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REVIEW OF CROSS-JURISDICTIONAL SHARING IN KANSAS

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Author

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Executive Summary

Background

In 2013, members of the Kansas Public Health Systems Group (PHSG)—a multi-sector coalition of Kansas state public health partners representing public health practice, academic institutions, government and charitable organizations—participated in a prioritization process to determine key activities to improve the public health system in Kansas. One of these priorities was the exploration of cross-jurisdictional sharing (CJS) in Kansas. CJS for public health is defined as, *"the deliberate exercise of public authority to enable collaboration across jurisdictional boundaries to deliver public health services and solve problems that cannot be easily solved by single organizations or jurisdictions."*[1]

Although there were a few prominent and well-known examples of CJS in Kansas, including two multi-county health departments and the 15 public health emergency preparedness regions, not much else was known about the extent of and attitudes toward service sharing in Kansas. A Kansas CJS workgroup was formed to undertake activities to explore opportunities for CJS in Kansas.

Kansas CJS Workgroup Activities

The Kansas CJS Workgroup, facilitated by the Kansas Health Institute (KHI), was tasked with leading a three-year project to better understand the landscape around CJS in Kansas. The Workgroup's activities included surveys, case studies, pilot projects, the development of tools and resources, and presentations about CJS on webinars and at conferences in Kansas.

This report details the results of the Assessment Surveys, conducted in 2014 and 2017, and the case studies, conducted in 2015.

Key Findings

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.

Several Kansas CJS arrangements are in place that have lasted 30 years or more. Among these arrangements, there are several common themes.

- Buy-in from local policymakers is key to the success of CJS arrangements. Though there was initial concern about losing local autonomy, a focus on efficiencies and continued communication about the sharing effort helped to increase support among local policymakers.
- CJS arrangements can increase public health effectiveness and efficiency by allowing partners to improve current services or acquire new ones, while maximizing the use of resources through shared staff and services.
- There can be challenges in CJS arrangements, like increased travel expense, difficulty communicating between partners, and lack of resources to conduct evaluations.

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 Public Health Services (FPHS)[2] were the Foundational Capabilities (FCs) and Foundational Areas (FAs), *All Hazards Preparedness and Response, Environmental Health,* and *Maternal and Child Health.*

There is a general willingness to engage in additional CJS for the FPHS. 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.

Conclusions and Next Steps

As work toward the FPHS continues to develop, system partners have begun to consider service sharing as a means to improve capacity and capability for FPHS implementation. Lessons from the existing FPHS arrangements can be used to inform the design of service-sharing efforts.

History of CJS in Kansas

Cross-jurisdictional sharing has a long history in Kansas. Though there has been growing interest in the topic in recent years due to declining financial resources and an increased focus on the FPHS, there are several CJS arrangements in Kansas that have lasted 30 years or more. Understanding the development and evolution of these arrangements can help to shed light on current and future CJS activities.

In 1949, the first bi-county health department was formed between Butler and Greenwood Counties. This arrangement lasted for nearly 50 years before dissolving in the late 1990s.

The early 1970s saw the development of two multi-county health departments that still exist today. In 1971, the Southeast Kansas (SEK) Multi-County Health Department was formed between the five counties of Allen, Anderson, Bourbon, Linn and Woodson. Today, four of the five counties remain part of the agreement (Linn County exited in 2006).[3] Shortly after the formation of SEK Multi-County Health Department, in 1972, the agreement forming the Northeast Kansas (NEK) Multi-County Health Department was signed. Initially, this arrangement consisted of four counties: Atchison, Brown, Doniphan and Jackson. Doniphan County exited the agreement after one year, and the remaining three counties continue their relationship.[4]

The above agreements are tightly integrated models. In each of the cases, a new public health agency was formed that provided public health services to all of the participating counties. In the mid-1990s, a group of seven health departments in South Central Kansas developed a different kind of partnership. Based on a desire to maintain local control and autonomy, these counties developed an interlocal agreement for public health in which each county retains its own public health agency, but sharing is facilitated through an eighth quasi-governmental agency called the South Central Kansas Coalition for Public Health. In this model, three of the counties each have responsibility for one of the primary programs provided by the health departments and serve in an administrative function. Their responsibilities include applying for and receiving the grants on behalf of the region. They then share the regional funds with each of the other health departments and the services are provided at each agency.[5]

In 2001, in response to terrorist attacks and the possible threat of biological and other forms of terrorism, the federal government developed Public Health Emergency Preparedness grants to increase state and local capacity to respond to a variety of public health threats. In Kansas, these

grants were distributed to self-organized regions consisting of between three and fifteen counties. As of June 2017, only two Kansas counties (Ellis and Rush) do not participate in a Public Health Emergency Preparedness region. These Public Health Emergency Preparedness regions are an example of CJS being used to increase capacity for emergency response in Kansas.

Kansas CJS Workgroup

The Kansas CJS Workgroup, facilitated by the Kansas Health Institute (KHI), was tasked with leading a three-year project to better understand the landscape around CJS in Kansas. The Workgroup's activities 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 the fall of 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 an 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 (this activity was added in 2016).

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

Survey Efforts

In order to better understand the full extent of CJS in Kansas, two survey efforts were conducted by the Kansas Cross-Jurisdictional Sharing 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.

CJS in Kansas Assessment Survey, 2014

A Kansas-specific public health CJS survey was developed based on a similar CJS assessment conducted in Wisconsin[6], as well as resources from the Center for Sharing Public Health Services[7]. The survey was deployed in October 2014. The survey was sent to all health department administrators, both Kansas Association of Local Health Department (KALHD) and non-KALHD members. A total of 105 individuals were sent the survey because the project team decided the county would be the unit of analysis. For the Northeast Kansas (NEK) Multi-County Health Department and the Southeast Kansas (SEK) Multi-County Health Department, multiple individuals from each health department, representing the constituent counties, completed the survey. Non-responders were sent email and phone reminders about completing the survey.

The survey included the following types of questions (See Appendix A for the full survey instrument).

