Minnesota Shared Services Learning Collaborative

Evaluation Report
February 2013-January 2015

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This evaluation would not be possible without the participation of Minnesota's local public health directors and CHS administrators who participated in the Shared Services Learning Collaborative and in the evaluation activities.

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Executive Summary

Minnesota's (MN) public health system is a strong and reciprocal state-local partnership. It is a coordinated, decentralized system made up of the Minnesota Department of Health (MDH) and 48 Community Health Boards (CHBs) that govern one or more of the state's 71 local health departments (LHDs). About two-thirds of MN counties are a part of a multi-county CHB. Chapter 145A of MN Statute provides the legal framework for MN's local public health system and outlines the support and coordination responsibilities of MDH. Chapter 145A offers significant flexibility to local jurisdictions regarding governance and organizational structure, and a substantial decision-making role in assessing the health of the community and determining ways to meet locally identified needs.

The Minnesota Shared Services Learning Collaborative (MN SSLC) involved four Level 1 projects and seven Level 2 projects, comprised of CHBs serving 25 counties. Level 1 Partners were currently implementing shared services arrangements in their jurisdictions at the beginning of this project. Most Level 2 Partners were in the earlier stages of cross-jurisdictional sharing (CJS) and participated in this mini-collaborative by exploring CJS options for their jurisdictions. MDH coordinated and implemented the MN mini-collaborative, which included quarterly collaborative meetings, provision of technical assistance to Level 1 and Level 2 partners, project management and oversight, and connections to resources and other best practices being used across other states and local jurisdictions.

The MN SSLC evaluation is comprised of a pre- and post-assessment, which Level 1 and Level 2 partners completed. In addition, MDH staff conducted semi-structured, qualitative interviews with participants to obtain greater detail than can be obtained from quantitative measures. Overall, the evaluation was aimed at identifying factors that contributed to success of these projects; measuring the extent to which specific projects reached their goals; and evaluating the effectiveness of MDH technical assistance and support.

The results of the pre- and post- assessment indicate that progress was made by partners. Twenty-seven out of a potential 28 respondents completed the pre-assessment in June/July 2013 (96% response rate). Due to staffing changes through the course of the project, the respondents for the post-assessment were not necessarily the same people who completed the pre-assessment, although they represented the same partner CHBs. Thirty-four potential respondents were identified to take the post-assessment, of which 29 completed the survey (85% response rate). Some key areas where partners reported progress included:

- The percent of respondents reporting they had clearly defined roles/responsibilities of CJS partners increased from 52% in the pre-assessment to 76% in the post-assessment.

- The percent of respondents reporting they identified a policymaker champion to promote CJS efforts increased from 48% to 72%.
- All respondents (100%) reported that they had identified areas that might be best-suited for CJS efforts, up from 82% in the pre-assessment. Emergency preparedness, the Community Health Assessment and Strategic planning remained the most-commonly identified areas considered for CJS (same in both the pre-assessment and post-assessment).

Key findings from the interviews included:

- Minnesota's model of regional nurse consultants, who provide tailored technical support to local health departments within their assigned regions, was invaluable to the success of many of these projects.
- While not all partnerships experienced actual governance or programmatic changes, all expressed that they had tangible long-term effects that resulted from this work.
- CJS isn't always appropriate. Participants felt that sometimes jurisdictions did not have comparable goals or visions that would suit them to CJS. This can relate to jurisdictional culture or significant differences in populations served.

Respondents had key lessons learned and advice for others exploring CJS. Overwhelmingly, respondents spoke of the importance of navigating the change with all staff and not rushing the process. Another frequently-mentioned strategy was the use of a strong project management framework to guide the work and adhere to timelines. The Roadmap Questions developed by the Center for Public Health Sharing were mentioned as particularly useful.

"It's a lot of work…well worth it, but a lot of work and time."

"Take the time for staff to reflect."

"Really, when you look back, so much of what we did we would do again."

