012 and 2016. Another reason could be due to priority changes or funding cuts. Nationally, HIAs and associated training have not had a sustainable funding source, so there may have been fewer training opportunities since 2012. As noted above, Western states were more likely to have participated in an HIA training and have staff on an HIA advisory committee compared to their counterparts in the Mountain and Midwest regions. These differences may be due to more active HIA networks and training opportunities in the Western states, but ASTHO does not have data to verify this hypothesis.

Limitations

Data on collaboration was reported by SHA leadership. With the complex structure of SHAs and turnover over the years, it is possible that there were collaborative activities that took place in addition to those reported on the survey. In addition, new questions (e.g., nature of collaboration and participation in HIA advisory committee) were added to the 2016 survey, so there is no previous survey with which to compare the data and speculate on trends.

Next Steps

ASTHO continues to expand its resources related to HiAP and works with SHAs to monitor and analyze their collaborative efforts, documenting both the agencies with which they collaborate and the nature of this collaboration. Using data from the 2012 Profile Survey as the baseline, ASTHO will continue to compare the data with future survey results to highlight changes in SHA collaboration.

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