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CROSS-JURISDICTIONAL SHARING WORKGROUP ACTIVITIES

Final Report 2014–2017

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Final Report 2014–2017

Prepared for the Public Health Systems Group

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Author

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About this Report

The purpose of this report is to document the activities and results of the Kansas Cross-Jurisdictional Sharing (CJS) Workgroup during its period of activity for the Public Health Practice Program (PHPP) from July 2014 through June 2017. The report also presents options for future work and next steps as Kansas moves toward a model of Foundational Public Health Services (FPHS).

Background and Project Activities Overview

In 2013, a group of Public Health Systems Group (PHSG) stakeholders participated in a prioritization process to determine what key activities would be funded through the public health practice program. One of the prioritized strategies was to "*Examine the potential of consolidation, regionalization, or sharing services to increase capacity."* In December 2013, the Kansas Health Institute (KHI) was asked to take the lead in developing a plan to execute this strategy.

KHI made a recommendation to the PHSG that a three-year project be funded which included the following activities.

1. **Assessment Survey**: Deploy a survey to create an inventory of the prevalence, scope, history and effectiveness of various types of shared-services arrangements in Kansas. Utilize the survey to explore the interest of organizations in implementing shared-services arrangements. This survey was conducted in 2014. Additionally, there was an opportunity to re-assess CJS in Kansas through questions on the Aid-to-Local survey in March 2017. This survey was oriented toward the Foundational Public Health Services (FPHS) in Kansas, due to the ongoing work of public health system partners.

2. **Case Studies:** Analyze the assessment survey to identify four high-performing shared-service arrangements. Conduct key-informant interviews with the health department personnel involved in those arrangements. Based on the key-informant interviews, develop case studies which document the history, process and results of the sharing arrangements.

3. **Pilot Projects:** Using the results of the assessment and case studies, develop and release a request for proposal (RFP) for funding up to four CJS pilot projects in Kansas.

4. **Tool/Resource Development:** Develop and disseminate five tools/resources specifically for Kansas local health department administrators (activity added in 2016).

5. **Presentations:** Throughout the project, presentations were also planned to share lessons learned from each of the components.

Figure 1 outlines the outputs that were planned for each year of the project.

Figure 1. **Outputs, Kansas CJS Workgroup**

Year 1: July—December 2014	Year 2: January-December 2015	Year 3: January -December 2016 (extended to June 2017)
Succeed in negotiating to obtain International City/County Management Association (ICMA) survey data for Kansas entities and receive a complete list with contact information for all Kansas entities that were surveyed by ICMA (including non-responders). Identify a list of additional questions that would be beneficial to Kansas. Develop Kansas specific survey to measure shared services. Achieve 80% response rate to Kansas-specific survey. Achieve 80% response rate among ICMA survey non-responders. Identify four "high performing" communities/ organizations engaged in sharing arrangements.	Analyze the Kansas-specific ICMA survey data to identify Kansas communities engaged in sharing services of administrative functions. Compile list of the variety of types sharing arrangements in Kansas. Produce report on findings from ICMA plus the Kansas-specific data that assesses opportunities and barriers to improving efficiency and effectiveness through Kansas shared-services arrangements. Submit abstract (in early spring) for presenting data results at Kansas Public Health Association (KPHA) annual meeting (in late fall). Schedule and conduct interviews by two project staff with a minimum of four key-informants from the various partners in the sharing arrangement, from the four "high performing" Kansas communities/organizations, with results to be written up as individual case studies focused on best practices for shared services in Kansas. Share project findings and case studies either individually or at a joint conference with Haskell University, KPHA, KALHD, Kansas Association of Counties, Kansas Association of State and Territorial Health Officials, Kansas County Commissioners Association, Kansas Hospital Association, and Southern Plains Tribal Epidemiology Center.	Post Kansas-specific CJS information on the Center's website. Four pilot projects are awarded. Lessons learned from pilot projects are documented for dissemination on Center's website and at local meetings. Share Kansas case studies of best practices at national association meetings (i.e., ICMA, American Public Health Association, National Association of County and City Health Officials, National Network of Public Health Institutes, Association of State and Territorial Health Officials). NEW: Develop and disseminate up to five tools/resources for CJS in Kansas. Re-assess the status of CJS in Kansas in the context of the Foundational Public Health Services.

Surveys

In order to better understand the full extent of CJS in Kansas, two survey efforts were conducted by the Kansas CJS Workgroup in 2014 and 2017. Due to differences between the questions and the dissemination strategies for the two surveys, comparison between the two is not possible. However, both surveys provide helpful information that can be used to understand CJS in Kansas.