- What are the types of shared-services arrangements in which Kansas LHDs are engaged?
- What is the history of and processes for utilizing shared services among Kansas LHDs?
- Who are the persons or what are the organizational positions responsible for engaging in shared-services arrangements in Kansas?
- What are the opportunities for and challenges encountered in shared-services arrangements in Kansas?
- What shared services models have been most effective in improving public health service delivery in Kansas?

- What are the characteristics of public health activities in Kansas that are improved by delivery through shared-service arrangements compared to those that are most effectively provided through highly localized arrangements?
- What are the costs, benefits, efficiencies and cost savings of Kansas LHD mergers and shared-service arrangements?

Survey Results Summary

Below is a summary of the key findings from the survey. A full report of survey responses is included in Appendix B.

The survey received 78 total responses from the 105 individuals who were sent the survey (a 74 percent response rate). However, four surveys were left blank, so only 74 responses were used for analysis (a 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.

One major limitation of this survey is that respondents were not required to answer each of the questions. Therefore, each of the questions below has a varying number of respondents. The percent of respondents for each question is presented below, and the detailed responses can be found in Appendix B.

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 reported shared services or functions were: Emergency Preparedness (71 percent) and Maternal and Child Health services (35 percent). Following were WIC; Community Health Assessment (CHA); and Inspection, Permitting and Licensing (all 29 percent).

The least commonly shared services or functions 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 service(s).

Those without CJS

The 18 respondents (25 percent of survey respondents) 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 selected by 39 percent of those without CJS) 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 of these four indicated a need for additional information and resources about CJS to be shared.

Of note, the 26 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.

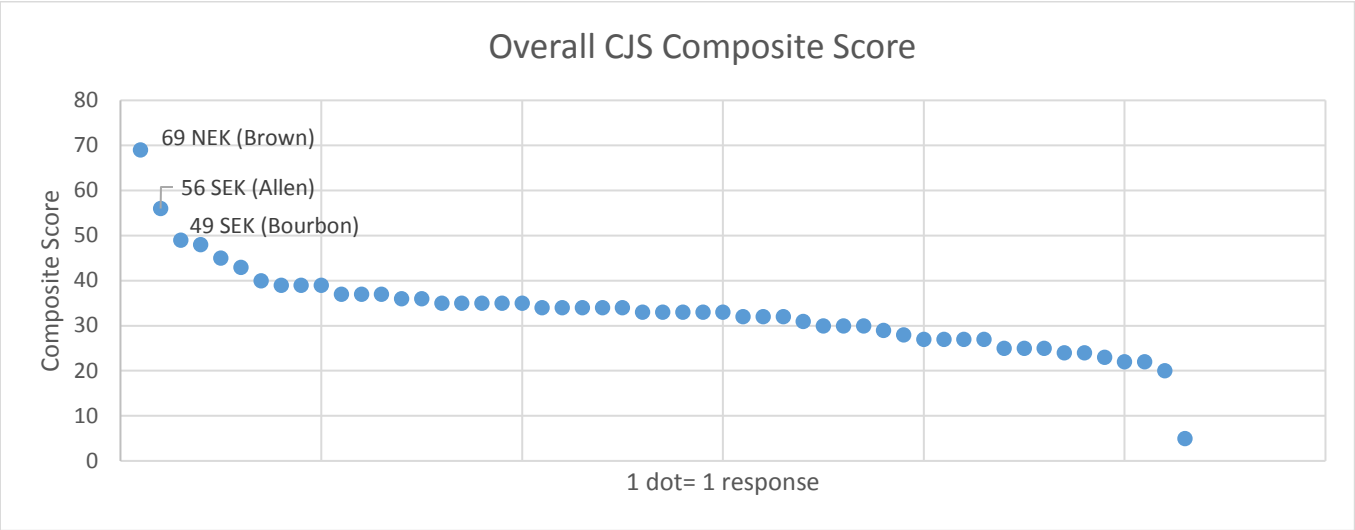
Domain Scoring

In order to select 'high-performing' CJS arrangements for the case studies in year two, KHI staff developed a scoring system for three domains. These were composite scores of several of the survey questions. The three domains were: experience, satisfaction, and diversity of arrangements.

Questions included in each of the domains and the corresponding scores based on answers are described below. Questions were scored so that a higher numeric value indicates a more affirmative response to the topic indicated within each domain. The maximum possible score for experience was 35, satisfaction was 22 and diversity of arrangements was 26. See Appendix C for the questions included within each domain.

Finally, an overall score was calculated by adding the three domain scores together. The maximum possible score was 83. The highest-scoring respondent was NEK (Brown County), with a total score of 69. Following that were two of the SEK counties (Allen and Bourbon Counties). In general, these scores were successful in identifying health departments that had strong CJS arrangements. For example, the highest-scoring respondents on the experience score were those that were involved in the multi-county health departments, which have both been in place since the 1970s (*Figure 1,* page 7).

Figure 1. **Overall CJS Composite Scores**



Note: Because the county was the unit of analysis, there are multiple surveys from both NEK and SEK multi-county health departments.

Source: KHI analysis of Kansas CJS Survey, 2014.

CJS in Kansas Aid-to-Local Survey, 2017

As part of the ongoing work to explore and support CJS in Kansas, KHI conducted a follow-up to the 2014 survey to examine the extent of CJS among Kansas local health departments. In the spring of 2017, KHI, in collaboration with the Kansas Department of Health and Environment (KDHE), added a short series of supplemental CJS questions to the Aid-to-Local survey, which is administered to all 100 local health departments in the state of Kansas. This survey is completed by all local health departments on a yearly basis. See Appendix D for the supplemental CJS questions.

Due to the ongoing work by KALHD and the Public Health Systems Group (PHSG) to assess and implement the Foundational Public Health Services (FPHS) in Kansas, the original CJS questions were re-framed around the Foundational Capabilities (FCs) and Foundational Areas (FAs) of the FPHS model. CJS has been discussed as one potential strategy to facilitate the implementation of FPHS through new governance and service delivery models. The adjustment of the original CJS questions allows for an exploration of which of the FPHS are currently shared and which might be strong candidates for shared services in the future. This will inform the PHSG partners as they develop an implementation plan to expand FPHS service provision while allowing departments to control costs and better manage limited resources.

