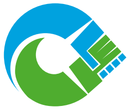

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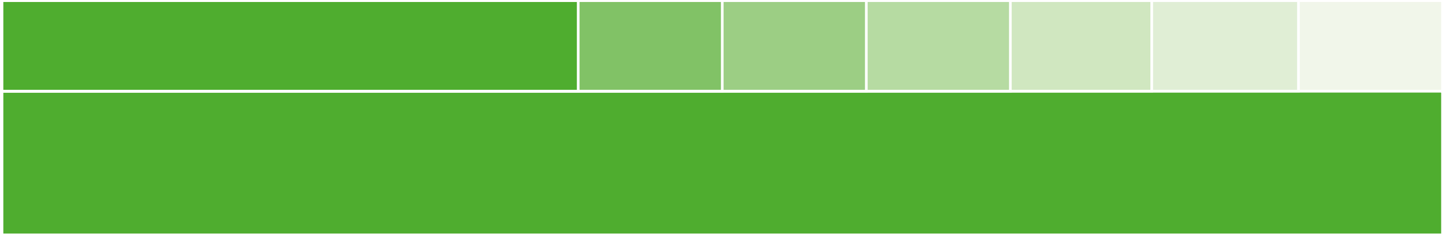

SMALL GRANT LEARNINGS

AUGUST 2018

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Table of Contents

Executive Summary iii
Success Factors iii
Phases of the Roadmap iv
Introduction 1
Background 1
What We Learned 3
General Findings 3
Success Factors 3
Trust 3
Success in Prior Collaborations 4
Strong Change Management Plans 4
Effective Communication 5
Strong Project Management Skills 6
Phases of the Roadmap 6
Phase 1 – Explore 6
Phase 2 – Prepare and Plan 10
Phase 3 – Implement and Improve 11
Additional Learnings 13
Working with State Health Departments 13
CJS as a Systems Change Tool 13
CJS and Tool Development 15
Conclusion 16

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Executive Summary

The Center for Sharing Public Health Services (the Center) granted competitive awards of approximately $10,000 each to a total of 15 sites through its small grants program. This program was designed to fill specific gaps in the Center's knowledge, affirm and/or refine initial learnings, and assist the sites in achieving their program goals.

As anticipated, the small grants program provided the opportunity to:

- Test the applicability of two of the Center's signature products (the *Roadmap to Develop Cross-Jurisdictional Sharing Initiatives* and the *Success Factors in Cross-Jurisdictional Sharing Arrangements*) among specific partners with unique characteristics;
- Ascertain how additional entities could contribute to CJS arrangements; and
- Identify what, if any, differences existed in how CJS arrangements were developed, implemented and/or operated in specific types of health departments.

At a very general level, as anticipated, the small grants did indeed affirm that the central tenets and issues covered in the Center's signature documents are applicable to a variety of partners in a variety of settings. The following points provide more specific learnings regarding particular *Success Factors* and areas of the *Roadmap*, as well as new areas of learning that emerged.

Success Factors

- Trust
  - The Center's collaborative trust scale can help teams identify areas that need to be addressed before delving into the exploration of a CJS arrangement.
  - Take the time needed to develop trust. Time invested at the front end is likely to save time later.

- Success in Prior Collaborations
  - Past collaborations can take many different shapes, and can be between individuals and/or organizations.
  - Partners need to know each other in some capacity before a successful CJS arrangement can be established and implemented.

- Strong Change Management Plans
    - Change management strategies are effective during all phases of CJS arrangements.
    - Engage staff who will be directly involved in the shared service or capacity in shaping the tools and processes to support the CJS arrangement.

- Effective Communication
    - Ongoing communication with all CJS stakeholders promotes transparency and reinforces trust among partners.
    - A strong communications plan can assist with change management by continually seeking feedback and gathering input on the project.
    - A strong communications plan also can facilitate project management by highlighting timelines and deliverables.

- Strong Project Management Skills
    - Specified roles and responsibilities, deliverables and due dates promote accountability and momentum, making it less likely that a task will fall through the cracks or that staff will get sidetracked with other work.

