

A Guide to Local Government and Military Partnerships in Public Health



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**Center for Sharing
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Rethinking Boundaries for Better Health

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Executive Summary

Partnerships can be effective approaches to public health services at the local level, but should not be overlooked as opportunities for service improvement between local agencies and neighboring military bases. This guide reviews areas where communication, training, planning, and response can better serve the public health needs of community residents, active duty military, dependents, and civilian employees, while building enduring relationships of trust and collaboration between the base leadership and city/county management.

Introduction

Public health issues respect no jurisdictional boundaries, and that is particularly the case when discussing military communities. For despite the presence of perimeter fencing, most military installations maintain housing for their personnel both on base and within the surrounding area, and also engage with a significant civilian workforce who may commute from further away. In the case of San Antonio, for example, it is estimated that 80 percent of the 40,000 uniformed service members in the region live off base.

From a public health standpoint, a base's clientele is combination of these active duty and civilian staff, plus the family members and retirees who reside in base housing or make use of base services. Likewise, the city, county, regional, or state health departments that overlay that base footprint are concerned both for the health of all those individuals, as well as their neighbors in the wider community.

Aside from the populations served being so intertwined, the nature of public health services is such that issues on either side of the fence line may in fact have ripple impacts on the health of those throughout the area.

In general, it makes sense that the public health service providers would coordinate their provision of services as well as their outreach efforts, infectious disease monitoring, environmental health efforts, and emergency preparedness planning. The Center for State and Local Government Excellence (SLGE), has been researching such collaborations between city, county, and town governments through a series of [case studies on staff sharing](#).

In no way are such collaborations limited by the size of the jurisdictions. Partnerships discussed here range from those in Geary County, Kansas (pop. 34,000) to San Antonio, Texas (pop. 1.5 million). Instead, the driving factors may be the housing of active duty staff and their dependents in the off-base community, the degree to which the base has its own hospital or public health directorate, and the interest of the base and community leadership in a cooperative approach.

For those interested in pursuing such arrangements, SLGE also compiled a [checklist for staff sharing](#) consideration and communication with elected and appointed officials in the respective communities.

When discussing partnerships between local governments and military bases, the potential for direct sharing of staff may be more limited, considering not just the differences in local and federal personnel systems, but also the special security considerations involved in base operation or the legal proscriptions against a federal agency partnering with a local applicant in pursuing a federally funded grant. Regardless, there remain many avenues for close collaboration between these diverse units of government, particularly within their shared, very mission-driven concern for public health. This report details existing relationships between those local-military organizations and presents key considerations for others who might want to follow their lead.

Military Base Administrative Structure

Before entering into the mechanics of local-military partnerships, it is worth devoting some background discussion to how military base communities are operated. These installations are often described as city-like in their function, offering many of the same municipal-like services as their local government counterparts – including streets, utilities, facility maintenance, housing, social services, parks and recreation, libraries, and public safety.

Whereas a city or county might have a mayor/board chair and a manager/administrator, military installations' counterparts might include an active duty garrison commander and a civilian deputy (or deputy to the) garrison commander. Of these staff, the active duty individual would be responsible for the base as a whole, as well as all the “tenant commands” – operational units or functions housed on the base. Meanwhile, the deputy would be more likely to deal with the service delivery and infrastructure issues. In fact, the similarity of their responsibilities to those of local government managers has led to the development of an Army [professional development exchange program \(CP-29\)](#), which operates through a partnership with the International City/County Management Association (ICMA). This program embeds these civilian managers and local government staff in each other's organizations in order to gain a better understanding of their respective roles and opportunities for collaboration.

Among the earliest such collaborations have been those focused on public works services, such as pavement maintenance or traffic management systems. Permission to pursue local-military partnerships began with a pilot project involving Monterey, California, and the Army Presidio of Monterey, as included in the 1995 Defense Authorization Act.¹ That legislation has been expanded several times since, as has the range of potential partnerships. This has led to such agreements as a Joint Base San Antonio asphalt contract with the

city valued at \$120 million, with the goal of enabling more cost-effective provision of services, particularly where local expertise, staff, or equipment are available.