KHI has analyzed these responses to better understand the current extent of cross-jurisdictional sharing for FPHS in Kansas. A summary of the results of the analysis are provided below. A full report of the analysis can be found in Appendix E.

Survey Results Summary

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 Foundational Capabilities (FCs) or Foundational Areas (FAs), respondents indicated a higher frequency of sharing; 92 respondents indicated sharing with any organization, while eight 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).*

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

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 and the 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 consider 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 10).

Figure 3. Number of Respondents Reporting Current and Potential Sharing for Each FA

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 and Common Themes

Case Studies

In order to provide a more in-depth exploration of the history, drivers, benefits and challenges of existing CJS arrangements, four case studies were developed of current sharing arrangements. Based on the results of the 2014 survey, the team used the following criteria to prioritize CJS arrangements for case study:

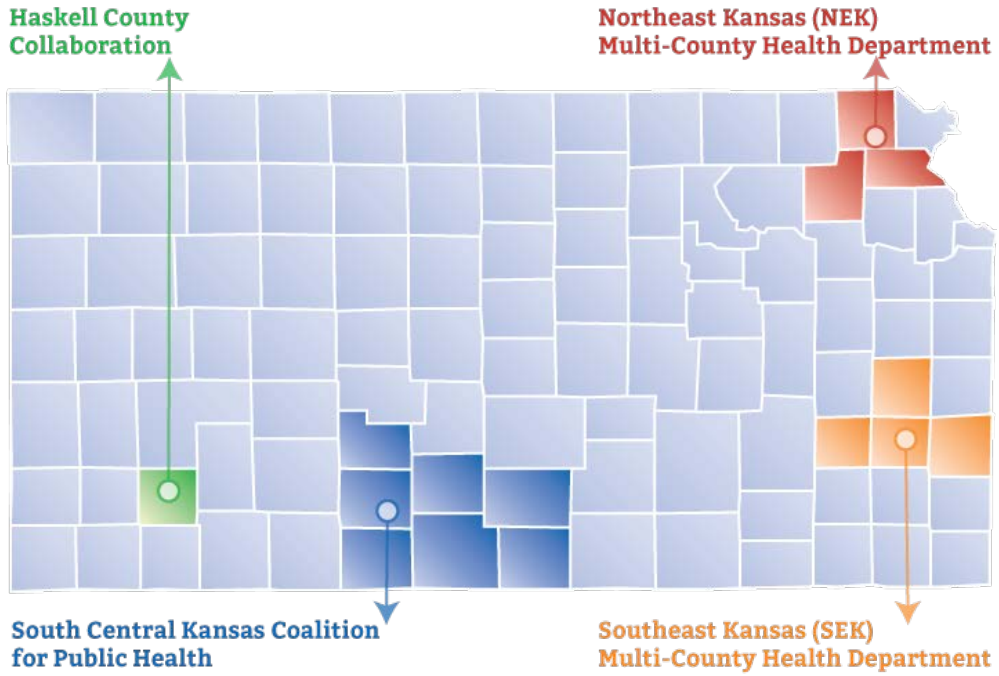
- Respondents with high 'experience' scores;

- 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. 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, but in general, the interviews included health department administrators from each of the health departments involved in sharing (if the sharing arrangement consisted of more than one public health 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 accountants.

The interview questionnaires were developed by KHI staff members and pilot tested in March 2015. The interview consisted of a 'pre-interview' with one the health department administrator involved in the arrangement, and the on-site interview with the larger group of stakeholders. Interviews took place between April and July 2015. See Appendix F for a copy of the questionnaire.

The interview responses were coded using both deductive (pre-identified) and inductive (identified based on the content of responses) codes. Using this coding scheme, each of the four interviews were summarized into issue briefs and published on KHI's website. The issue briefs can be found at: http://www.khi.org/policy/article/kansas_cjs.

Common Themes

A fifth document identified themes that emerged as common between the case studies, using the codes that were identified in the case study development for each of the individual case studies. This document was developed and published in December 2015. Below are some of the key findings from that document.

All four of the sharing arrangements had been in place for more than 20 years. Additionally, despite having different numbers of health departments involved in each arrangement, three of the four arrangements served similarly sized combined populations: between 35,000 and 40,000 people. The fourth was a public-private partnership within one county.

Limited Resources: Each arrangement began when community members, policymakers, and/or health department administrators saw a need to efficiently provide public health services in small counties. Because these areas had limited resources, they share staff and other resources as a solution to build economies-of-scale or meet minimum program requirements. While the CJS

survey found that the primary motivation for health department administrators to enter a CJS arrangement was to offer more and higher-quality services, the case studies found that in communities where CJS was successful, limited resources often catalyzed the discussion, especially with policymakers.

Governance and Funding: Each sharing arrangement has its own unique structure for funding, administration and management of public health activities. However, all the sharing arrangements are governed by a board of health, board of directors, or executive board. In some cases, this board is made up entirely of county commissioners, and in other cases it is a combination of county commissioners, medical professionals, and community members. Funding is arranged to be fairly distributed among the sharing partners, either at equal portions or based on population size.

Policymaker engagement: Gaining political support from commissioners has been important in all the studied CJS arrangements. In the beginning of the sharing arrangements, the commissioners were concerned about losing local autonomy. However, focusing on efficiencies was one way that health department administrators were successful at gaining buy-in. As the arrangements developed and grew, so did support from the commissioners.

Benefits: The number of public health services in these counties has increased through the development and growth of CJS arrangements. Collectively, the sites added WIC, family planning, child health, immunizations, women's health and other services. These services are more efficient as well. One efficiency is sharing staff members, which can contribute to a reduction in un-occupied staff time and overhead costs. One other benefit is the spirit of teamwork that has been fostered between the collaborating organizations. These supportive, trusting and self-motivated teams have contributed to the success of the CJS arrangements.