Phases of the Roadmap

- Phase 1: Explore
    - It is critical to achieve a balance of efficiency and effectiveness, and there are many ways to do this.
    - Build CJS agreements around a specific service(s) or capacity(ies), as it is very difficult to craft a generic agreement that will cover all necessary details.
    - Ensure that all partners understand the contributions that each will make through the agreement – all partners need to perceive a benefit from the agreement in order for it to be successful.
    - CJS can be used as a temporary strategy to build capacity, e.g., one health department can lend their expertise and provide technical assistance to help another health department build its own capacity.

- Consider how a third party can help achieve the goals of a sharing arrangement.

- Phase 2: Prepare and Plan
  - A careful review of the entirety of the *Roadmap's Phase 2* can potentially help long-time partners address areas that previously had been ignored and help new partners ensure clarity and equity in even a single, narrowly focused arrangement.
  - Foster connections not only at the director level but also at the staff level, where the sharing agreement typically is operationalized.

- Phase 3: Implement and Improve
  - Consider how to be strategic in selecting new efforts for collaboration as partners approach their capacity to share resources.
  - Consider sending one representative from a CJS arrangement to represent all public health partners at a variety of coalitions, councils or other types of collaborations within the community.
  - Maintain an active plan to orient new policymakers and public health officials to CJS efforts and otherwise work to obtain their buy-in to existing CJS agreements.
  - Periodically assess protocols, especially those for long-standing agreements and as-needed assistance that may not have been activated in a long time.

- Additional Learnings
  - State health departments seeking to support locally driven CJS efforts may encounter suspicion that the state plans to mandate some form(s) of CJS, regardless of how carefully the state conveys that is not the case.
  - CJS can effectively be used as a means of changing public health delivery systems at the regional and state levels, provided that local health departments (LHDs) are meaningfully engaged in determining CJS partners, funding and funding formulas.
  - A CJS approach can be taken to develop tools for use by individual health departments, resulting in a lower price and higher quality than is possible when done by one LHD.

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Introduction

The Center for Sharing Public Health Services (the Center) has supported grant-funded sites since 2013. The size of the grants has ranged from $10,000 to $125,000, and the funding periods have been as short as six months and as long as 18 months. Through its grant programs, the Center has assisted grantees in their cross-jurisdictional sharing (CJS) work, learned about various CJS arrangements, and developed tools for CJS work based on actual field experience. Following a very brief description of the Center's grant-making activities, this paper will summarize learnings from the small grants program.

Background

During the Center's first phase, 16 demonstration grants of $125,000 each were awarded to sites for an 18-month period to work on exploring, planning and implementing CJS arrangements. These sites comprised the Shared Services Learning Community (SSLC), through which grantees shared their activities and work products and provided peer assistance and support. As is typical of demonstration grants, their work helped to establish a new body of knowledge and identified some best practices for CJS in public health. Simultaneously, the Center engaged in literature reviews (both peer-reviewed publications and gray literature) and engaged partners in other public sectors to understand how CJS has been used outside of public health. The Center also developed, collected and catalogued resources for the field. Collectively, these activities served as the foundation for all of the Center's activities, including the development of two of its signature documents, the *Roadmap to Develop Cross-Jurisdictional Sharing Initiatives* and the *Success Factors in Cross-Jurisdictional Sharing Arrangements*.

During the Center's second phase (beginning mid-2015), the Center awarded three types of grants. Five of the original demonstration sites were selected for follow-up grants during this phase. These sites were awarded $10,000 each to participate in quarterly interviews that focused on progress and challenges faced during longer-term implementation of their CJS arrangements. In addition, four demonstration grants of $75,000 each were awarded to sites that had recently entered into a significant CJS arrangement. The purpose of these demonstration grants was to test whether changes in efficiency and effectiveness resulting from the sharing could be systematically measured. Finally, the third type of grant was awarded

through the small grants program, whose findings are the subject of this paper. Through the small grants program, competitive awards of approximately $10,000 each were granted to a total of 15 sites in two rounds of funding. This program was designed to fill in specific gaps in the Center's knowledge, affirm and/or refine initial learnings and assist the sites in achieving their program goals.