At the other end of the spectrum, some partnerships are so vast that they may include multiple surrounding jurisdictions to enable coordination on training, education, emergency planning, and process improvement – such as Fort Bragg has with nine surrounding counties and the University of North Carolina Gillings School of Global Public Health in Chapel Hill.²

Behind all such collaborations, however, is the challenge of turnover among the key stakeholders. Local government leaders are accustomed to turnover around election cycles, as city/county managers may be terminated, or as staff retire, but in the military, command staff generally rotate to another duty station every two years. And while civilian garrison staff do not move quite as often, they rotate to other bases as well. As a result, the partnerships developed between agencies need to be nurtured, codified, or woven into the culture of the organizations in order to endure.

Public Health Services

In considering what services might be coordinated between local and military agencies, it is important to look at the range of services that might be encompassed under public health. Traditionally, these services are often provided by a county, but they may also be provided by cities, special districts, or other agencies. For purposes of this report, we have focused on:

- Infectious diseases
- Environmental health
- Mass casualty preparation and response
- Wellness
- Support and administrative services

Infectious diseases

Response to infectious diseases is one of the clearest areas of partnership among agencies. Through standing agreements, many of them have a clear expectation that as there is a need to draw on the Strategic National Stockpile of medications, they can rely on their neighboring agencies as either a short-term source of the supplies that may be needed or a dependable partner that will restock any supplies used. As Col. John Melton of Fort Bragg indicated, there tends to be considerable leeway in such arrangements when they involve in-kind exchange of goods or services, while directly compensated service contracts tend to require more thorough vetting and approval. Perhaps just as importantly, coordination of such stocks keeps each local health department from needing to maintain excess supplies of pharmaceuticals that have a limited shelf life. Similar agreements for infectious disease pharmaceuticals are in place between Joint Base Lewis-McChord and Tacoma/Pierce County Public Health, and between other local government/military partners.

When a particular infectious disease becomes a matter of concern, the agencies often coordinate on planning or preparedness drills. Since the incidence of Ebola virus in 2014, the Sedgwick County, Kansas Department of Health has convened monthly partner meetings with other community stakeholders, which include McConnell Air Force Base. With the initial emergence of the COVID-19 virus, those meetings became more frequent.

A similar apparatus is in place in New York with the Army serving as the lead agency for the Fort Drum Regional Health Planning Organization, with Jefferson County participating in monthly meetings and health department nurses in at least daily contact with counterparts on base, and coordinating as appropriate on any required monitoring or quarantines.

This coordination is particularly relevant because many base employees or family members actually live within the surrounding communities, and quarantines or other controlled containment may take place within such private housing or in on-base facilities, depending

on the circumstances or severity of the case. At Fort Leavenworth, since there is no on-base hospital, the county is responsible for managing any quarantines – from the organization of related communications to actual supervision of those being monitored, whether they are located on or off base.

On a more routine basis, infectious disease testing and treatment tends to involve tuberculosis and sexually transmitted infections (STIs). For routine tests, patients often have a choice of which care provider to choose, typically either the local health department, an on-base hospital or clinic, or a provider within the military network (e.g., TRICARE). Stigma may be one consideration in the choice of care providers, as some active duty personnel may prefer to have testing performed at a non-military facility.

For those care providers in the military whose area of expertise is not epidemiology, partnerships with the local health department can provide valuable orientation. The City of San Antonio Health Department and Joint Base San Antonio have a memorandum of understanding that provides military nursing students a rotation within the city's clinics to familiarize themselves with care and management of those with infectious diseases. The city also serves as the key point of contact for on- and off-base rabies cases and worked with the military epidemiology staff to conduct a study on the extent of Chagas infection in the community.

From a prevention standpoint, immunizations may be offered by both military facilities and local health departments. But as Tammy Von Busch, Health Department Administrator of Geary County, Kansas indicated, if a particular immunization is in short supply, or if Fort Riley were to prioritize active-duty personnel, then civilians or family members may choose to come to a county clinic.