Challenges: Time spent driving and the cost of travel between counties was mentioned as a substantial barrier to sharing services. Communication between locations and across county lines has also been a challenge for some of the arrangements. Finally, measuring and evaluating the success of CJS has also been a challenge.

Recommendations made in the common themes report included seeking assistance from the Center for Sharing Public Health Services and referencing the Center's resources when developing and improving CJS arrangements; conducting regular evaluations of existing CJS

arrangements to identify areas for additional efficiency and to share lessons learned with other communities; and exploring the use of CJS to deliver the Foundational Public Health Services.

Conclusions and Next Steps

Since 2014, the Kansas CJS workgroup has learned a great deal about the current state of CJS in Kansas, as well as the benefits and drivers of sharing and willingness to engage in future sharing. There have also been several lessons learned about the barriers and challenges to sharing. The lessons learned to-date can inform the future of CJS in Kansas. In Kansas, future CJS activities are likely to arise as a result of the ongoing work of moving towards a model for Foundational Public Health Services in Kansas. The quantitative results of the 2017 survey can provide a launching point for identifying services that may be good candidates for sharing as plans for FPHS implementation are developed. The qualitative results of the 2015 case studies can provide additional information on how to effectively manage concerns and barriers as communities consider CJS.

Appendix A: CJS in Kansas Survey Instrument, 2014

Kansas Public Health- Shared Services Survey

Q1.1 (Intro) The Kansas Health Institute, in partnership with the Kansas Public Health Systems Group, has received funding from the Kansas Health Foundation to conduct a survey to identify the current use of cross jurisdictional shared services by Kansas local public health departments.

*Cross jurisdictional sharing is the **deliberate exercise** of public authority to **enable collaboration across jurisdictional boundaries** to deliver essential public health services. We are most interested in cross jurisdictional shared services, also referred to as just "shared services," across **county** or **tribal** boundaries.*

The survey will answer the following questions:

- What are the types of shared services arrangements in which Kansas local health departments (LHDs) are engaged?
- What is the history of and process for utilizing shared services among Kansas LHDs?
- What are the opportunities for and challenges encountered in shared services arrangements in Kansas?
- What shared services models have been most effective in improving public health service delivery in Kansas?
- What are the characteristics of public health activities in Kansas that are improved by delivery through shared service arrangements compared to those that are most effectively provided locally?

You are invited to contribute to this significant body of knowledge by taking the following survey. We will share the aggregate results with respondents via email once the data have been compiled.

The survey should take no more than 15 minutes for you to complete. Your participation is entirely voluntary. All survey responses are confidential and will be reported only in the aggregate. Your responses will be known only to the project staff who analyze survey results. If

the project staff would like to follow up on a response, you may be contacted to provide additional information. Any participation in subsequent information-gathering efforts will be entirely voluntary as well. If you have questions at any time about the survey or the procedures, you may contact Sarah Hartsig at the Kansas Health Institute at 785-233-5443, or by email at shartsig@khi.org. We ask that you please complete the survey by **October 22, 2014.**

Q1.2 Please select the county you represent.

(Drop-down list of counties)

Q1.3 Please provide your contact information, which will be used for follow-up if needed:

	Information will be shared only with project staff
First name: Last name: Organization: Title/Role: Email: Phone:	

Q2.1 READ THIS FIRST:

*Cross jurisdictional sharing is the **deliberate exercise** of public authority to **enable collaboration across jurisdictional boundaries** to deliver essential public health services.*

*For the purposes of this survey, cross jurisdictional shared services, also referred to as just "shared services," may include program-related **public health services** (e.g., emergency preparedness, epidemiology, etc.) and **general administrative/back-office functions** (e.g.., IT support, human resources, etc.)*

Q2.2 Does your public health department engage in any cross jurisdictional shared services with another county or tribal entity?

- ❍ Yes
- ❍ No
- ❍ We are currently considering/developing a shared services agreement

Q2.3 Have you had any shared services arrangements in the past that are no longer being implemented?

- ❍ Yes
- ❍ No
- ❍ Don't know

YES PATHWAY (If Yes is selected on Q 2.1)

Q7.1 When did your health department begin sharing services?

- ❍ Less than 1 year ago
- ❍ 1-5 years ago
- ❍ 6-10 years ago
- ❍ 11-20 years ago
- ❍ 21 + years ago
- ❍ Don't know

Q7.2 How many arrangements do you currently have for shared services?

- ❍ 1-3
- ❍ 4-6
- ❍ 7-9

❍ 10+

Q7.3 On average, approximately what length of time does it take to move from the idea of shared services to actual implementation of shared services?

❍ 1-3 months

❍ 4-6 months

❍ 7-12 months

❍ More than 12 months

❍ Don't know

Q7.4 What type of agreements has your organization used for shared services arrangements? (check all applicable)

❑ An informal "hand-shake" agreement

❑ Memorandum of understanding

❑ Service provision agreement

❑ Inter-local agreement

❑ Consolidation or merging two or more health departments into one entity

❑ Other (please describe) _____

Q7.5 With what type of organization(s) does your health department share services? (check all applicable)

❑ One other city or county public health department

❑ A group of several city or county public health departments

❑ Tribal health center or Tribal government

❑ Military base

❑ Other (please describe) _____

Q7.6 Which of the following services do you share with another organization? (check all applicable)

- ❑ Emergency preparedness
- ❑ Epidemiology or surveillance
- ❑ Physician and nursing services
- ❑ Communicable disease screening or treatment
- ❑ Maternal and child health services
- ❑ Population-based primary prevention programs
- ❑ Inspection, permit, or licensing
- ❑ Environmental health programs (other than inspection, permit or licensing)
- ❑ Community health assessment/community health improvement planning
- ❑ Strategic planning
- ❑ Laboratory services
- ❑ Executive leadership
- ❑ Fund raising and grant writing
- ❑ Finance and accounting
- ❑ IT support
- ❑ Human resources
- ❑ Office and facility maintenance
- ❑ Purchasing
- ❑ Communications and outreach
- ❑ Billing

❑ Other (please describe) _____

Q7.7 Please name the other partner organization(s) with which you are engaged in shared services arrangements. Please list organization(s) and contact person(s).

