INTRODUCTION

The Center for Sharing Public Health Services visited the Shared Services Learning Community site in Northern Nevada on December 9 to 10, 2014. This *Site Visit Report* documents the activities from the site visit as well as some of the Center's observations.

The report includes a lengthy *Background* section for those not familiar with the partnership. For those familiar with the partnership, go directly to the *Observations* section, which starts on page 4.

BACKGROUND

About the Center

The Center for Sharing Public Health Services helps communities learn how to work across jurisdictional boundaries to deliver essential 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.

Building Evidence: One way the Center builds evidence is by working closely with a Shared Services Learning Community (SSLC), made up of demonstration projects in several states that encompass a diverse spectrum of CJS initiatives, from small-scale initiatives to full consolidation of health departments. The Center provides technical assistance and a forum that allows these communities to share lessons learned with each other and the Center. In return, the SSLC acts as a learning laboratory by providing real world experiences that the Center collects and analyzes and shares with the nation.

Producing and disseminating tools, methods and models: The experiences of the SSLC, along with other research and expert opinions, provide the knowledge and insight the Center needs to provide tools and assistance to any community or group of communities considering CJS arrangements.

The Center for Sharing Public Health Services is a national initiative managed by the Kansas Health Institute with support from the Robert Wood Johnson Foundation.

About Northern Nevada

One urban county and seven rural counties make up this demonstration site. The urban county, Washoe, is home to the city of Reno. That county has its own public health agency, which is one of only three local public health agencies in the state. The rest of the counties involved are legally obligated to have a board of health and a health officer but not a health department. In those counties some public health services are provided by the Nevada Division of Public and Behavioral Health (NDPBH). Counties are assessed a fee for those services.

A list of the counties that participate in this demonstration site is listed below, along with their 2013 population and the percent of people who live below the federal poverty level.

- Churchill County, 24,063 population, 13.1 percent of people live below the federal poverty level
- Elko County, 52,384 population, 7.8 percent of people live below the federal poverty level
- Eureka County, 2,076 population, 14.9 percent of people live below the federal poverty level
- Humboldt County, 17,363 population, 12.7 percent of people live below the federal poverty level
- Lander County, 6,032 population, 11.8 percent of people live below the federal poverty level
- Pershing County, 6,877 population, 17.3 percent of people live below the federal poverty level
- Washoe County, 433,731 population, 14.7 percent of people live below the federal poverty level
- White Pine County, 10,057 population, 13.9 percent of people live below the federal poverty level

About the CJS Project

Joe Iser, former health officer of Washoe County Health District, originally led this effort. He left the health department part way through the effort and Randall Todd, Director of Epidemiology and Public Health Preparedness at Washoe County Health District, took over the lead role.

The original goal of the demonstration site was to determine whether a CJS approach could be developed and implemented that would improve the efficiency and effectiveness of the region's public health service delivery. The project team developed a public health inventory questionnaire and a public health service gaps and priorities questionnaire. They originally expected to prepare a baseline report describing public health services offered in each jurisdiction, public health funding, infrastructure capacity in each county, and stakeholder perceptions. The team then planned to assess gaps in services and determine if they could be filled through a CJS arrangement, with Washoe County providing most of the needed services. They planned to recommend CJS models, an implementation strategy and a sustainable funding approach.

SITE VISIT

Participants

The host team included:

- Randall Todd, Director or Epidemiology and Public Health Preparedness at the Washoe County Health District (Team Lead)
- Kevin Dick, District Health Officer, at the Washoe County Health District (Project Director)
- John Packham, Director of Health Policy Research, Office of Rural Health, University of Nevada-Reno

Other participants included:

- Gerald Ackerman, University of Nevada School of Medicine Outreach Office
- Joe Pollock, Public Health Engineer and Program Manager for Environmental Health Section at Nevada Division of Public and Behavioral Health

- Mary Wherry, Deputy Administrator with the State of Nevada Department of Health and Human Services
- Danika Williams, Rural Epidemiologist and Preparedness Coordinator, Nevada Division of Public and Behavioral Health
- Robin Williams, Manager of Developmental Service with the State of Nevada Health and Human Services

Churchill County:

- Wade Carner, Churchill County Civil Deputy District Attorney
- Shannon Ernst, Social Services Department Director
- Carl Erquaiga, Churchill County Commissioner, member Churchill County Board of Health
- Rose Lorentzen, Public Health Nurse, State of Nevada Public Health Nurse (Churchill County Office)
- Tedd McDonald, Churchill Health Officer
- Pam Moore, Churchill County Clerk of the Board
- Bus Scharmann, Churchill County Commissioner, Chair Churchill County Board of Health
- Hoyt Skabelund, CEO, Banner Churchill Community Hospital
- Ben Trotter, Churchill County Sherriff, member Churchill County Board of Health
- Stephanie Utz, RN, Churchill County School District
- Andrea Zeller, Director, Churchill Community Coalition
- Eleanor Lockwood, County Manager
- Sue Chambers, Manager of Special Programs and Board Chair for Churchill Community Coalition