Taken together, the results of the evaluation components suggest that the implementation of CJS in MN, via the MN SSLC, was very effective. One reason for this success may have been MN's ability to leverage multiple sources of funding to support a collaborative that had multiple partners and different stages in the process. Local partners also highlighted several factors that contributed to their success, as well as local realities that either worked to support or hinder their progress. All of the main project goals were met. In addition, MDH's goal of learning about when CJS arrangements might be most appropriate and effective was accomplished through the qualitative interviews.

Project Goals

<u>Goal 1:</u> Each Level 1 partner achieves its two year goals and objectives
<u>Goal 1 Measures of Success:</u>

1) All Level 1 partners document progress and achievement of goals/ objectives.
2) MDH staff documents the number of staff hours of technical assistance provided to support Level 1 partners.

<u>Goal 2:</u> Implement a systematic, statewide approach to CJS.
<u>Goal 2 Measures of Success:</u>

1) CJS arrangements successfully implemented in at least three local jurisdictions.
2) Level 2 partners advance along the CJS continuum during the grant period, as measured by the RWJF Guided Questions Tool.
3) CJS related measures are identified for future reporting in PPMRS.

<u>Goal 3:</u> Foster a two-way exchange of information on CJS between the national community and Minnesota's local public health system.
<u>Goal 3 Measures of Success:</u>

1) Development of an MDH website containing CJS tools and resources.
2) CJS is on the agendas at the Local Public Health Association (LPHA) and SCHSAC at least twice a year.
3) Concurrent session on CJS at 2013 & 2014 Community Health Conference.
4) Tools, guidance documents and evaluation results are shared nationally via the RWJF learning community.

Evaluation Design

All Level 1 and Level 2 partners completed a pre- and post-assessment, which was comprised of questions modified from the Robert Wood Johnson Foundation (RWJF) *Guided Questions Tool*. The Pre- and Post-assessment tools have been submitted as grant products. The pre-assessment was fielded as an online survey in June 2013 and the post-assessment in January 2015. One project completed before the end of the grant period, so they completed their post-assessment at the end of their project period.

MDH staff conducted semi-structured, qualitative interviews with all remaining project partners during December 2014/January 2015. These interviews were designed to augment the quantitative evaluation and provide more detailed information about the experiences of the Level 1 and Level 2 partners. These questions asked for information about factors that facilitated their projects, factors that served as barriers and lessons learned from their experiences. In addition, it asked specifically about the role of MDH and its effectiveness in supporting their work. The qualitative interview tool has been submitted as a grant product.

Finally, overall project goals were assessed to determine whether they were met during the time frame. Data used to support that assessment included:

- Project Storyboards completed by each partner

- MDH staff tracking of technical assistance provided
- Project status updates, provided by local partners to MDH on an ongoing basis
- Documenting CJS on the Community Health Services Conference agenda
- Documentation of the development of CJS measures for annual, online reporting by local public health

Minnesota SSLC Mini-Collaborative Participants

Level 1 Partners:

- Bloomington-Edina-Richfield CHB
- Kandioyohi-Renville CHB
- Partnership4Health (Becker, Clay-Wilkin, and Otter Tail CHBs)
- Polk-Norman-Mahnomen CHB

Level 2 Partners:

- Brown-Nicollet CHB
- Carlton-Cook-Lake-St. Louis CHB
- Fillmore-Houston CHB
- Hennepin and Minneapolis CHBs
- Isanti-Mille Lacs CHB
- North Country CHB
- Olmsted CHB