Approximately three-fourths of Kansas LHDs currently engage in some degree of CJS. However, sharing with other public and private organizations—that are not geopolitical entities—may be a practice in as many as 90 percent of health departments.

As of 2014, Emergency Preparedness and Maternal and Child Health services were the most commonly shared services. Other commonly shared services included WIC; CHA; and inspection, permitting, and licensing. As of 2017, the most commonly shared Foundational Capabilities and Foundational Areas were *All Hazards Preparedness and Response, Environmental Health,* and *Maternal and Child Health.*

There is a general willingness to engage in additional CJS for the Foundational Public Health Services. The FCs and FAs for which survey respondents indicated the greatest willingness to consider future sharing include *All Hazards Preparedness and Response, Health Promotion and Chronic Disease and Injury Prevention,* and *Environmental Health.* However, there are some health department administrators that indicated they would not consider sharing any of the FCs or FAs.

Summary of 2014 Survey Findings

The survey received 78 total responses from the 105 individuals who were sent the survey (74 percent response rate). However, four surveys were left blank, so only 74 responses were used for analysis (70 percent response rate). Of those that responded, 55 (74 percent) indicated current sharing arrangements, 1 (1 percent) indicated that they were currently exploring/developing a shared-service arrangement, and 18 (25 percent) indicated that they did not have sharing arrangements.

Those with CJS

Of those with current sharing arrangements, 66 percent of respondents reported that they had been sharing for 11 years or more. Additionally, the majority (76 percent) of those that reported sharing had just one to three sharing arrangements in place.

The most commonly shared services were: Emergency Preparedness (71 percent) and Maternal and Child Health services (35 percent). Following were WIC; CHA; and Inspection, permitting, and licensing (all 29 percent).

The least commonly shared services were: executive leadership (four percent); fundraising and grant writing (eight percent); and laboratory services (eight percent). Additionally, just ten percent indicated sharing population-based primary prevention programs, and just 13 percent indicated sharing epidemiology or surveillance.

The top three drivers for entering into shared-services arrangements were:

- To provide better services (65 percent);
- To access needed expertise (62 percent); and
- To promote higher quality/more effective service delivery (54) percent.

Saving money was the fourth-highest driver, at 52 percent. This is consistent with other research highlighting the primary motivations for shared services as being quality-related for local health department administrators.

Respondents were asked about policymaker support for shared services. Among those with shared services, 50 percent agreed or strongly agreed that policymakers in their jurisdiction supported the vision for shared services.

When asked whether they would recommend considering shared services to other local health departments, 87 percent indicated that they would. Additionally, 93 percent indicated that the shared-services arrangement had been successful in improving or expanding public health services, 91 percent indicated that it had been successful in saving money, and 78 percent indicated that it had been successful in improving efficiency. Less than half felt that shared services had improved accreditation readiness.

One notable gap in the CJS arrangements in Kansas was that only 21 percent of those with CJS engaged in any type of review or evaluation of the shared services.

Those without CJS

The 18 respondents (25 percent) without shared services were asked to indicate the top three reasons that contributed most to why they didn't engage in CJS. The top responses (all of the following responses were selected by 39 percent of the 18 respondents who indicated no CJS arrangements) were:

- They had not considered it;
- They didn't know where to start;
- There was no perceived need or benefit; and
- There was local political opposition.

The first three above indicated a need to distribute additional information and resources about CJS.

Of note, the 25 percent (18 respondents) who indicated no shared services—as well as the 29 percent of those with shared services that didn't select Emergency Preparedness (16 respondents)—did not perceive the Emergency Preparedness program to be a shared service. In all, slightly less than half of those who responded to the survey (43 percent, or 32 of 74) did not perceive Emergency Preparedness as a shared service. This illustrates differing perceptions of what is and is not considered a shared service.

Summary of 2017 Survey Findings

Seventy-two local health departments (LHDs) out of 100 total LHDs currently have a shared-service agreement with another county, military base, or tribal entity, while 26 do not. Two respondents reported that they were currently considering or developing a shared-service agreement.

When asked whether they share specific FCs or FAs, respondents indicated a higher frequency of sharing; 92 respondents indicated sharing with any organization, while 8 did not. This may indicate sharing between local health departments and other private or public organizations that are not geopolitical jurisdictions.