In terms of education and training, courses are often opened to attendees in nearby agencies. For example, both Jefferson County and Fort Drum open their trainings to each other, Sedgwick County's TB/STI program manager has taught on multiple subjects on McConnell Air Force Base,

and in San Antonio, joint training occurs at both on- and off-base facilities.

Vector and animal control also factor into infectious disease coordination. Sedgwick County and McConnell Air Force Base maintain separate mosquito monitoring and larvicidal dump programs, and while they do not share results on a routine basis, the countywide data is available to the base to plan its own response, and base data can also be shared upon request. If an on-base animal is suspected of carrying rabies, county personnel facilitate transport of that animal for testing. For both mosquitos and rabies, the Kansas state veterinarian also coordinates with all military bases in the state. In Washington, Joint Base Lewis-McChord works directly with Thurston County to provide all of its animal control services.

As Dr. John James of McDonald Army Health Center indicated, public health partnerships around infectious disease include not only shared notification of cases with local and state agencies and memoranda of understanding around the Strategic National Stockpile, but also inter-service partnerships (such as in the Tidewater area of Virginia between public health staff at Portsmouth Naval Hospital and Joint Base Langley-Eustis), and community partners such as the Eastern Virginia Health Care Coalition and the Peninsula Health District. Whether around Ebola, measles, or other recent infectious disease issues, Dr. James has found such collaborations to help provide consistent messaging to the community. In addition, he said, “Having a good relationship established allowed us to reach out to the epidemiologists locally and regionally for expertise and advice.”

Environmental health

Environmental concerns are another area that transcends the boundaries of base/community maps.

Water quality has been an area of partnership between the City of Dayton and Wright-Patterson Air Force Base. Although the base has its own water utility provider that’s separate from the city, the groundwater that underlays the area holds the potential

for contamination in one area to flow toward water wells in other areas. Discussion is ongoing around containment of chemicals such as PFAS (often found in airport firefighting foam). In early technical team meetings on this issue, the city and the base, “brought attorneys from both sides, and that was a self-fulfilling prophesy [for gridlock],” said City Manager Shelley Dickstein. To move beyond that, she and her counterpart, Col. Thomas Sherman, have committed to working transparently – sharing data, hydrology studies, and cell phone numbers – and setting a problem-solving tone for their teams that has enabled real progress. While the federal standards call for remedial action *after* contamination exceeds allowable limits, the city and the base personnel are working together to address the issues before such thresholds are reached, achieve short-term successes, and put in place a multiyear action plan.

At Fort Bragg, the base and local health departments also coordinate around air quality and hearing conservation – sharing industrial hygiene best practices relevant for those on or near flight lines or other industrial uses.

The inspection of housing for potential contamination from lead-based paint has become less of a direct concern for the military as on-base housing is now often managed by private contractors. However, Fort Bragg also found this to be an opportunity for coordination, as they leveraged relationships with local agencies to provide their staff with the training and certifications necessary to inspect that base housing and ensure the contractors were adhering to standards. Fort Belvoir works directly with the state of Virginia to certify the base’s inspectors to assess housing for mold.

At Fort Riley, the schools on base are administered by the local school district, so the Geary County environmentalist performs inspections of those facilities.

Food inspections tend to be handled by each jurisdiction, but sometimes they cross into each other’s territory. For instance, where food truck services or caterers may be serving food on base, Joint Base Lewis-McChord veterinary staff, who are responsible

for food inspections, would go to the off-base sites of food preparation to conduct inspections. This could be an area where future coordination might eliminate duplicate inspections of the same businesses.

Mass casualty preparation and response

The grounding for most mass casualty response is the mutual aid relationship that typically exists between the base and the local fire/EMS service. Such agreements open the door to ongoing discussions, tabletop or community-wide exercises, or more programmatic connections.

