CASE EXAMPLE

Combining Contracts to Fight Chronic Disease in Montana

THE CHALLENGE

The Chronic Disease Prevention and Health Promotion Bureau, in the Public Health and Safety Division of the Montana Department of Health and Human Services, encompasses several programs dedicated to tobacco use prevention and fighting chronic diseases such as asthma, arthritis, diabetes and cancer. Before 2011, each chronic disease program contracted with local health departments separately and in different ways. Consequently, there was a lot of duplication of resources and work. It was not only confusing — it was counterproductive.

"Often, these chronic diseases are linked to each other," said Leah Merchant, section supervisor of the Montana Cancer Control program. "Tobacco prevention is asthma prevention. But we were sending the opposite message by working in silos."

For example, a contract from the asthma control program might require staff from a local health department to reach out to providers with information about the Montana Asthma Home Visiting program. At the same time, a contract from the tobacco use prevention program might require staff from the same local health department to reach out to the same providers with information about the Montana Quit Line.

"Instead of helping the providers understand that the local contractors and local health departments were one central place for all of these services, they were confusing them by reaching out at different times with different information," said Merchant.

CONTRACTING THROUGH COUNTY "HUBS" TO REDUCE CONTRACTS AND WORK MORE EFFECTIVELY

In 2011, the bureau received a CDC grant to closely examine their internal processes, so they could regionalize their work and combine individual contracts, with the ultimate goal of better addressing chronic disease prevention and health promotion at the local level.

It seemed like a lofty goal, but there had been precedence for such regionalization within the cancer program. Unlike the other chronic disease programs, which contracted with most of Montana's 56 counties, the cancer program only contracted with 13 multi-county hubs (see map).

The hub structure helped the cancer program cut down on the number of individual contracts it had, but it still remained siloed from the other programs. To break down these silos, the bureau decided to implement the hub structure across its programs. Doing so gave them an opportunity to step back and analyze what the goals of each program were and how they could work together to achieve those goals. This would eventually lead to less individual contracts and greater collaboration across programs. But a lot happened in between.

The process involved meeting with staff monthly, conducting calls with health officials at local health departments, rewriting contracts to align deliverables, hosting bi-monthly webinars with contracting local health departments to assist in writing yearly work plans, and start establishing regional chronic disease programs.

"With the new regional approach, health departments that didn't have the capacity to have certain services could now turn to the counties around them and be connected to more services than before," said Mandi Zanto, section supervisor at the Chronic Disease Prevention and Health Promotion Bureau at the Montana Department of Health and Human Services.

THE RESULTS

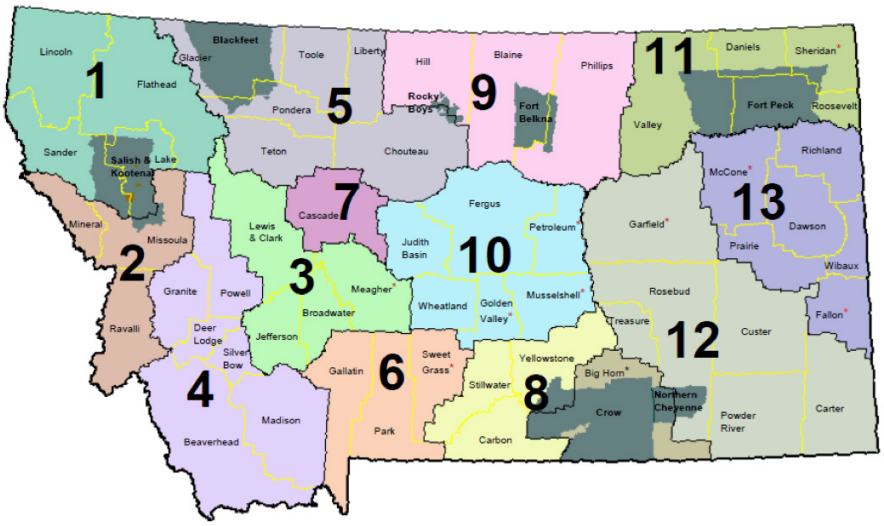
Thanks to the cross-jurisdictional sharing agreement, the local health departments:

- Worked more efficiently to maximize resources and reduce the amount of duplicative work. As a result, they cut down on administrative time and paperwork, and reduced the total number of contracts issued from 45 to 13 (see map);
- Decreased the burden on contractors by creating one standard reporting system where they could catalog all of their work; and
- Better understood what other programs were doing and how they could work together on different grant deliverables.

KEYS TO SUCCESS

- *Communication.* From the beginning of the process, the bureau made an effort to keep an open dialogue with all parties involved. The coordinated contracts group, which had representatives from all the chronic disease programs, met monthly. They also met with key local health departments — small and large — across the state, because it was important for them to take into account the landscape of varying regions. And they set up standard communication channels to be able to easily get in touch with contractors.
- *Prior success in collaboration.* Being able to share alternative approaches to regional implementation across chronic disease programs helped ease some of the contractors' resistance to change.

CHRONIC DISEASE REGIONAL MAP



REGION LEGEND

1. Flathead CCHD
2. Missoula CCHD
3. Lewis & Clark CCHD
4. Butte-Silver Bow CCHD
5. Teton CCHD
6. Gallatin CCHD
7. Cascade CCHD
8. RiverStone Health
9. Blaine CCHD
10. Fergus CCHD/ CMFP
11. Daniels CCHD
12. Custer CCHD
13. Richland CCHD

Urban Indian Health Centers Not Noted on Map

- Great Falls Indian Family Health Clinic
- Helenda Indian Alliance
- Missoula Indian Center
- MT-WY Tribal Leaders Council
- North American Indian Alliance

Chronic Disease Regional Map — Effective July 2017

*Counties not receiving tobacco funding (Fallon, Garfield, Golden Valley, McCone, Meagher, Musselshell, Petroleum, Sheridan, Sweet Grass)

*Region 8, RiverStone Health, will provide cancer screening and worksite wellness services to Big Horn County

*Region 12, Custer CCHD, via Treasure County, will provide tobacco prevention services to Big Horn County

Note: While the Center for Sharing Public Health Services was not involved with this project, Center staff heard about the work and found it a great model to share with the practice community.