Thirty-two respondents said they anticipated developing new or additional cross-jurisdictional shared services in the next two or to three years, while 19 respondents said they did not. Forty-nine respondents indicated that they were unsure if they anticipated new or additional shared services in the next two to three years.

Sharing of Foundational Capabilities

Fourteen respondents reported not sharing any FCs and 13 respondents indicated they shared all seven foundational capabilities. Nineteen respondents indicated that they would not consider sharing any FCs, while 25 respondents reported that they would consider sharing in all seven of the FCs.

The most shared FC was *All Hazards Preparedness and Response* with 80 respondents reporting they shared this FC. Less than half of respondents reported sharing any other FCs, with about 40 respondents reporting that they shared *Assessment*, *Communications* and *Community Partnership Development*. Around a quarter of respondents reported sharing *Policy Development and Support*, *Health Equity and Social Determinants of Health* and *Organizational Competencies.*

Over half of respondents reported they might consider sharing *All Hazards Preparedness and Response* (59), and about half of departments reported they might consider sharing of *Community Partnership Development* (51), *Assessment* (48) and *Health Equity and Social Determinants of Health* (47). Nineteen departments would not consider sharing any FCs (*Figure 2,* page 7).

Figure 2. **Number of Respondents Reporting Current and Potential Sharing for Each Foundational Capability**

Foundational Capabilities	Number Currently Sharing	Number that Would Consider Sharing
All Hazards Preparedness/Response	80	59
Assessment	41	48
Communications	40	41
Community Partnership Development	40	51
Policy Development & Support	27	45
Health Equity & Social Determinants of Health	27	47
Organizational Competencies	23	43
None	14	19

Sharing of Foundational Areas

Eighteen respondents reported no current sharing for any of the FAs, while 16 respondents reported sharing all five FAs. Twenty respondents reported they would not consider sharing FAs and 29 respondents reported they would considering all five FAs.

The most shared FA was *Environmental Health,* with 52 respondents reporting they shared this FA. About half of the respondents (49) reported sharing *Maternal and Child Health*, and less than half reported sharing any other FA. Eighteen respondents reported sharing no FAs. When asked which FAs LHDs might consider sharing, the highest responses were for *Health Promotion and Chronic Disease and Injury Prevention* (58) and *Environmental Health* (55). Twenty respondents reported that they would not consider sharing any FPHS services (*Figure 3,* page 8).

Figure 3. **Number of Respondents Reporting Current and Potential Sharing for Each Foundational Area**

Foundational Areas	Number Currently Sharing	Number That Would Consider Sharing
Environmental Health	52	55
Maternal and Child Health Services	49	50
Access to Clinical Care	42	52
Communicable Disease Control	40	41
Health Promotion and Chronic Disease and Injury Prevention	39	58
None	18	20

Other Comments

Respondents also provided several comments that were not related to FCs or FAs currently shared or that LHDs might consider sharing.

- One respondent identified an informal sharing practice, responding that they worked with other entities/organizations but that there was no contract for the services or programs.
- Another respondent identified an interest in working and sharing with others to better the community but identified the need for guidance and technical assistance.
- Finally, across multiple comments from respondents, there was a general interest in sharing services and agreements to better serve their communities.

Case Studies

Based on the results of the 2014 survey, the team used the following criteria to prioritize CJS arrangements for case study:

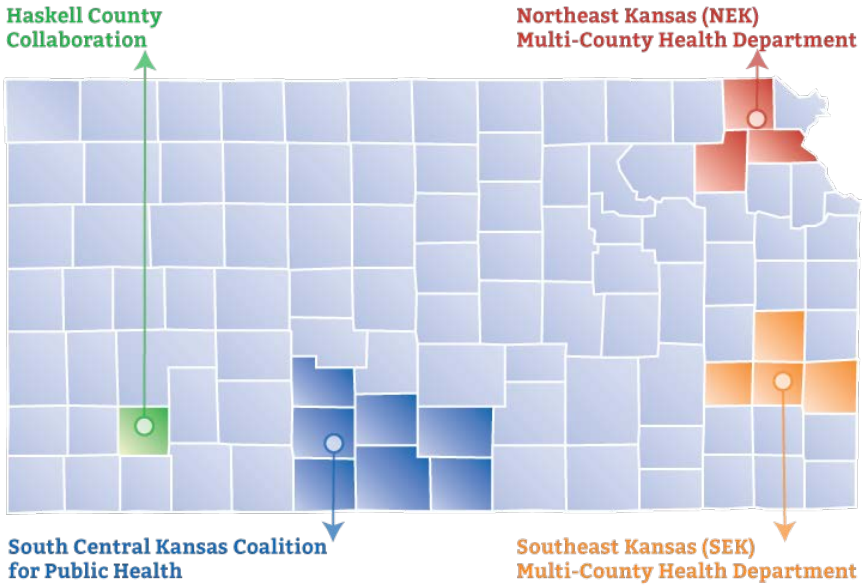
- Respondents with high 'experience' scores;
- Respondents with high 'satisfaction' scores;
- More formal, rather than informal, agreements;