While the SSLC demonstration sites covered a wide gamut with respect to different types of shared programs, types of partnerships and other categories, the Center recognized the importance of considering the applicability of its work to specific areas that were not represented in its work to date. In the first round of the small grants program, the Center gave preference to applicants whose work included at least one of the following priority areas of learning:

a. The appropriate role of state health departments in supporting CJS activities at the local level.
b. The appropriate role of state health departments in improving overall public health system performance.
c. Models for CJS involving tribes.
d. The applicability of the *Roadmap* to sharing arrangements among two or more public health jurisdictions also involving entities beyond public health agencies, such as other government entities, hospitals and private nonprofit organizations within an inter-jurisdictional context.
e. The role of a third party (an organization other than the participating jurisdictions) in managing or coordinating a shared service arrangement or directly providing a service on behalf of the participating jurisdictions. This could include a state association of local health officials or other organizations.
f. The role of CJS as a tool to promote the implementation of foundational public health capabilities and services (described at http://www.resolv.org/site-foundational-ph-services/).

In the second round of small grants funding, the Center sharpened its focus on grantees that would provide the richest learning opportunity in the priority areas, and two additional areas were identified:

- Generalizable processes and indicators to measure the impact of CJS arrangements on the effectiveness and efficiency of public health services.
- The purposeful utilization of CJS as means of enabling participating jurisdictions to meet Public Health Accreditation Board (PHAB) standard(s).

What We Learned

General Findings

The Center has gained a wealth of knowledge from the small grants program. At a very general level, as anticipated, the small grants did indeed affirm that the central tenets and issues covered in the Center's signature documents are applicable to a variety of partners in a variety of settings. The following sections detail learnings regarding particular *Success Factors* and areas of the *Roadmap*, as well as new areas of learning that emerged.

Success Factors

The Center's *Success Factors* provide valuable guidance to partners at any stage of a CJS arrangement – from exploration all the way through a mature, long-standing collaboration. The Center has identified three types of *Success Factors* (Prerequisites, Facilitating Factors and Project Characteristics) and the following were particularly noteworthy in the experience of the grantees.

Trust

Trust is a "prerequisite" to any successful CJS arrangement, and through the small grants program the Center observed how a more deeply rooted sense of trust can be developed as CJS work proceeds. One strategy is to assess levels of trust before delving into the exploration of a CJS arrangement, using an established tool. Doing so can reveal areas that need to be addressed. Polk and Marion Counties (Oregon) used a collaborative trust scale developed by the Center at the outset of their exploration to discuss potential sharing opportunities. This team's leaders recognized the importance of understanding whether any trust issues needed to be addressed at the beginning to help ensure that the group's discussions were focused and productive. They used the same scale at the end of their initiative and found that trust had increased in all dimensions.

Another strategy is to extend the length of time, as needed, to ensure buy-in at every step of the way. As the project manager working with the four federally recognized tribes in Kansas said, "Progress happens at the speed of trust," and with that in mind she extended the timeline for the team's work on developing a data-sharing agreement. Not only does the agreement have very strong support, but even before the agreement was finalized this team successfully pursued funding for another joint initiative. The project manager credits the concerted time taken to ensure a high level of trust to the team's eagerness to expand their work together. The project manager noted the importance of understanding that a delay is not necessarily an indication that work will not proceed, and time invested at the front end is likely to save time later. Without a high level of trust and commitment, the team may well encounter challenges that can stall or even derail an effort.

Success in Prior Collaborations

Another learning that emerged was that partners in each of the small grants (and, in hindsight, all of the Center's grantees) had collaborated in some way prior to the CJS grants. Prior collaboration takes different shapes and forms. Some collaboration had been between the same individuals now working on a CJS effort, while other collaboration was between different partners in the respective organizations. Collaboration could mean activating an informal agreement for "as-needed" assistance; these types of arrangements are generally considered to be low-risk and many health departments have had these in place for a long time. Collaboration might also have occurred through a non-CJS effort such as working together on a regional or statewide effort, e.g., a coalition, committee, workgroup, or any other capacity that provides exposure to and experience with potential partner organizations. Regardless, it is rare for CJS partners to lack some form of successful prior collaboration, either with specific individuals or between the organizations. This history is an important "facilitating factor" that can help strengthen the level of trust required before meaningful collaboration can take place and also can provide useful insights for project planning.