Beyond advance planning discussions, emergency management coordination among public health providers also carries with it an understanding, as Norfolk Deputy City Manager Michael Goldsmith indicated, that as the military base personnel are required to turn their attention to the nation's warfighting capability, the local authorities are prepared to look after the public health needs of their dependents, regardless of whether they live on or off base.

In Leavenworth County, Kansas, such coordination is accomplished by the regular interaction between Fort Leavenworth personnel and the director of the health department – a former emergency manager for the installation.

Having already conducted standup exercises with the surrounding counties and performed legal reviews, Fort Bragg is prepared for emergency sharing of supplies and equipment as needed.

In Jefferson County, New York, morgue capacity is limited, so as part of the county's emergency operations planning, they signed a memorandum of understanding with Fort Drum so that during a mass casualty event, the county medical examiner may make use of the fort's cold storage facility as an additional morgue location. This MOU was approved in 2014 and has since been extended through 2027. By entering into a long-term agreement, the two jurisdictions built predictability into what might otherwise be a haphazard and ad hoc response to events.

Joint Base Lewis-McChord also has memoranda of understanding in place to work with the coroners in both Pierce and Thurston Counties.

Wellness

Cumberland County, North Carolina is currently working to expand its WIC nutrition program to a location on Fort Bragg, to provide greater convenience to program beneficiaries at their place of employment, even if they live off base. The two jurisdictions also partner on childhood obesity initiatives.

As Col. Melton noted, relationships with the various county health departments and faith-based groups with which they partner for programs on pregnancy and well-child nutrition, substance abuse, sexual assault, and suicidal/homicidal ideation vary by local economics and resources. But most importantly, their goals remain aligned. Partnerships are welcome, because "nobody looks at us as a competitor."

Smoking cessation programs are being pursued both by base staff and local partners, but there can be limitations on how involved a military partner can be in an off-base program. The Joint Base San Antonio leadership were very helpful, said Juan Ayala, the city's Director of the Office of Military and Veteran Affairs. "While they couldn't take an official position around the Tobacco 21 initiative, they did help us connect with some veterans groups who could advocate [the importance of quitting]," said Ayala. Metro health staff were also allowed to go on base to share educational content with base personnel.

Another area that Joint Base San Antonio has cooperated with the city, county, and courts has been around domestic violence, with a collaborative commission meeting monthly to address this key priority area among a large pool of young, mostly married personnel.

At Fort Riley, the Geary County Health Department participated in an on-base safety fair in 2018, providing information on insect-borne diseases, limiting mosquito habitat, and ensuring proper installation of car seats.

Support and administrative services

Local governments that engage effectively with their base communities often do so via designation of a formal liaison. These may simply be the assignment of a new duty to an existing staff member or the hiring of a new individual who has a military background. Examples of the latter model include Retired Marine Corps Major Gen. Juan Ayala, liaison for the city of San Antonio, Texas, and Retired Navy Capt. Len Remias, liaison for the city of Norfolk, Virginia. Regardless of the type or level of liaison assigned, such an individual has the ability to foster ongoing relationships between the local government and the base community, and thus facilitate programmatic linkages as proposals arise.

More generally, whether former military staff will work in a liaison role or another capacity, Columbus, Georgia, views them as a key source of skilled staffing to fill essential vacancies and meets regularly with those who are separating from service. This was the case when a staff member retiring from Fort Benning with extensive experience in wastewater and environmental management was hired to be the city/county government's Assistant Director of Public Works.

Site tours can also contribute to familiarity both with each other's personnel and facilities. Sedgwick County staff were recently able to tour both McConnell Air Force Base and the base medical clinic. At Joint Base Langley-Eustis, personnel were able to take advantage of a similar tour of Newport News' water and wastewater facilities. While the fort and city water systems are separate, such peer exchange can be helpful both in local service provision and in informing the water treatment activities those military personnel might be involved in when on deployment. In San Antonio, those operational tours are mobile, with military doctors participating in ride-alongs with city EMS ambulances.