Clark County:

- Dr. Joe Iser, Director of Southern Nevada Health District

Elko County:

- Mary Headley, School Nurse at Elko County School District
- Ray Langer, School Nurse at Elko County School District
- Cash Minor, CFO/Comptroller of Elko County

Lander County:

- Philip Hanna, CEO, Battle Mountain General Hospital

Lincoln County:

- Antoinette Acuff, Director of Human Services for Lincoln County
- Elaine Zimmerman, Grants Administrator for Lincoln County

Visitors from two other Shared Services Learning Community Site attended the site visit:

- Carson City / Douglas County, Nevada
  - Marena Works, Deputy City Administrator
  - Nicki Aaker, Carson City Health and Human Services Director
  - Dustin Boothe, Cason City Environmental Health Director
- Project Smile North Carolina:
  - Merle Green, Program Manager, Guilford County Health Department
  - Janie Woodie, Dental Director for Cabarrus County

Two representatives from the Center for Sharing Public Health Services facilitated the site visit:

- Patrick M. Libbey, Center Co-Director
- Gianfranco Pezzino, Center Co-Director

Site Visit Activities

On Tuesday, December 9, 2014, the team drove to Fallon, Nevada, the Churchill County seat. Center staff provided an overview of the Center and of CJS in general. The project team lead and others provided an overview of the Northern Nevada effort, its original intent and the changes that have occurred over the duration of the initiative. It was noted that while all the counties had been involved in the survey work it did not appear that pursuing a CJS relationship involving all counties was feasible at that time. Instead, the initiative focused its time and attention on assisting the Churchill County Board of Health in better fulfilling its role in developing a local public health presence within the county.

This was followed by a facilitated discussion with all of the attendees about the role of public health, and a discussion about CJS. They then talked about the Churchill County experience specifically including what sparked their interest in having a more active board of health. They also had a discussion with Carson City representatives about their experiences with CJS. That was followed by a Churchill County Board of Health meeting.

The following day, the team met at the Airport Plaza Hotel for a debriefing with the host team. The Washoe County Health District Health Officer was not able to attend, however Dr. Joe Iser did participate in the debriefing.

OBSERVATIONS

Site visits provide a valuable learning opportunity, both for the Center staff and for the participants. There is only so much information the Center can gather from reports or phone calls. Meeting with people in their actual environment completes the picture and contributes to a better understanding of the project.

Some observations gleaned by the Center as a result of participating in the site visit are listed below.

State law incentivizes CJS, but health officials at the state level are reluctant to support it.

In 2011, Nevada passed legislation that requires counties to pay an assessment to NDPBH for the provision of certain services. However, counties can provide their own services or purchase services elsewhere (e.g., from another county) and be exempted from the assessment if they receive approval from the governor and the interim finance committee of the state legislature. Some counties, wanting better services and/or lower costs, began to consider CJS arrangements as a result of this new legislation.

By law, every county in the state must have a board of health and a health officer. Over time, however, many boards of health have become dormant, especially in rural areas, where the state provides some public health services — mostly environmental health services and public health nursing. In these areas, there is not a management role for the boards of health to fill.

NDPBH seems to agree, in principle, with some counties' desires to build their own public health capacity. In practice, however, NDPBH may be reluctant to support it. Nevada is a large, sparsely populated state, with the majority of its population centered in three counties. It would be difficult for the state to provide economical services in the smallest counties if the larger non-urban counties decided to step out of the state system. If that would happen, overhead costs of the state would shift to the counties left depending on the state. Those rural counties have fewer people and fewer resources. The state system could become unsustainable, unless they raise the levy on the remaining counties. Smaller counties might not be able to pay an increased assessment, but also might not be able to provide services on their own.

Clear rules of governance are not established for all partners — state, local and district. Until they are established, CJS initiatives there will be difficult to initiate.

This site is pre-exploratory on the Roadmap.

As an initial step in their process, the team met with the seven most rural counties. They found that most of the counties had a very rudimentary and fragmented public health system and that local leadership often did not have a thorough understanding of the role of public health. Several of the counties did not have an appointed health officer. Only two counties regularly convened their local boards of health — Washoe and Churchill. The CJS team realized that, without an understanding of public health in general, CJS would be difficult in these areas.

They also found that counties in the initiative are not dissatisfied, for the most part, with the services they receive from the state, possibly because they did not know what services they should expect.

Ultimately, they found there was not a sense of mutual benefit among the partners. Mutual benefit is essential in CJS work.

As one team member put it, this demonstration site is not even *on* the *Roadmap to Develop Cross-Jurisdictional Sharing Initiatives*, which is the Center's guide for jurisdictions considering or adopting CJS

approaches. They are in a pre-exploration or a pre-contemplation stage. It is unclear when CJS will become a tool that will benefit them.

The team shifted focus and discussed public health in general with some counties in their initiative.

The team realized the region was not ready for discussions about CJS, so they shifted their focus and discussed public health in general with some counties.