Strong Change Management Plans

A strong change management plan continues to be an important "project characteristic," and the small grants program has illustrated the importance of weaving change management strategies into all phases of the *Roadmap*. Engaging all staff who will be involved in a new sharing

arrangement in shaping the tools and processes that support the new arrangement has emerged as a particularly important strategy that was used in several small grants. Franklin County (Ohio) involved staff in their CJS effort to develop a new, shared online module for reporting environmental health inspections. The Capital Consortium (Florida) elicited input from all levels of staff (front desk to leadership) to inform the foundation of an information technology system that would be shared with several local health departments (LHDs). The Washington State Department of Health Diamond Project worked extensively with LHDs while revamping the funding and service delivery models for the Vaccines for Children (VFC) program and the Assessment, Feedback, Incentives, and eXchange (AFIX) program. Specifically, the Diamond Project moved from funding nearly every LHD in the state to funding a single LHD in each region to provide these services to surrounding health departments. Soliciting staff feedback in the exploration, planning, and implementation phases of the *Roadmap* helped facilitate decision-making, maintained buy-in, and paved the way for a smooth transition once implementation occurred.

Effective Communication

Another "project characteristic" is effective communication, which can go a long way in keeping all parties engaged in CJS efforts, including participating health departments, external partners and other stakeholders potentially affected by the new arrangement. Ongoing communication promotes transparency and reinforce trust among partners. For example, the Diamond Project (Washington) worked hard to ensure that all vaccine providers throughout the state were aware of the effort to centralize some immunization program functions; the project staff recognized that most vaccine providers would have a new governmental staff member conducting site visits and wanted to be sure that the providers were not caught off guard as a result.

The Nebraska Association of Local Health Directors (NALHD) also exemplified the value of effective communication. NALHD developed a website template for use by any health department across the state. At the outset, NALHD implemented a very thorough communications plan that proved to be quite efficient. The one plan served three purposes, as it kept stakeholders informed, assisted with change management by continually seeking feedback and gathering input on the project, and facilitated project management by ensuring that various items were completed on time.

Strong Project Management Skills

Taking a strong project management approach is a "project characteristic" that greatly facilitates the work and keeps the effort on track. Specified roles and responsibilities, deliverables and due dates promote accountability and momentum, making it less likely that a task will fall through the cracks or that staff will get sidetracked with other work. While this is particularly important for CJS arrangements that have a lot of moving parts and that require a high level of detail, it also is useful for more narrowly focused agreements. Franklin County (Ohio) demonstrated this success factor while developing their online environmental health module. Most impressively, their very ambitious timeline successfully proceeded right on schedule throughout the project period. The Finger Lakes Public Health Alliance (FLPHA) in New York developed tools and templates to ensure smooth implementation of a long-standing, eight-county emergency preparedness plan. FLPHA established a project management timeline with well-defined activities and deadlines that made it possible to coordinate a great deal of work among numerous partners within a fairly short time frame. NALHD illustrated this concept as well, most notably with a strong communications plan that both kept stakeholders informed and also elicited critical input to the template website's design.

Phases of the Roadmap

The *Roadmap*, another signature product of the Center, is designed to lead partners through the three phases of exploring, preparing and planning, and implementing and improving CJS arrangements. Through the small grants program, the importance of several areas of the *Roadmap* were magnified and additional areas to address were identified.

Phase 1 – Explore

Goals and Expectations

A key task in the exploration phase is to understand each partner's drivers for pursuing a CJS arrangement. The motivation for CJS typically revolves around efficiency and effectiveness, and the small grants program helped to further articulate and illustrate the interdependence.

Many health officials and policymakers equate "efficiency" with cost savings; i.e., spending less on a service or function when it is shared than it costs to provide the service or function on their

own. This is a legitimate policy objective, and when cost-savings is a driver it is important to discuss CJS within that context. That said, it's equally, if not more, important to understand whether cost *savings* or cost *efficiencies* will be achieved. "Cost efficiencies" refers to achieving a greater output or a higher value for the amount of money spent; put another way, it means getting a "better bang for the buck." In other words, a jurisdiction may spend the same amount of money as before but in return, for example, the health department is able to maintain a program or service that otherwise would have been cut, can offer more services within a specific program area, or gain access to staff with greater expertise. Cost efficiencies also can occur when a new program or service is offered that costs less through a CJS arrangement than it would cost to do alone. Even if cost savings will not be achieved with CJS, deriving cost efficiencies can be a compelling motivation for health officials and policymakers.