Evaluation Results

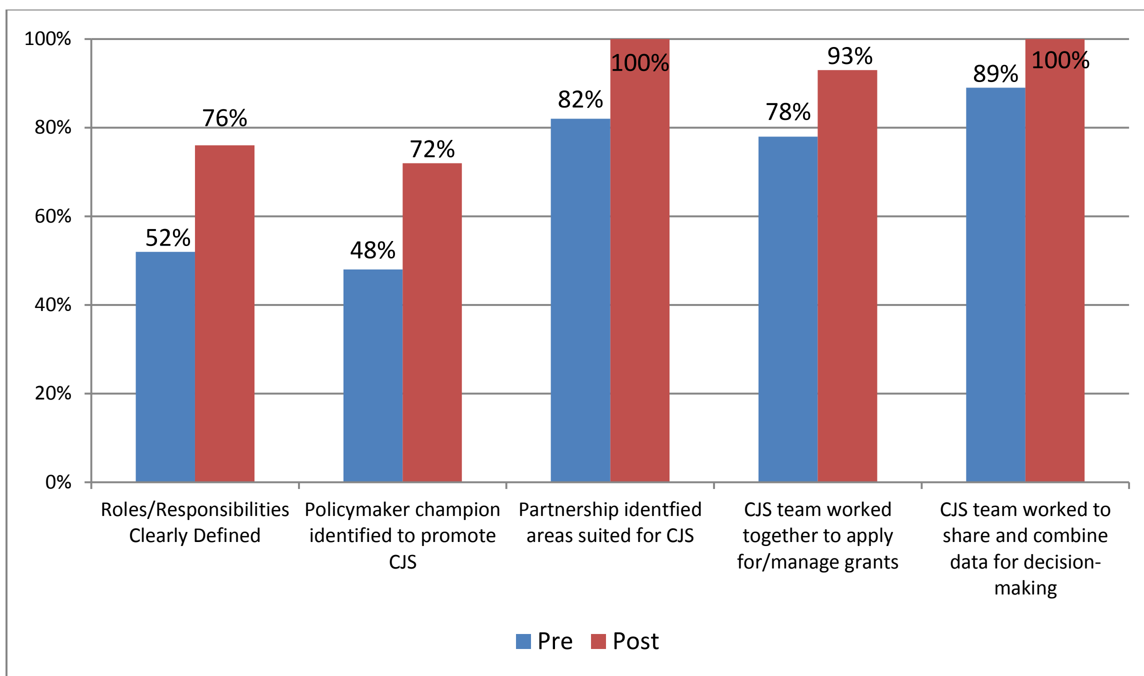
Pre-Post Assessment

Twenty-seven project partners completed the pre-assessment in June 2013 (96% response rate). Partners from both jurisdictions with the CJS arrangements were asked to participate. The top three reasons cited for pursuing CJS among respondents were to: make better use of resources (96%), provide better services (74%) and to respond to program requirements (67%). The top three topic areas considered most for pursuing CJS were: community health assessment (82%), strategic planning (77%) and emergency preparedness (73%). Not surprisingly, when results were compared between Level 1 and Level 2 partners, Level 1 partners had higher support from key decision-makers (82% vs. 77%), more clearly identified roles/responsibilities (82% vs. 31%), more likely to have an identified policymaking champion (64% vs. 23%) and more likely to have a formal agreement between policymaking bodies (91% vs. 77%).

The post-assessment results, when compared to pre-assessment results, indicate that progress was made by partners. Due to staffing changes through the course of the project, the respondents for the post-assessment

were not necessarily the same people who completed the pre-assessment, although they represented the same partner CHBs. Thirty-four potential respondents were identified to take the post-assessment, of which 29 completed the survey (85% response rate). Previously stated reasons for motivating exploration of CJS were consistently noted in the post-assessment. Making better use of resources (93%) was still the top reason cited, followed by provide better services (66%) and meet or prepare for voluntary accreditation requirements (48%). Although preparing for voluntary accreditation was the third most-commonly noted rationale in the post-assessment, it actually decreased from the pre-assessment (63% vs. 48%). Overall, all of the response options decreased in the percent frequency between the pre- and post-assessment, with the exception of provide new services (22% increased to 24%) and increase the department's credibility in the community (7% increased to 24%). For those with a formal, written document to support the exploration of CJS, the most-commonly used document was the joint powers agreement, which remained consistent between the pre- and post-assessments.