Technology also plays a role in public health collaboration, with off-the-shelf software like Tableau or more specialized systems like the CDC's Essence Platform, the North Carolina Electronic Disease Surveillance System (NCEDSS), or the Washington state

immunization information system, each facilitating the mapping or analysis of public health issues, resources, or related community metrics. Where direct technology linkages are not in place, such as with Fort Bragg and NCEDSS, Cumberland County enters the fort's communicable disease data. Still to be addressed are areas where technology may not be compatible or there may be limits on direct linkages for cybersecurity reasons. For example, in Geary County, the regional IRIS referral system for early childhood care allows for electronic communication between area public health, mental health, emergency rooms, and other agencies, but Fort Riley is not currently a participant in that system, so any information sent to the base must be communicated via phone, mail, or fax.

Through a Washington state prescription database, military providers on Joint Base Lewis-McChord/Madigan Army Medical Center can also determine whether a patient they're seeing has had an order for opioids filled through an off-post provider so that such medications are not double-prescribed.

In most cases, those interviewed indicated that laboratory services between the local public health agencies and the military bases remained separate. One exception was in San Antonio where the Metro Health Department did coordinate lab tests during a *Legionella* outbreak, as well as some measles testing.

One area that remains mostly separate is record keeping. Even with electronic medical records, HIPPA requirements and separate database systems mean that local government authorities do not have access, for example, to immunization records that are maintained by the military. Only if there is an identified exposure do the two systems communicate to ensure appropriate tracking or follow-up.

Community Health Improvement Plans (CHIPs) are another avenue for potential partnership, with each of the local/military stakeholders potentially contributing to the development of those documents. On a practical level, however, none of those interviewed as part of this project indicated an active collaboration in that planning process.

But despite that CHIP path not being taken, another that is being pursued is accreditation. The Public

Health Accreditation Board (PHAB) was originally launched to accredit local, state, tribal, and territorial public health departments. In 2014 the U.S. Army Medical Command expressed an interest in using the standards and measures of the accreditation process to improve their operations, including criteria related to collaboration with state and local agencies around service capacity or sharing of resources, as well as interagency communication around response to health risks.³

In 2019, Fort Riley became the first army base to achieve accreditation, with Fort Bragg becoming accredited in 2020 and additional bases already in the pipeline for consideration and more planned over a five-year implementation schedule. The criteria remain fairly consistent with those used for local agency accreditation, but as Jessica Kronstadt, Director of Research and Evaluation of PHAB indicated, there has been some adjustment required in making sure each party understands the others' terminology, jargon, and acronyms.⁴ "Our hope with these measures is that they encourage coordination," said Kronstadt.

Future partnerships

Special events are one area where there's been an interest expressed in partnering more closely – for instance setting up an information table at a health fair, air show, or other on-base gathering.

Sedgwick County Animal Control Supervisor Nika Orebaugh expressed an interest in greater coordination on monitoring the dogs that run on and off the base property and military housing neighborhoods.

In the Tidewater area of Virginia, Dr. James also indicated room for additional coordination around animal control – specifically bite reports. With such a range of medical providers available, both in the community and on the various army, air force, and navy installations, communication is not as seamless as it could be.

Results

It is difficult to put a price tag on the partnerships outlined above, as most involve staff hours dedicated to interagency committees (often monthly or quarterly) or which revolve around specific events, such as mass casualty drills, exposure tracking, or health fairs.

The more important result highlighted by those interviewed is the benefit gained from building relationships between the military and civilian agencies so that when there is program-based or emergent need for coordination, there is not a scramble to update contact lists, negotiate agreements from square one, or identify areas of overlaps or gaps in service.

Across all the disciplines discussed above, military-local public health partnerships accomplish more than meeting the needs of the individual patients served or fostering the health of the larger community. They also serve to enable the military installation to focus on its core missions, while making most efficient use of local expertise. And just as infrastructure maintenance and services contracting grew out of the Base Realignment and Closure (BRAC) process, these public health partnerships help to improve the value of the base, which in turn contributes to the region's economic vitality.