Effectiveness also can be achieved in a number of different ways. CJS may improve effectiveness due to increased reach; i.e., more people being served by a program. An existing program may expand its scope through CJS and provide additional services to its constituents. Enhanced staff expertise is another type of increased effectiveness and can be realized if CJS results in new staffing patterns that enable staff to "divide and conquer" activities according to specific topics or issues. Improved effectiveness also can mean that a new service is provided – one that a single health department could not afford, but is affordable when done through a CJS arrangement.

Three grantees undertook CJS efforts that readily illustrate the interdependence of cost efficiencies and effectiveness. The development and implementation of a new online module for reporting environmental health inspections by Franklin County (Ohio) and its partners was affordable due to shared costs, and it also provided access to a much more efficient reporting process. The development and implementation of a template website by NALHD also was affordable due to shared costs, and it resulted in a much more robust product than would otherwise be affordable by individual jurisdictions. Finally, the joint fitness challenge developed by Bourbon County (Kentucky) in partnership with two neighboring jurisdictions enabled the partners to organize an event that otherwise could not have been carried out by individual jurisdictions.

Scope of the Agreement

Partners may see a benefit in positioning themselves to share should opportunities arise, or may think that having an agreement in place will pave the way for future opportunities. However, without a specific service or program in mind, it is difficult to identify and tend to the types of details needed to ensure that the agreement is mutually workable. Bourbon County (Kentucky) noted the benefit of developing an agreement around a specific service and anticipated that the agreement likely will cover a wide realm of additional sharing opportunities in the future.

Another issue to explore regarding the scope of the agreement is the potential contributions of each partner. It's not unusual for mutual trepidation to exist between small and large health departments contemplating a sharing arrangement, and the small grants program provided some additional insights regarding the respective contributions of health departments with vastly different capacities.

FLPHA clearly reflected the consistent value of all health departments collaborating on emergency preparedness; each and every staff member who contributes to surge capacity brings tremendous value to the collaboration. This is true regardless of the overall size of the health department.

In another example, a large health department wisely observed the benefit of partnering with a neighboring, small health department to ensure sufficient capacity to handle public health problems. Public health issues do not respect jurisdictional boundaries, and it's typical for people to travel from smaller counties to larger ones for work, commerce, medical care, entertainment, etc. Therefore, if the smaller health department does not have the needed capacity, the larger health department solely could bear the responsibility for addressing a public health issue or crisis. The Polk and Marion Counties (Oregon) CJS work around communicable disease demonstrated this point, with Polk County receiving capacity and expertise that it wanted but could not afford on its own.

Moreover, it is a mistake to assume that the largest health department in a sharing arrangement should always take the lead in any part of CJS efforts, whether it be exploring, planning or implementing. Even the smallest health department can serve as fiscal agent, project director, or other lead role – permanently or on a rotating basis. The grantees for the small grants program were not always the largest health department in the collaboration. Another example can be

found in the San Luis Valley (SLV) Public Health Partnership (Colorado). The partnership was funded to develop a strategic plan that would guide decisions about what additional programs and services should be pursued. The local health officials in the partnership rotate the leadership role and all LHDs (not only the largest) serve as the fiscal agent for at least one shared service.

The CJS work done by the Burlington District Office (Vermont) illustrated an alternative way of using CJS to increase an LHD's capacity. Historically, the Center has viewed CJS as a model through which services and capacities would be shared in a static arrangement that would exist over time. In Vermont, however, CJS was used as a temporary strategy to build capacity for a state health department's district office. Burlington District Office staff provided technical assistance and coaching to staff in St. Johnsbury Office (SJO) for how to conduct a health impact assessment (HIA), thus helping SJO meet a new statewide priority. This model can be considered by others in the process of understanding what each partner brings to the table, determining how CJS can help solve the issue being addressed, and delineating the scope of agreement.

Potential New Area: The Role of a Third Party

LHDs considering CJS may be well-served by considering how a third party could assist in their efforts. The third parties supported by the small grants included a rural health network, state association of county and city health officials (SACCHO), and a public entity created by a centralized state health department. A third party can handle administrative functions and thus free up health department staff to focus solely on the relevant subject matter; this arrangement ensures a wise use of everyone's time and talent. In addition, a third party can handle a volume of tasks that health departments do not have the capacity to address. For example, NALHD tended to all of the logistical issues generated by designing a shared website template with a great deal of input from multiple parties, leaving local health officials to focus only on content issues. FLPHA (a rural health network) developed, tested and refined the very detailed policies, procedures and templates for use by the eight local health departments participating in the emergency preparedness collaboration; once again, the health officials' time was dedicated exclusively to the substance of the products.