- Arrangements that included a higher number of shared services;
- Sharing agreements with unique features (such as a relationship with tribes, a unique sharing agreement, etc.); and
- Geographic diversity (tried to identify sharing arrangements across the state).

Based on these criteria, four sharing arrangements were prioritized for case studies (*Figure 4*).

- NEK (Atchison, Brown, and Jackson)
- SEK (Allen, Anderson, Bourbon, Woodson)
- Barber, Comanche, Edwards, Harper, Kingman, Kiowa, Pratt
- Haskell County Health Department/Haskell County Hospital

Figure 4. **Cross-Jurisdictional (CJS) Case Study Locations**



In each of these four locations, KHI staff traveled on-site to hold a series of key-informant interviews with various personnel connected to the sharing arrangement. The individuals involved in these interviews varied from community to community based on the structure of the arrangement and the individuals' availability. In general, the interviews included health department administrators from each of the health departments involved in sharing (if more than one agency), county commissioners from each of the counties engaged in sharing, health

department staff, health department and/or county human resources, health department and/or county accountant.

Each of the four interviews were summarized into issue briefs and published on KHI's website. A fifth document identified themes that emerged as common between the case studies. This document was developed and published in December 2015. The four location-specific issue briefs and the common themes report can be found at: http://www.khi.org/policy/article/kansas_cjs.

Pilot Projects

With expertise from the Center for Sharing Public Health Services (Center), project staff developed an RFP for up to four pilot projects for CJS in Kansas. The RFP was released in September 2015, and two projects were selected for funding in December 2015.

Butler/Greenwood Counties: Family Planning Services

The Greenwood and Butler County Health Departments were awarded a grant to explore the potential of entering into a cross-jurisdictional sharing agreement to provide family planning in Greenwood County. Butler County already offered the family planning program, but Greenwood County did not. Approximately 6 percent of the Butler County clients were Greenwood County residents, and the administrator in Greenwood County had received inquiries about the availability of family planning services.

The goal of the pilot project was to determine whether CJS was feasible for the family planning program. To reach this goal, the participating county teams planned to conduct a feasibility study to identify potential barriers and find solutions to ensure success, to identify the scope of the agreement, and to engage the communities to determine the need and possible utilization of the service by the intended population. The collaborative partners aimed for a formal agreement for shared services that would be approved and adopted by the County Commissioners in both counties. After the development of the agreement, the administrators planned to determine the logistics, financial structures, policies and procedures agreements to provide services across the jurisdictions.

As they conducted the feasibility study, the health department administrators identified a past CJS arrangement for public health between these two counties that had been in place from 1949

until 1998. The agreement dissolved due to disagreements over funding equity, and there was a level of residual mistrust that made the commissioners in both counties hesitant to enter into an arrangement.

Additionally, through the feasibility study, the health department administrators identified that a Federally Qualified Health Center (FQHC) was already delivering family planning services on a sliding scale in Greenwood County. The commissioners were against duplication of services, and as a result, the decision was made to not continue with the development of the CJS arrangement.

Despite the decision not to share services, both counties learned lessons about the importance of conducting a feasibility study prior to developing an agreement, as well as the key role that trust plays among participating members. Additionally, an agreeable solution for funding a CJS arrangement was found to be a key element in any possible future agreement that might take place between these counties. Details of the lessons learned in this CJS Pilot Project were detailed into a case study developed by the CJS Workgroup. A description of and link to the case study can be found on page 14.

Crawford/Montgomery: Becoming A Mom (BAM) Maternal Education

Crawford and Montgomery Counties received a pilot project award for the development of a CJS arrangement. The two counties are part of the Lower 8 Public Health Preparedness region and had collaborated informally on other projects in the past.