	Organization	Contact Person
Partner 1		
Partner 2		
Partner 3		
Partner 4		
Partner 5		
Partner 6		
Partner 7		
Partner 8		
Partner 9		
Partner 10		
Partner 11		
Partner 12		
Partner 13		

Q7.8 Please identify the motivation to share services with another organization: (check all applicable)

- ❑ To achieve economies of scale
- ❑ To save money
- ❑ To promote regional service integration
- ❑ To provide better services
- ❑ To promote higher quality/more effective service delivery
- ❑ To provide new services
- ❑ To access needed expertise
- ❑ To strengthen collaborative intergovernmental relations
- ❑ To respond to policymaker interest
- ❑ To comply with state requirements or policies
- ❑ To respond to program requirements
- ❑ To increase the department's credibility in the community
- ❑ To aid in recruitment of qualified staff
- ❑ To meet or prepare for voluntary accreditation requirements
- ❑ Other (please describe) _____

Q7.9 What processes has your organization used to negotiate the terms of the shared services arrangement(s)? (check all applicable)

- ❑ Meetings among local government staff
- ❑ Meetings among elected officials and other policymakers
- ❑ Outside consultant or negotiator

- ❑ Secured through a request for information/proposals
- ❑ Contract negotiations for fee-for-service or other service arrangement
- ❑ Other (please describe) _____

Q7.10 Who in your organization has been involved in developing the shared services arrangement(s)? (check all applicable)

- ❑ Local health department director/administrator
- ❑ Elected officials (county or city)
- ❑ Local board of health
- ❑ Health officer
- ❑ Tribal leader or tribal council
- ❑ Human resources director
- ❑ City attorney
- ❑ County attorney
- ❑ Private attorney/counsel
- ❑ County administrator
- ❑ City administrator
- ❑ Community partners
- ❑ Don't know
- ❑ Other (please describe) _____

Q7.11 Please rate the following statement: Roles and responsibilities of the partners in the shared services arrangement(s) are clearly defined.

- ❍ Strongly Agree

❍ Agree

❍ Neutral

❍ Disagree

❍ Strongly Disagree

Q7.12 Please rate the following statement: In general, key decision-makers and policymakers in my community support a vision for cross jurisdictional shared services.

❍ Strongly Agree

❍ Agree

❍ Neutral

❍ Disagree

❍ Strongly Disagree

Q7.13 Please briefly describe whether the shared services arrangements are accomplishing/have accomplished what your department hoped. (e.g., If it was created to increase program capacity, has capacity increased?)

Q7.14 In your opinion, has your organization's shared services agreement(s) been successful in the following ways:

	Yes	No	Don't know
Improving or expanding public health services	❍	❍	❍
Fostering progress towards accreditation	❍	❍	❍
Realizing new efficiencies	❍	❍	❍
Cost savings	❍	❍	❍

Q7.15 What obstacles, if any, has your health department encountered to achieving your goals through shared services arrangements? (check all applicable)

- ❑ None
- ❑ Concerns about decision authority/control
- ❑ Concerns about potential costs
- ❑ Opposition from elected officials or other policymakers
- ❑ Opposition from local health director
- ❑ Opposition from the public
- ❑ Labor contracts/agreements are complex
- ❑ Legal constraints
- ❑ Lack of precedent
- ❑ Institutional rigidities
- ❑ Organizational culture differs from that of partners
- ❑ Other (please describe) _____

Q7.16 Does your health department have any process in place for reviewing or evaluating shared services agreements?

- ❍ Yes
- ❍ No
- ❍ Don't know

If **yes** is selected on Q 7.16, the following question displays:

Q7.17 If yes, please describe the review or evaluation process:

Q7.18 Would you recommend considering shared services arrangements similar to what your organization has to other local health departments?

❍ Yes

❍ No

Q7.19 Thank you for telling us about your cross jurisdictional shared services. Please rank the top reasons that contribute MOST to why your public health agency does not have ADDITIONAL arrangements for shared services? (rank up to three)

Top three reasons (drag and drop)
_____ Have not considered it
_____ Not thought to be cost effective
_____ Local political opposition
_____ Computer/financial systems not compatible
_____ State law or state policy creates barriers
_____ Local regulations create barriers
_____ Work cultures not conducive to collaboration
_____ Shared services in the past were not successful
_____ Program funding is cut or cancelled
_____ No perceived need or benefit
_____ Not sure where to start
_____ Start-up costs are a barrier
_____ Other (please describe)

Q7.20 Would you be interested in developing additional cross-jurisdictional shared services arrangements if assistance was available?

❍ Yes

❍ No

❍ Unsure

NO PATHWAY (If NO is selected on Q 2.1)

If **NO** is selected on Q 2.1, the following question displays:

Q6.1 Please rank the top reasons that contributed MOST to why your public health agency does not engage in cross-jurisdictional shared services. (rank up to three)

Top Three Reasons (drag and drop)
_____ Have not considered it
_____ Not thought to be cost effective
_____ Local political opposition
_____ Computer/financial systems not compatible
_____ State law or state policy creates barriers
_____ Local regulations create barriers
_____ Work cultures not conducive to collaboration
_____ Shared services in the past were not successful
_____ Program funding has been cut or cancelled
_____ No perceived need or benefit
_____ Not sure where to start
_____ Start-up costs are a barrier
_____ Other (please describe)

If **NO** is selected on Q 2.1, the following question displays:

Q6.2 Would you be interested in developing cross-jurisdictional shared services arrangements if assistance was available?

- ❍ Yes
- ❍ No
- ❍ Unsure

THANK YOU

Q5.1 Thank you for completing this survey. Your responses are valuable to us! We will share the aggregate results with respondents via email by December 31, 2014.If you have any questions about the survey or the procedures, you may contact Sarah Hartsig at the Kansas Health Institute at 785-233-5443, or by email at shartsig@khi.org.