Another variation on using a third party was illustrated in Florida. This centralized state health department was instrumental in developing a new entity (the Capital Consortium) to provide information technology support to a group of county health departments. The county health departments had vastly differing capacities for all of their administrative functions, and the new

entity provided a level of service that exceeded what the smaller health departments could support on their own.

A third party may be used in a transitional or temporary manner, such as when a CJS approach results in a product that is then completed (e.g., the role of NALHD in developing the website template). Third parties also may be used to sustain CJS work. For example, FLPHA provides a number of CJS services that go beyond what was funded through the small grants program. Over time, the structure and function of a third party may need to be evaluated to determine whether it can continue to serve the purposes of the CJS partners – a concept that is described below, under *Phase 3* of the *Roadmap*, with respect to the SLV partnership.

Phase 2 – Prepare and Plan

The value of considering all areas in *Phase 2* of the *Roadmap* has become increasingly clear. Consciously reviewing each area does not necessarily mean that each has to be specifically addressed; rather, it means that a decision not to take action in any specific area is deliberate and considered. Partners may be tempted to skip various elements of *Phase 2* thinking that it contains extraneous details that do not apply, for example, to long-standing partnerships or a simple and straightforward CJS agreement. However, careful review of the entirety of the *Roadmap's Phase 2* can potentially help long-time partners address areas that previously had been ignored and help new partners ensure equity in even a single, narrowly focused arrangement. Ultimately, the most advantageous part of going through all the items of *Phase 2* is the resultant agreement. Small grant sites have expressed the benefit of having a written agreement both to provide clarity and equity regarding current work, and to establish a mechanism to sustain work in the future, even in the face of key staff turnover. Bourbon County indicated the importance of taking time to consider all issues raised in *Phase 2*.

Fostering connections not only at the director level but also at the staff level, where the sharing agreement typically is operationalized, is very valuable. As planning progresses, staff connections become increasingly important and should be nurtured; e.g., through working together on developing policies and tools to operationalize a newly shared service. Not only is this a good change management strategy, but staff also are well-equipped to identify some service implications as well as workforce and logistical issues. The small grant activities of the West Central Public Health Partnership (Colorado) magnified this point. This partnership had existed

for about ten years, with a great deal of health official turnover occurring during that time and fewer communications among staff regarding programs that were being shared. The partnership's CJS project was focused on developing a communications plan, and a key program staff member was appointment to serve as project lead. The communications plan provided a framework to ensure that standardized information about CJS work was shared by all staff with their respective health officials. In the process, staff appreciated the opportunity to do more joint planning together and communicate more with one another.

Phase 3 – Implement and Improve

Before the small grants program, the Center's experience with implementation was limited to relatively short time frames (i.e., the first months, or up to a year or two), with a particular emphasis on transitioning to the new agreement and getting it underway. The small grants provided a look into three different agreements that had been in existence longer (from about three to ten years), thereby expanding the Center's understanding of issues associated with maintaining CJS arrangements over the long term.

One issue that arose was how to be strategic in selecting new efforts for collaboration as partners neared their capacity to share resources. Two key questions that emerge when space and time for grant administration becomes tight are how to determine the costs of sharing a new program or service and also whether it is "worth it" to try and create the capacity to manage something new. The SLV partnership wrestled with developing guidance on how to determine whether and how to pursue a new CJS opportunity when there is no capacity among existing partners to manage the effort under consideration. The partnership was established through an intergovernmental agreement that facilitates sharing among its six member counties and had been in existence for about two years at the time of the small grant. While this partnership engaged in very rich discussions about the issue and agreed on the value of everything currently shared, they were unable to generate any guidance on how to be strategic in the future when undertaking additional sharing activities or otherwise expanding the capacity to manage them. It is possible that a structure that works well for the purposes of initial implementation of sharing arrangements may not work over the long term as the shared work expands. The Center believes this issue merits further exploration.