Key Areas--Partners Reported Progress:



Write-in comments from the post-assessment largely mirrored information gained from the qualitative interviews (information provided below). Many mentioned "intangibles" in terms of accomplishments, including increased comradery among staff across the jurisdictions, affirming their ability to work together, an increased understanding of the process of sharing services and helping them and their policymakers stay tuned into possible future work together.

Qualitative Interviews

Semi-structured interviews were conducted by MDH staff with all Level 1 and all but two of the Level 2 partners in December 2014/January 2015. The average interview length was 48 minutes. Key findings from the interviews included:

- Minnesota's model of regional nurse consultants, who provide tailored technical support to specific local health departments within their assigned regions, was invaluable to the success of many of these projects.
- Most participants would not have changed the way they implemented their projects, even with the benefit of hindsight. Participants acknowledged that obstacles presented themselves, but that overcoming those obstacles was simply part of the process.
- While not all partnerships experienced actual governance or programmatic changes, all expressed that they had tangible long-term effects that resulted from this work.
- CJS isn't always appropriate. Participants felt that sometimes jurisdictions are too different for CJS to be effective. This can relate to jurisdictional culture or differences in populations served.
- Expanding your population and geopolitical boundaries via CJS can translate into being more competitive for funding opportunities.

Lessons Learned/Advice for Exploring CJS:

- Use the Roadmap Questions to help identify where you are currently and where you'd like to go.
- Consider performing a stakeholder analysis at the beginning of the project, to help identify champions as well as where additional work is needed to educate and bring people along.
- Implement a solid project management framework, which includes a project charter (project goals, timelines and deadlines). In addition, progress reports and bi-monthly reflections of where you've been are important.
- Implement change management strategies to engage staff and stakeholders at all levels.
- Make sure to educate all stakeholders on the responsibilities of public health. Using stories is often a more effective way to educate County Boards of Commissioners.
- Network with other jurisdictions further along in the process—try to learn from them as much as possible.

> ***"It is imperative to be clear about the purpose—what is the purpose? There has to be a shared sense of purpose."***

Several partners expressed the importance of having a clear goal, a shared vision and a resulting value to all involved. Successful projects involved stakeholders from the onset, including staff, governing Board members, community members and health department leadership. Partners spoke of giving everyone a voice, limiting egos, taking the time to do things well and the importance of open and honest communication.

Key Benefits of Participating in the MN Mini-Collaborative:

- National site visit and opportunity to participate in national meetings.
- Motivated by listening to other projects, particularly from those further ahead in the process.
- Nice to be given time to spend on exploring CJS—and this collaborative allowed them to carve out time to spend on it (able to justify time spent to the Board as well).
- Access to OPI staff and technical expertise.
- Project timelines and deadlines reinforced through necessity of submitting regular progress reports to OPI staff.
- Having resources available in a variety of formats with a wide range of mechanisms and tools that LHDs can access.
- Provision of conceptual materials, as well as the change management information.
- Financial support---while the amount of grant funding wasn't large, it did provide necessary support and allowed partners to spend time on their projects.

Meeting Specific Project Goals

1.1 Percent of Level 1 Partners who achieved project goals/objectives in Year 2: 100%

1.2 MDH staff hours dedicated to providing technical assistance to Level 1 Partners: Approximately 125 hours

2.1 Number of CJS arrangements implemented in local jurisdictions (Goal=3): 6 arrangements

2.2 Number/percent of Level 2 partners who progressed along the CJS continuum: 5 of 7 (71%) partners

2.3 CJS measures identified for inclusion in annual local public health reporting:

Three CJS measures were developed and approved for inclusion in MN's local annual public health reporting system for the 2015 reporting time frame. The list of CJS measures included in annual online reporting has been submitted as a grant product. This information is also available on the MDH website: http://www.health.state.mn.us/ppmrs/resources/performancemeasures/#instructions

3.1 Development of an MDH website containing CJS tools and resources: A toolkit has been developed to help local jurisdictions move along the CJS continuum. That toolkit is currently being used by MDH's regional public health nurse consultants and will be available online in spring 2015.