Appendix B: Full Results of CJS in Kansas Survey, 2014

OPENING QUESTIONS

Q2.2. Does your public health department engage in any cross jurisdictional shared services with another county or tribal entity?

#	Answer		Response	%
1	Yes		55	74%
2	No		18	25%
3	We are currently considering/developing a shared services agreement		1	1%
	Total		74	100%

Q2.3. Have you had any shared services arrangements in the past that are no longer being implemented?

#	Answer		Response	%
1	Yes		21	33%
2	No		42	67%
	Total		63	100%

'YES' TO SHARED SERVICES

Q7.1. When did your health department begin sharing services?

#	Answer		Response	%
1	Less than 1 year ago		0	0%
2	1-5 years ago		7	15%
3	6-10 years ago		9	19%
4	11-20 years ago		19	40%
5	21 + years ago		12	26%
	Total		47	100%

Q7.2. How many arrangements do you currently have for shared services?

#	Answer		Response	%
1	1-3		42	76%

2	4-6		11	20%
3	7-9		2	4%
4	10+		0	0%
	Total		55	100%

Q7.3. On average, approximately what length of time does it take to move from the idea of shared services to actual implementation of shared services?

#	Answer		Response	%
1	1-3 months		13	42%
2	4-6 months		8	26%
3	7-12 months		9	29%
4	More than 12 months		1	3%
	Total		31	100%

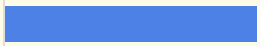
Q7.4. What type of agreements has your organization used for shared services arrangements? (check all applicable)

#	Answer			Respon
1	An informal "hand-shake" agreement	20	38%	
2	Memorandum of understanding	30	58%	
3	Service provision agreement	24	46%	
4	Inter-local agreement	18	35%	
6	Consolidation or merging two or more health departments into one entity	4	8%	
7	Other (please describe)	11	21%	

Other (please describe)
State Grant Program Agreement
By-laws of our Public Health Coalition
Public Health Resolution & Agreement
KDHE grants give to us or other counties
do not know
state grants
shared purchase of items verbal agreement
Legal coalition group that works together on several

I don't know
ESF 8, LEPC

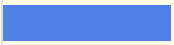
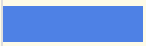
Q7.5. With what type of organization(s) does your health department share services? (check all applicable)

#	Answer		Response	%
1	One other city or county public health department		27	52%
2	A group of several city or county public health departments		32	62%
4	Military base		1	2%
6	Other (please describe)		6	12%
7	Tribal health center or Tribal government		1	2%

Other (please describe)
Private contract
University
School
Other County Departments
LEPC, ESF 8
Regional preparedness group

Q7.6. Which of the following services do you share with another organization? (check all applicable)

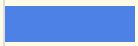
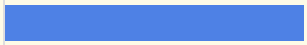
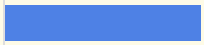
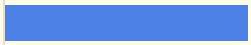
#	Answer		Response	%
1	Executive leadership		2	4%
2	Fund raising and grant writing		4	8%
3	Finance and accounting		5	10%
4	IT support		6	12%
5	Human resources		6	12%
6	Office and facility maintenance		5	10%
7	Purchasing		6	12%
8	Communications and outreach		7	13%

9	Billing		6	12%
10	Other (please describe)		20	38%
11	Emergency preparedness		37	71%
12	Epidemiology or surveillance		7	13%
13	Physician and nursing services		5	10%
14	Communicable disease screening or treatment		7	13%
15	Maternal and child health services		18	35%
16	Population-based primary prevention programs		5	10%
17	Inspection, permit, or licensing		15	29%
18	Environmental health programs (other than inspection, permit or licensing)		11	21%
19	Community health assessment/community health improvement planning		15	29%
20	Strategic planning		3	6%
21	Laboratory services		4	8%

Other (please describe)
Child Care Licensing
WIC
Family Planning and WIC
Child Care Licensing Surveyor
WIC
Population based checked above representing WIC and Family Planning Programs
School Nursing
WIC
WIC
WIC, Childcare Lic and Family Planning
HIV/AIDS Medical Case Manager & Center for Community Support & Research, WSU
WIC
WIC Satellite Program
Women, Infants, and Children (WIC) Program
FP & WIC
WIC
Family Planning & WIC (Cl. Co. is our parent county)

WIC Nutritionist
Dietician WIC

Q7.8. Please identify the motivation to share services with another organization: (check all applicable)

#	Answer		Response	%
1	To strengthen collaborative intergovernmental relations		15	29%
2	To promote regional service integration		21	40%
3	To promote higher quality/more effective service delivery		28	54%
4	To achieve economies of scale		13	25%
5	To access needed expertise		32	62%
6	To save money		27	52%
7	To comply with state requirements or policies		21	40%
8	Other (please describe)		7	13%
9	To respond to program requirements		26	50%
10	To aid in recruitment of qualified staff		10	19%
11	To provide new services		11	21%
12	To provide better services		34	65%
13	To meet or prepare for voluntary accreditation requirements		5	10%
14	To increase the department's credibility in the community		7	13%
16	To respond to policymaker interest		2	4%

Other (please describe)
To share the load due to lack of staff.

Initially started to have adequate caseload numbers to provide WIC services in local communities
Finney County does our Child Care Licensing & WIC we are a small health department and unable to do those programs
Required by grant to get funds
Grant requirements
to learn from one another and to build on each other's strengths (CHA)
Lincoln Co. is the parent agency for our WIC and Family Planning programs

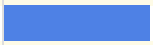
Q7.9. What processes has your organization used to negotiate the terms of the shared services arrangement(s)? (check all applicable)

#	Answer		Response	%
1	Meetings among local government staff		27	57%
2	Meetings among elected officials and other policymakers		16	34%
3	Secured through a request for information/proposals		3	6%
4	Contract negotiations for fee-for-service or other service arrangement		13	28%
6	Other (please describe)		10	21%
7	Outside consultant or negotiator		4	9%

Other (please describe)
it was done before I came
don't remember
terms of regional preparedness arrangements made between the 8 LHD administrators
KDHE grants
Contract
Not sure
state grant
regional agreement
I don't know
meetings among health dept. administrators