Another issue is about evolving to a place where partners see value in sending one representative from their group to represent all public health partners at a variety of coalitions, councils, or other types of collaborations within the community. This tactic can be especially valuable when these collaborations cover all of the CJS partners' jurisdictions, as is often the case in health care. Depending on the CJS arrangement, the history of working together and the degree of trust, it will take some partners longer than others to reach this point – if they ever do (and some partnerships may never get to this point). The decision to have a single representative at other convenings needs to be carefully explored before it is pursued. All that said, in San Luis Valley this type of cooperation has proven to be a very powerful way of bringing more visibility to public health and working with health-related systems that otherwise aren't likely to engage several smaller health departments in community-based health improvement efforts.

As time moves on, so do key players in CJS efforts. Health officials retire, elected officials are not re-elected, and other changes occur. For these reasons it is important to maintain an active plan to orient new leaders to CJS efforts and otherwise work to obtain their buy-in to any existing CJS agreements. West Central Public Health Partnership (Colorado) worked hard to revive an agreement that had almost become dormant over time due to extensive turnover in both staff and elected officials, coupled with a lack of deliberate and focused attention on potential sharing opportunities.

Finally, there is a need, especially for longer-standing partners, to periodically test protocols. Technology, state and national policies and programs, environmental factors, staffing patterns, etc., change over time and may render old protocols ineffective or obsolete. This may be especially true for long-standing agreements for as-needed assistance that have not been activated in a long time. FLPHA's work on developing detailed protocols for a long-standing emergency preparedness plan provided an excellent example of the value of refreshing policies and procedures.

Additional Learnings

Working with State Health Departments

A state health department faced a considerable challenge when seeking to understand how best to support LHDs that decide to pursue CJS – from initial exploration, to planning and preparing, to implementing and improving. The New York Department of Health received a grant to understand how best to support locally driven CJS efforts. The funding went to the New York Association of County Health Officials to cover their members' transportation to the state's annual county commissioners' meeting; the state staff made in-kind contributions to the effort by developing three interactive sessions for the meeting about CJS tailored to both local health officials and county commissioners. The funding arrangement was a key strategy in getting LHDs to the table to have this discussion – both in terms of making it more affordable and also having a trusted party publicize the sessions to the LHDs. However, the challenge that the state health department faced was rooted in suspicion by LHDs and their county commissioners that the state was going to mandate some form of CJS, despite the state's repeated assertion that this was not their intention. It is not unusual for LHDs in any state to feel tension and be suspicious of the motives of the state health department (or the state legislature, if it is involved), and this experience illustrated just how difficult it can be to overcome those barriers, even when seeking to support local efforts and in the complete absence of any current or pending mandates.

The Diamond Project in the Washington Department of Health provided another opportunity to learn about working with state health departments. This project was narrowly focused on regionalizing just one statewide service – immunizations. State staff relied heavily on input from the local level and used a funding formula that had been generated with consensus between the state and local level as part of a statewide effort to improve the public health system. The experience with the Diamond Project illustrated the benefits of state-local collaboration when CJS is used as a systems change tool (described in more detail below).

CJS as a Systems Change Tool

The use of CJS as a systems change tool was a new concept during the small grants program, and one that emerged primarily due to the initiation of the 21C project, funded by the Robert Wood

Johnson Foundation.[1] Cross-jurisdictional sharing was included in the workplan of each 21C grantee (i.e., Ohio, Oregon and Washington) and thus the Center deliberately funded a CJS effort in these states through small grants. Experience with these grantees illuminated some state-level factors to be addressed while planning for widespread use of CJS – factors that can facilitate or hinder CJS arrangements. Learning from these three states is summarized below.

Administrators at the state level need to understand the importance of local CJS partners choosing each other, as opposed to having partners chosen for them. The Center's experience to date with statewide CJS has reinforced this notion, and in all cases the local decision-makers have expressed that CJS efforts would not be successful if their partners were assigned to them. The Ohio Department of Health reflected this principle as part of its mandate for all local health departments in the state to begin the national public health department accreditation process by 2020. The state noted that some health departments may need to work together or even merge or consolidate in order to achieve accreditation status; however, the local stakeholders clearly have the power to determine whether and how to collaborate. The Center funded survey efforts in Ohio to determine the level of CJS activity and also to understand what services lend themselves to successful sharing agreements.