They concentrated on Churchill County, the jurisdiction best poised to revitalize its board of health and engage in public health activities. The team provided a dashboard to assist Churchill County in understanding the health of their population. They hoped by setting an example in Churchill County, the other counties would want to engage their boards of health and would discuss how to use local data to engage leadership within their own communities.

Churchill County's interest in revitalizing their board of health was not driven by dissatisfaction with state services. Instead, they want to take a more active role in the health of their community and to build ownership for public health there. The Churchill County Board of Health is not focused on service management, but on health conditions. Recent experiences with disease clusters served to heighten this focus. There are strong champions in key leadership positions. One member of the Churchill County Board of Health, Bus Scharmann, is providing strong leadership and positioning the Board to take a leadership position by proactively engaging the community in health related matters. The county Health Officer, Dr. Ted McDonald, is effectively integrating his public health role with his overall health care role and credibility within the community. And Shannon Ernst, the county's Social Services Department Director, also serves as staff on the Board of Health. She is highly organized and extremely well connected within the county greatly benefitting the Board's work and development. There is trust and good interpersonal relationships among the board members. It is speculated that because the Board of Health is not responsible for managing services and contracts, it is able to pay greater attention to community development and coalition work.

The Churchill County Board of Health has focused heavily on individual clinical services. Churchill County and the local hospital are considering engaging in Community Health Assessment (CHA) using the MAPP model.

Other counties present at the site visit are further developing their boards of health and are open to listening about CJS, but seem uncertain about whether it provides a value-add over the status quo.

The Office of Rural Health plans to support the emerging role of public health.

Going forward, there could be a number of grants coming out of the Office of Rural Health to support the emerging role of public health. There was talk of developing a state association of local health officers that would involve rural health officers, then creating a venue for them to meet virtually. The Nevada Association of Counties could also possibly provide a venue for health officers to meet.

More observations:

- It will be difficult for Washoe County to continue this work with a large group of counties over such a large geographical area, especially in the absence of grant funding.
- The state may want to consider broad systems development instead of supporting individual counties on an ad hoc basis.
- In a public health development sense, it is important for the boards of health in the initiative to understand their responsibilities before moving into the management of services.
- The CHA could be an opportunity to rebalance Churchill County's focus, so that public health receives as much attention as individual health services.
- Churchill County should make sure they do not completely turn over ownership of the CHA to a contractor. The CHA is a great opportunity to engage and educate the community about public health issues.

LESSONS LEARNED

Consideration of CJS is probably premature in systems or situations where the jurisdictions involved do not have public health service delivery responsibilities. In such instances developing a sense of public health role and responsibility at the local level needs to precede service management strategies such as CJS.

Geographic scope (distance and time) needs to be carefully considered both for purposes of feasibility. Too large an area makes service delivery inefficient and difficult and often lacks any sense of shared identity.

SELECTED COMMENTS AND QUOTES FROM THE SITE VISIT AND FOLLOW-UP EVALUATIONS

Shortly after the visit, the Center sent out an electronic evaluation. The comments below came from the site team and the site visitors via the evaluations.

Q: Please describe what you learned as a result of participating in the site visit:

> *I learned that sharing services is a workable concept and collaborations are already developing as a result of this effort.*
>
> *I understood shared services and progress taking place in Churchill County. I could see a functioning board that would work in rural Nevada.*
>
> *It confirmed the need for cross-jurisdiction cooperation.*
>
> *I learned that Churchill County is moving in the right direction. In fact, I was very pleased with the work of those in our county who have helped to identify public health needs and priorities.*

I found the information very helpful. We are hoping to either share services with another county in Nevada or get a Public Health Nurse in Elko County.

Public Health is seen very differently within different states and you really need to find a "special champion" to head up the efforts to pursue and achieve any movements in local county or district public health.

Q: What did you find valuable about hosting the site visit?

The valuable input from participants.

The opportunity to reflect and share.

I particularly enjoyed the interaction from the visitors and leaders of the visiting team. Their insight into what is happening nationwide was very helpful.

Q. What did you find valuable about participating as a peer site visitor?

Hearing the different philosophies (sometimes political) behind what some folks really feel public health is about was very interesting.

Q. What is your advice to the Center as we plan future site visits?

Insert federal citations. It's helpful to use examples from other states. The challenge is that every state is so unique, e.g., we say that if you've seen one Medicaid program, you've seen one Medicaid program. Each state has such different eligibility rules and different services as well as financing strategies that without knowing what the CFR allows, the applicability may not be relevant.

More discussion on state-county shared models.

Q. What is your advice to the other teams that host site visits?

Listen to peer site visitors. Their perceptions of what the host people may be saying might provide some insight that the host people can't really see because they have been entrenched in their environment for so long.

Plan ahead. Get the involvement of many agencies and services in your community before the site visit becomes a reality. Our subcommittee did a great job included various agencies so that their final determination to focus on the mental health of our community was extremely valid.

Be open, honest and unafraid of allowing others to see your strengths and challenges.