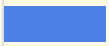
Q7.10. Who in your organization has been involved in developing the shared services arrangement(s)? (check all applicable)

#	Answer		Response	%
1	Health officer		11	22%

2	Human resources director		1	2%
3	City attorney		0	0%
4	County attorney		15	30%
5	Local health department director/administrator		47	94%
6	Private attorney/counsel		2	4%
7	Elected officials (county or city)		20	40%
8	County administrator		5	10%
9	City administrator		1	2%
10	Community partners		9	18%
11	Local board of health		21	42%
13	Other (please describe)		9	18%
14	Tribal leader or tribal council		1	2%

Other (please describe)
County Clerk
County Counselor
County Counselor (different from County Atty)
Previous LHD Administrator
Environmental Health Director
We had several partners initially to get this coalition formed
State of Kansas
program staff (MCH, STD, HIV)

Q7.11. Please rate the following statement: Roles and responsibilities of the partners in the shared services arrangement(s) are clearly defined.

#	Answer		Response	%
1	Strongly Agree		11	21%
2	Agree		29	56%
3	Neutral		10	19%
4	Disagree		1	2%
5	Strongly Disagree		1	2%
	Total		52	100%

Q7.12. Please rate the following statement: In general, key decision-makers and policymakers in my community support a vision for cross jurisdictional shared services.

#	Answer		Response	%
1	Strongly Agree		6	12%
2	Agree		20	38%
3	Neutral		24	46%
4	Disagree		2	4%
5	Strongly Disagree		0	0%
	Total		52	100%

Q7.14. In your opinion, has your organization's shared services agreement(s) been successful in the following ways:

#	Question	Yes	No	Total Responses	% Yes
1	Improving or expanding public health services	43	3	46	93%
2	Fostering progress towards accreditation	18	19	37	49%
3	Realizing new efficiencies	32	9	41	78%
4	Cost savings	41	4	45	91%

Q7.15. What obstacles, if any, has your health department encountered to achieving your goals through shared services arrangements? (check all applicable)

#	Answer		Response	%
1	None		23	47%
2	Concerns about decision authority/control		12	24%
3	Concerns about potential costs		10	20%
4	Opposition from elected officials or other policymakers		6	12%
5	Opposition from local health director		0	0%
6	Opposition from the public		2	4%
7	Organizational culture differs from that of partners		7	14%

8	Labor contracts/agreements are complex		4	8%
9	Legal constraints		4	8%
10	Lack of precedent		3	6%
11	Institutional rigidities		3	6%
12	Other (please describe)		6	12%

Other (please describe)
Completing the work to fit all 3 counties
time
It was a lot of work when we first established our coalition but it has worked well over the years because of the things we set in place from the beginning
In one arrangement, there is lack of communication and the person contracted to provide services in our county is not readily accessible & does not give progress reports or updates
have not had to implement as of yet

Q7.16. Does your health department have any process in place for reviewing or evaluating shared services agreements?

#	Answer		Response	%
1	Yes		11	21%
2	No		34	65%
3	Don't know		7	13%
	Total		52	100%

Q7.17. If yes, please describe the review or evaluation process:

Text Response
Annual Board of Directors review of agreements for cost and effectiveness.
County attorney and County administrator will review contracts. Approval from County Commissioner's/Board of Health
as needed make changes
All contracts are reviewed on a yearly basis.
Informal review.
Annually we review our work plans, determine if contract changes are necessary and meet quarterly to ensure communication and efficiency of resources are in line with objectives.
We work with the Riley County Counselor to review contracts.
Administrators meet quarterly or more often if necessary to review Preparedness plans and finances; Community Planners/Coordinators meet without Adm/Dir to review the routine activities to ensure we're meeting KDHE requirements.

Contracts for shared services are up for review and re-instatement on an annual basis, in the counties we provide contracted services, such as environmental health inspections and child care licensing.
Grant and State requirements

Q7.18. Would you recommend considering shared services arrangements similar to what your organization has to other local health departments?

#	Answer		Response	%
1	Yes		45	87%
2	No		7	13%
	Total		52	100%

Q7.19. Thank you for telling us about your cross jurisdictional shared services. Please rank the top reasons that contribute MOST to why your public health agency does not have ADDITIONAL arrangements for shared services? (rank up to three)

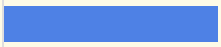
#	Answer	Top three reasons (drag and drop)
1	Have not considered it	17
2	Not thought to be cost effective	8
3	Local political opposition	10
4	Computer/financial systems not compatible	7
5	State law or state policy creates barriers	2
6	Work cultures not conducive to collaboration	5
7	Shared services in the past were not successful	2
8	Other (please describe)	8
9	Program funding is cut or cancelled	14
10	No perceived need or benefit	23
11	Not sure where to start	16
12	Start-up costs are a barrier	8
14	Local regulations create barriers	2

Other (please describe)
Unsure county attorney is knowledgeable enough regarding contracts
Haven't had the chance to establish
The members of the SKCPH discuss other programs during our regular monthly meetings and email group listing and this has been adequate for the other program service areas to date.
We don't have shared services in the aspect of PHAB standards. All we have are the same decades old multi-county programmatical grant random groupings of contiguous counties
we are exploring further at this time
Have discussed with other providers about shared services and they feel it would take away from their business. When wanting to work towards shared services. Not sure how to get this across to them without causing upset. Especially with the Doctors

taking the time to think about it
Desire of the county residents to keep services "local"
Time, staff, and funding
Too Small of a county and don't need it.
it takes time to educate and build interest

Answer	Top three reasons (drag and drop) - Mean Rank
Have not considered it	1.53
Not thought to be cost effective	2.00
Local political opposition	2.00
Computer/financial systems not compatible	2.14
State law or state policy creates barriers	2.00
Work cultures not conducive to collaboration	2.40
Shared services in the past were not successful	2.00
Other (please describe)	1.88
Program funding is cut or cancelled	2.14
No perceived need or benefit	1.78
Not sure where to start	1.88
Start-up costs are a barrier	1.88
Local regulations create barriers	2.00

Q7.20. Would you be interested in developing additional cross-jurisdictional shared services arrangements if assistance was available?