The service to be shared was the Becoming a Mom (BAM) program for maternal education in Montgomery County. Crawford County had already received a grant and had successfully initiated their program, and additional funding was available from KDHE for Montgomery County to offer the program as well. The counties shared the exploration, development, partner engagement, and staffing for the program in Montgomery County. Specifically, Crawford County aimed to assist Montgomery County Health Department staff in capacity building, technical assistance, development of program materials, engaging local stakeholders, and promotion and marketing of the program. Crawford County staff also hoped to assist with the implementation and monitoring of the program.

When the program was initiated in Crawford County, the goal was to offer it regionally. Additionally, high rates of premature births, low birthweight infants, infant mortality, teen births,

and mothers who smoke while pregnant, drove the interest in offering this program to combat some of these issues.

Both counties had strong support from their county commissioners. An initial Memorandum of Understanding (MOU) was developed between the health departments which outlined the types of assistance and support that would be provided to Montgomery County by Crawford County in developing the BAM program. At the end of the exploration period, a second MOU was signed that committed a shared staff member to continue to assist in the implementation of the program. It was decided that both counties would share equally in the decision-making and the cost of the shared staff member for the BAM program.

Tools/Resources Development

Based on input from Center staff, the CJS Workgroup, and other stakeholders, five tools/resources were prioritized for development. Each of the resources are described and linked below. These resources will be shared on both the KHI and Center for Sharing Public Health Services websites, and will be emailed to all local health department directors in Kansas. The Board of Health document will also be emailed to all Kansas county commissioners.

1. ***Foundational Public Health Services and Opportunities for Cross-Jurisdictional Sharing in Kansas***: This report describes the history of CJS in Kansas and the process of developing a local FPHS model. It also explores the extent to which other states (e.g. Oregon, Ohio) have included CJS in their approaches to providing FPHS. It highlights examples from the states that have provided specific guidance or requirements for health departments in using CJS to assist in meeting the FPHS. It also notes how these concepts may be applied in Kansas, and where there are differences in context that may require a unique approach. This resource can be found at: http://www.khi.org/policy/article/17-10.

2. ***Role-Play Exercise: Cross-Jurisdictional Sharing and Foundational Public Health Services***: This resource was developed as a group exercise for the KPHA meeting in 2016. This document presents a case scenario of two fictional local health departments exploring shared services for one of the Foundational Capabilities within the Foundational Public Health Services model. There are four 'roles' in this case scenario, which can be used to role-play and explore key themes in the exploration of CJS for public health services. It includes links to resources from the Center that will provide additional support in addressing some of the topics

addressed in the role-play exercise. This resource can be found at: http://www.khi.org/policy/article/17-11.

3. *Authorities for Cross-Jurisdictional Sharing in Kansas*: This resource outlines the authorities and legal structures that impact sharing of public health services. These include home rule, interlocal agreements, contracts, and the makeup of joint boards of health. The document highlights the broad home rule given to Kansas cities and counties through the constitution and Kansas statutes, and it outlines the content and structure of interlocal agreements and contracts, as stated in statute. It also lists the authorities of a joint board of health. This resource references the statutes that relate to interlocal agreements in 12-2901 et seq. and the statutes that relate to local boards of health in 65-201 et seq. This resource can be found at: http://www.khi.org/policy/article/17-12.

4. *Local Board of Health Guidance for Cross-Jurisdictional Sharing Arrangements in Kansas*: Many CJS tools are developed with the local health department director in mind, however, boards of health are often the entity that has final authority over entering into a CJS arrangement. This document provides board of health members with information on CJS arrangements, focusing on the concepts of effectiveness and efficiency, and including possible financing models. This resource can be found at: http://www.khi.org/policy/article/17-13.

5. *Case Study: Exploration of Public Health Shared Services- Butler and Greenwood Counties in Kansas*: This resource is a description of the process that was undertaken by the Butler and Greenwood County Health Department administrators to explore CJS for their family planning program. It presents the goals, process and barriers that were experienced during the exploration. The document includes a description of the decision not to share services and the factors that contributed to that decision, and outlines some of the lessons learned by the health department administrators. This resource can be found at: http://www.khi.org/policy/article/17-14.

Presentations

Throughout the project period, KHI staff presented at Kansas meetings regarding CJS and the results of the Workgroup activities. The CJS presentations relevant to the Kansas CJS Workgroup are listed below.