3.2 CJS is on the agendas at the Local Public Health Association (LPHA) and SCHSAC at least twice a year. CJS was discussed at regional LPHA meetings, as well as the full LPHA membership meeting during the project period.

3.3 Concurrent session on CJS at 2013 & 2014 Community Health Services Conference (CHS): CJS was a topic at both CHS conferences, with MDH in a lead role for one and a supporting role for the other (local leadership had the lead in 2014).

3.4 Tools, guidance documents and evaluation results are shared nationally: Tools and other products that were developed through the collaborative have been shared with the Center for Sharing Public Health Services. These include organizational assessment tools, communication templates, project management tools, new ordinances, agreements for sharing staff across jurisdictions, and tools for selecting programs for sharing. In addition, MDH and local partners have participated in site visits to other RWJF SSLC grantees and national meetings associated with the grant.

Implications

Taken together, the results of the evaluation components suggest that the implementation of CJS in MN, via the MN SSLC, was very effective. One reason for this success may have been MN's ability to leverage multiple sources of funding to support a collaborative that had multiple partners and different stages in the process. Doing so maximized RWJF resources for local partners while providing for effective support and coordination at the state level. Local partners highlighted several factors that contributed to their success, but also identified local realities that either worked to support or hinder their progress. All of the main project goals were met. In addition, MDH's goal of learning about when CJS arrangements are most appropriate and effective was accomplished through the qualitative interviews.

Evaluation of Mini-Collaborative Activities

Overwhelmingly, local partners spoke of the benefits of coming together and sharing their experiences with a broad range of local peers. Those partners who were able to travel and participate in site visits of other grantees nationally also spoke of the value of that experience. In terms of resources or information provided within MN as part of the mini-collaborative, the time and resources devoted to change management were almost universally mentioned by local partners as being particularly helpful and informative. Other topics addressed during the collaborative included identifying programs to share, addressing shared supervision of staff working across jurisdictions, creating effective partnerships with policymakers, and implementing strong project management strategies.

Key Lessons Learned

- Shared governance is a significant facilitator for CJS among our participants. It provided a foundation and history of some shared work. This could have implications for how to best support local

jurisdictions that have different structures, e.g. multi-county vs. single county CHBs. CJS between different CHBs would add a layer of complexity and may require different types of support and technical assistance.

- Supporting Level 1 and Level 2 partners in the same collaborative created challenges. While the Level 1s were able to help Level 2s explore questions and concerns, it was difficult to meet everyone's needs through quarterly collaborative meetings. There are likely better ways to structure peer-to-peer learning and sharing that would be more effective, such as bringing in specific Level 1 team leads for focused topics.
- CJS is very local. Every situation and context is different, because the personal relationships and local strengths and challenges can vary greatly from one place to another. While there are best practices for process—explore, plan, implement, evaluate—that can be implemented across the board, there is no one-size-fits-all for CJS arrangements.
- Minnesota CHBs have been sharing programs and/or governance functions across boundaries for years—this is not necessarily a new idea here. What has been new is the language and resources for talking about CJS and supporting its effectiveness.

Next Steps

Local partners strongly encouraged MDH to continue providing technical assistance and resources to support their efforts around CJS. In particular, the role of regional nurse consultants is an important factor for success, thus local partners would like their continued support in regard to exploring, pursuing and implementing CJS arrangements. MDH is committed to continuing its support and provision of technical assistance to local jurisdictions interested in furthering this work.

Selected Responses, Local Partners' Planned Next Steps:

"We will continue to build upon the relationship."

"We are continuing with QI projects and also looking at ways we can work together."

**"We plan to continue formalizing our common policies and practices…
to make CJS easier and more likely."**

**"We will continue with CJS efforts.
It's built into our Strategic Plan and culture of the organization."**

**"Continue the work of 'We' vs. 'Us' and 'Them.'
Explore other areas that might benefit from sharing."**

**"We will continue CJS in programs that we have started and will look at other programs…
small bits at a time."**