Lessons Learned

Among the broad advice those interviewed would offer to others considering a local-military public health partnership are the following steps:

<p>Communicate</p> <p>Maintain open lines of communication between agencies to ensure that when a need arises, the contact lists are up-to-date, and people are already aware of their counterparts' programs and available resources. These lines of communication are relational, not necessarily flowing from organizational charts, and may also include other DOD installations, faith-based or community groups, and private health care providers.</p>	<p>Build Trust</p> <p>Drive a culture of cooperation via the top leadership in each organization or designated liaisons. Additionally, trust can be built through a shared sense of values, whether in the public health mission or in the recognition of the intertwined nature of the military-local government community.</p>	<p>Lay the Groundwork</p> <p>Achieve small victories, whether by exploring preliminary legal frameworks, adopting mutual aid agreements, enacting or practicing emergency operations plans, or finding ways to share specialized expertise.</p>	<p>Train Together</p> <p>Invite personnel from the other jurisdictions to participate in training, or schedule ride-alongs and facility tours.</p>
<p>Think Big</p> <p>Consider the benefits of regional collaborations with county, city, and other stakeholders. A military-civilian partnership does not need to involve just one local government or one base.</p>	<p>Pursue Accreditation</p> <p>Work with national accreditation agencies to explore both the accreditation itself, but more importantly, the focus on process improvement, collaboration, standards, and metrics that are integral to being considered for accreditation.</p>	<p>Speak the Same Language</p> <p>Learn those acronyms. Also, since local and federal bureaucracies differ so significantly, educate each other on the expected processes and timelines for action.</p>	<p>Plan for Continuity</p> <p>Know the names, phone numbers, cell numbers, and e-mails for each key functional area, as well as the rotation dates for current staff and the onboarding schedules for their successors. Plan for how you will maintain the partnerships you implement now over the next 3-5 years.</p>

In addition to that list, it is also worth keeping an open mind about the nature of your public health constituency. This is not limited to the local residents, homeowners, or even those who commute into the downtown business district. It does not align to your terms of office or the local district's school year. Personnel rotate in and out of base communities

via permanent change of station orders, shorter-term deployments, family relocations, and even the contract life-cycle for civilian-led projects on base. And with those fluctuations, the two overlapping populations can have significant positive and negative impacts on the health not only of each other but of other communities in the state and around the world.

Additional Resources:

[Case Studies in Staff Sharing in Local Public Health](#), SLGE, April 2019.

[Staff Sharing in Public Health: A Checklist for Communicating with Elected and Appointed Officials](#), SLGE, December 2018.

[Staff Sharing Arrangements for Local Public Health](#), SLGE, November 2017.

Interviews:

SLGE thanks the following for their assistance with this research:

City of Dayton, Ohio (pop. 141,000):

Shelley Dickstein, City Manager

City of Fayetteville, North Carolina (pop. 209,000):

Angel Wright-Lanier, Assistant City Manager

City of Minot, North Dakota (pop. 47,000):

Kelli Kronschnabel, Fire Chief

City of Norfolk, Virginia (pop. 244,000):

Michael Goldsmith, Deputy City Manager, and Retired Navy Capt. Leonard Remias, Military Affairs Liaison

City of Oceanside, California (pop. 176,000):

Deanna Lorson, City Manager

City of San Antonio, Texas (pop. 1.5 million): Retired Marine Corps Major Gen. Juan Ayala, Director, Office of Military and Veteran Affairs; Colleen Bridger, Assistant City Manager; Caitlin Krobot, Special Projects Manager; Dr. Anita K. Kurian, Assistant Director, Metro Health District, Communicable Disease Division; John Peterek, Assistant to the City Manager; Erik Walsh, City Manager

Columbus Consolidated Government, Georgia (pop. 194,000):

Reather D. Hollowell, Human Resources Director

County of Cumberland, North Carolina (pop. 332,000):