Administrators working to adopt a centralized approach to public health services and programs ought to ensure that a diverse sample of LHDs in the state is part of the planning process. Even with this strategy, administrators should anticipate that each individual LHD will have its own, unique perspectives and needs that will not necessarily align with their peer health departments. In Washington state, the Department of Health (DOH) sought to reconfigure part of its vaccine program, moving from a highly decentralized approach in which nearly all of the state's 37 LHDs received state funding to a more centralized model in which nine LHDs were awarded funding and performed a specific set of tasks within their region. Although the DOH highly recommended using the state's Accountable Care Organization (ACO) regions, the LHDs were permitted to decide on their regions' composition. (Ultimately, the ACO regions were used, with the exception of a single health department being covered by a different yet contiguous region.) The regions, not the DOH, also determined which LHDs would receive the funding, and only one application per region was received (reflecting consensus among the region's LHDs) and the

[1]The "21C" program is administered by the Public Health National Center for Innovation and supported by the Robert Wood Johnson Foundation. Ohio, Oregon and Washington received a grant to test and implement systems transformations. The use of CJS is part of each state's strategy to modernize their public health system.

applicant was not always the largest LHD in the region. DOH distributed the remaining local program funds among all LHDs, using the funding formula established by a working group supporting the state's 21C efforts.

The Diamond Project also illustrated the importance of carefully considering travel time and costs for staff to perform their duties when shaping a regional model. These calculations need to be based on the locations of population centers and actual travel routes, as opposed to estimates based on mileage to geographic centers. Moreover, any intra-regional differences in staff salaries and mileage reimbursement also should be part of the equation.

In Oregon, after undertaking a months-long outreach effort to educate local health departments and their governing boards about foundational public health services, the state's Division of Public Health offered grants to health departments collaborating on communicable disease, without mandating specific collaborating partners. Polk and Marion Counties had been exploring potential collaborations to pursue, and the state grant opportunity provided support to build on the existing partnership and further enhance the partners' ability to successfully address communicable disease.

CJS and Tool Development

The small grants program provided examples of CJS and tool development. In some cases, an awardee used a CJS approach to develop a tool to facilitate individual health department operations. In another case, an awardee developed tools to facilitate CJS. In all cases, the tools themselves were expanded or replicated in order for any interested health department across the state to benefit from its use.

One example, in Franklin County (Ohio), was the development of an online module to replace the paper version of environmental health reports to the state. Most notably in this example was that the reports are for the Department of Environmental Quality and not the state health department – illustrating a successful partnership with another government sector. While five health departments initially bought into the module and its development, the module can be expanded at any time to include other health departments in the state who are interested in purchasing access.

Another example was in Nebraska, where NALHD developed a website template for health departments. Four health departments were invested in its development and piloted it. More were involved in the design and all were involved in the communication, and now any other interested health department can purchase the template and personalize it for their jurisdiction.

A third example of shared tool development was a set of templates to operationalize emergency preparedness protocols in a CJS arrangement involving eight local health departments. Developed by FLPHA, the templates were tested and revised to ensure that they were specific enough to address the myriad details for smooth implementation of the protocols. At the same time, the level of detail was balanced with the need for the templates to be general enough to be applicable for all participating health departments and also to conform to their respective jurisdictions' overall emergency management plans. The result was a set of templates that can now be used by other partnerships throughout the state.

A final example is a data sharing agreement for the four tribes in Kansas that resulted in two frameworks that can be used by others: a data continuum and a description of four levels of data access. The partners needed to navigate many legal issues regarding data sharing and ownership, and the entire effort was more complex than originally envisioned by the project leads. The availability of these frameworks for use by other tribes could greatly facilitate their data sharing efforts.

Replicating tools that support CJS arrangements can result in great system and statewide efficiency for public health departments. The Center will take a fresh look at tools developed by other grantees and also examine tools developed by other CJS arrangements the Center identifies to see what other, untapped opportunities for replication might exist.

Conclusion

The small grants program has further solidified the Center's belief that CJS can be a powerful and effective way for local health departments to become more efficient and effective in fulfilling their missions. New models of CJS, the particular importance of several *Success Factors*, and CJS as a tool to change statewide systems and enhance systemwide efforts have further broadened the Center's understanding of the roles and impacts of CJS on public health practice.

Small grants have proven to be an effective tool to both expand and hone the knowledge base of CJS in public health.

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Center for Sharing
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Rethinking Boundaries for Better Health