- Public Health Grand Rounds, April 1st, 2015
    - *Multi-Jurisdictional Sharing: National Efforts and Kansas Activities*
- Public Health Systems and Services Keeneland Conference (Keeneland, Kentucky), April 21st, 2015
    - *Poster Session*
- Governor's Public Health Conference, April 30th, 2015
    - *Sharing Services for Greater Public Health Impact in Kansas: Survey results and preliminary case study learnings*
- KALHD Mid-Year Meeting, June 16th, 2015
    - *Multi-Jurisdictional Sharing Arrangements: What We Have Learned*
- KPHA, September 21st, 2016
    - *Poster Session*
- Kansas Association of Counties, November 5th, 2015
    - *Multi- County Interlocal Agreements: A Model for Public Health and Beyond*
- Governor's Public Health Conference, April 28th, 2016
    - *Café Session: Multi-Jurisdictional Sharing*
- Presentation to the Wildcat Public Health Preparedness Region (Riley, Pottawatomie and Geary Counties), May 4th, 2016
    - *Cross-Jurisdictional Sharing: An Innovative Approach to Public Health Governance*
- KALHD Mid-Year Meeting, June 21st, 2016
    - *Cross-Jurisdictional Sharing: A strategy to advance FPHS coverage and accreditation readiness*

- Kansas Public Health Association (KPHA) Conference, September 20th, 2016
    - *We're All in This Together: Experiences with Cross-Jurisdictional Sharing*
- Webinar for the Council on the Future of Public Health in Kansas, February 24th, 2017
    - *Cross-Jurisdictional Sharing: What is Happening in Kansas?*

**Additional presentations in 2017 are pending (abstract accepted for KPHA in October 2017).*

CJS and FPHS

As Kansas moves toward the concept of the FPHS for all Kansans, there is a need to examine possible governance structures that will enable efficient and effective provision of the services that will keep the public safe and healthy. CJS provides one option for health department leaders, working with boards of health, to ensure that their communities have access to these public health services.

While some health departments already have high capability and capacity to implement the FPHS for Kansas, others have low numbers of staff and other difficulties that limit their capacity and capability for FPHS implementation. In these cases, especially when the health departments are located jurisdictions with small and declining populations, CJS has been identified as one possible way to share capacity and increase the quality and quantity of services provided to meet the FPHS package.

Several other states have already taken steps to move toward the FPHS, and some of these states have identified CJS as a key strategy for FPHS implementation. Ohio and Oregon are two states that included specific reference to CJS in their FPHS models, and Ohio provided guidance and recommendations about in what circumstances to consider various forms of CJS.

The examples of the integration of FPHS and CJS in states with similarly structured public health systems offer food for thought as Kansas develops an implementation strategy for the FPHS. However, due to the different context in which the decisions are being made, there are some important distinctions that should be made between these states' approaches and the Kansas model.

First, although Ohio has the most robust guidance around CJS and FPHS, a requirement to apply for accreditation by 2018 and to become accredited by 2020 has been a primary driving factor in the move toward consolidation and other CJS efforts. In Kansas, this requirement does not exist. The FPHS have been described as an achievable milestone on the journey to accreditation readiness, but there is no current intent to require all health departments to become accredited. Second, Ohio's guidance recommends that jurisdictions consider sharing if the population is less than 100,000. If adopted in Kansas, all but very few health departments would meet this criterion. If Kansas puts forth similar guidelines for consideration of CJS based on population served, the threshold would need to be reconsidered in the local context.

Finally, in comparison to the states above, in which approximately 50 percent of health departments in Ohio serve populations of fewer than 50,000, more than 90 percent of Kansas health departments serve populations of fewer than 50,000.[1] This presents an additional challenge for Kansas, both for efficient implementation of the FPHS, as well as for identifying a unique model for CJS that maintains local autonomy and effective service for Kansas residents.

Future Work and Next Steps for Kansas

The CJS Workgroup has been meeting regularly over the past three years. Though attendance has varied from meeting to meeting, participants generally include representatives from KDHE, KHI, KALHD, academia and local health departments. With funding now absent, the Workgroup may have fewer deliverables and activities to discuss, however, the Workgroup does have relevance to the future of public health in Kansas. Due to this, we recommend continuing to meet on a quarterly or bi-annual basis to continue the discussion of concepts related to CJS in Kansas.

Additionally, it is recommended that the exploration of CJS and FPHS continues, with the participation of state and local public health as well as other public health systems group partners.

Appendix A: Endnotes

1. National Association of City and County Health Officials. (2013). *National Profile of Local Health Departments: Kansas.* Retrieved from: http://nacchoprofilestudy.org/wp-content/uploads/2014/01/NACCHO9314-State-Brief_KS.pdf

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