Dr. Jennifer Green, Health Director; Dr. Lori Haigler, Health Department Medical Director; Duane Holder, Deputy County Manager; Krystle Vinson, Health Department Director of Nursing

County of Geary, Kansas (pop. 33,000):

Dr. Tammy A. Von Busch, Health Department Administrator

County of Jefferson, New York (pop. 112,000):

Robert Hagemann, County Administrator, and Ginger Hall, Public Health Director

County of Sedgwick, Kansas (pop. 514,000):

Christine Steward, Deputy Health Director; Kaylee Hervey, Epidemiology Manager; Adrienne Byrne, Public Health Department Director; Nika Orebaugh, Animal Control Supervisor; and John Lucero, Tuberculosis and Sexually Transmitted Infection Program Manager

Fort Belvoir, Virginia (2,500 active duty):

Dr. John M. Moeller, Deputy to the Garrison Commander

Fort Bragg, North Carolina (52,000 active duty):

Col. John J. Melton, Commander - Womack Army Medical Center

Fort Hood, Texas (50,000 active duty):

Keith M. Gogas, Deputy to the Garrison Commander

Fort Leavenworth, Kansas (5,400 active duty):

John T. Hughes, Acting Director, Installation Management Command-Training

ICMA:

Rob Carty, Director of Career Services and Next Generation Initiatives

Joint Base Langley-Eustis, Virginia (8,000 active duty):

McDonald Army Medical Center - Lt. Col. Jason B. Faulkenberry, Commander, and Dr. John F. James

Joint Base Lewis-McChord, Washington (40,000 active duty):

Julie Martin, Chief, TRICARE Operations Branch, Managed Care Division, Madigan Army Medical Center; Kristen Orcutt, Agreements Manager JBLM Garrison; Helen Swan, Management Analyst, Resource Management Division, Madigan Army Medical Center Support Agreements Manager; Melanie Wilczek, Management and Program Analyst, Army Community Partnership.

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Public Health Accreditation Board:

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John M. Burt, Town Manager

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Endnotes

- 1 For more information on the Monterey Partnership, see *The Presidio of Monterey Partnership*, available at https://monterey.org/Portals/0/TheMontereyModel/Literature/RR1419_Appendix.pdf.
- 2 This Fort Bragg regional partnership started in 2018 and includes monthly meetings with the partner agencies.
- 3 John J. Melton, MSC, USA, Lauren A. Shirey, Evelyn M. Barraza, MC, USA, (Ret.), Steven H. Bullock, SP, USA, (Ret.), "Public Health Accreditation of Army Preventive Medicine Departments: Improving Military Medical Treatment Facility Practice to Impact Force Readiness," *Military Medicine* 184, no. 5-6 (2019): 117–121. Available at: <https://academic.oup.com/milmed/article/184/5-6/117/5194151>
- 4 Here are the Public Health Accreditation Board standards and measures for state/local/tribal health departments: https://phaboard.org/wp-content/uploads/PHABSM_WEB_LR1-1.pdf. While similar, the U.S. Army standards are here: https://www.phaboard.org/wp-content/uploads/PHAB_Army-Standards-Measures-V.1.5.pdf

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About the Center for State and Local Government Excellence

The Center for State and Local Government Excellence (SLGE) helps local and state governments become knowledgeable and competitive employers so they can attract and retain a talented and committed workforce. SLGE identifies leading practices and conducts research on public retirement plans, health and wellness benefits, workforce demographics and skill set needs, and labor force development. SLGE brings state and local leaders together with respected researchers. Access all SLGE publications and sign up for its newsletter at slge.org and follow @4govtexcellence on Twitter.



About the Center for Sharing Public Health Service

The Center for Sharing Public Health Services helps communities learn how to work across jurisdictional boundaries to deliver public health services. The Center serves as a national resource on cross-jurisdictional sharing (CJS), building the evidence and producing and disseminating tools, methods and models to assist public health agencies and policymakers as they consider and adopt CJS approaches. The Center is funded by the Robert Wood Johnson Foundation and is managed by the Kansas Health Institute.