#	Answer		Response	%
1	Yes		23	44%
2	No		6	12%
3	Unsure		23	44%
	Total		52	100%

'NO' TO SHARED SERVICES

Q6.1. Please rank the top reasons that contributed MOST to why your public health agency does not engage in cross-jurisdictional shared services. (rank up to three)

#	Answer	Top Three Reasons (drag and drop)
1	Have not considered it	7
2	Not thought to be cost effective	3
3	Local political opposition	7
4	Computer/financial systems not compatible	0
5	State law or state policy creates barriers	0

6	Work cultures not conducive to collaboration	1
7	Shared services in the past were not successful	1
8	Other (please describe)	5
9	Program funding has been cut or cancelled	2
10	No perceived need or benefit	7
11	Not sure where to start	7
12	Start-up costs are a barrier	1
14	Local regulations create barriers	0

Other (please describe)
There have been no obvious opportunities nor needs to engage in cross-jurisdictional sharing
Distance
We are a department of our local hospital and share services with them
Don't really know what services could be shared
Finding the time to figure it out.
Distance and Locations
We do cross jurisdictional but not in a formal manner. NO public authority is involved.

Answer	Top Three Reasons (drag and drop) - Mean Rank
Have not considered it	2.00
Not thought to be cost effective	2.33
Local political opposition	1.57
Computer/financial systems not compatible	0.00
State law or state policy creates barriers	0.00
Work cultures not conducive to collaboration	2.00
Shared services in the past were not successful	3.00
Other (please describe)	1.60
Program funding has been cut or cancelled	2.00
No perceived need or benefit	1.71
Not sure where to start	2.14
Start-up costs are a barrier	2.00
Local regulations create barriers	0.00

Q6.2. Would you be interested in developing cross-jurisdictional shared services arrangements if assistance was available?

#	Answer		Response	%
1	Yes		4	22%
2	No		4	22%
3	Unsure		10	56%
	Total		18	100%

Appendix C: Kansas CJS Domain Scoring

Experience (Max Score: 35)

Q: When did your health department begin sharing services?

- < 1 year ago = 1
- 1-5 years ago = 2
- 6-10 years ago = 3
- 11-20 years ago = 4
- 21 + years ago = 5

Q: How many arrangements do you currently have for shared services?

- 1-3 = 1
- 4-6 = 2
- 7-9 = 3
- 10+ = 4

Q: With what type of organization(s) does your health department share services? (check all applicable)

- Score = number checked (5 choices given: *see survey instrument*)

Q: Which of the following services do you share with another organization (check all applicable)

- Score = number checked (21 choices given: *see survey instrument*)

Satisfaction with Shared Services (Max Score: 22)

Q: In your opinion, has your organization's shared services agreement(s) been successful in the following ways:

- Improving or expanding public health services
    - Yes = 3; Unsure = 2; No = 1
- Fostering progress toward accreditation
    - Yes = 3; Unsure = 2; No = 1
- Realizing new efficiencies
    - Yes = 3; Unsure = 2; No = 1
- Cost savings
    - Yes = 3; Unsure = 2; No = 1

Q: Please rate the following statement: Roles and responsibilities of the partners in the shared services arrangement(s) are clearly defined.

- Strongly Disagree = 1
- Disagree = 2
- Neutral = 3
- Agree = 4
- Strongly Agree = 5

Q: Would you recommend considering shared services arrangements similar to what your organization has to other local health departments?

- Yes = 2; No = 1

Q: Would you be interested in developing additional cross-jurisdictional shared services arrangements if assistance was available?

- Yes = 3; Unsure = 2; No = 1

Diversity of Arrangements (Max Score: 26)

Q: What type of agreements has your organization used for shared services arrangements? (check all applicable)

- Score = number checked (6 choices given: *see survey instrument*)

Q: What processes has your organization used to negotiate the terms of the shared services arrangement(s)? (check all applicable)

- Score = number checked (6 choices given: *see survey instrument*)

Q: Who in your organization has been involved in developing the shared services arrangement(s)? (check all applicable)

- Score = number checked (14 choices given: *see survey instrument*)

Appendix D: CJS Questions on the Aid-to-Local Survey, 2017

Q1 READ THIS FIRST:

Foundational Public Health Services (FPHS)

The FPHS are the suite of skills, programs, and activities that should be available in every community through state or local public health agencies as basic components to keep the public safe and healthy. The FPHS are primarily population-based preventive health services that are best addressed by governmental public health and may be mandated by state or Federal law. The model consists of Foundational Capabilities and Foundational Areas. The ***Foundational Capabilities*** *are the cross-cutting skills that need to be present everywhere for the system to work anywhere. They are the essential skills and capacities tended to support the Foundational Areas.* ***Foundational Areas*** *are the substantive areas of expertise or program-specific activities. Click here for a full list of the current FPHS for Kansas.*

Cross-Jurisdictional Sharing:

Cross-jurisdictional sharing is the ***deliberate exercise*** *of public authority to* ***enable collaboration across jurisdictional boundaries*** *to deliver public health services. Click here for more information about cross-jurisdictional sharing.*

Q2.1 Does your public health department currently engage in any cross-jurisdictional shared services with another county, military base, or tribal entity?

- ❍ Yes
- ❍ No
- ❍ We are currently considering/developing a shared services agreement

[If no, skip to Q 3.1]

Q2.2 Which of the following Foundational Capabilities (skills and capacities) do you share, in part or entirely, with another organization? (check all applicable)

- ❑ Assessment (including the ability to develop a Community Health Assessment, the ability to collect primary and secondary data, the ability to identify patterns of disease (epidemiology), the ability to evaluate programs, etc.)
- ❑ All Hazards Preparedness/Response (including the ability to develop and rehearse emergency response strategies and plans, the ability to promote community preparedness and resilience, the ability to issue emergency health orders, the ability to be notified and respond to emergencies on a 24/7 basis, etc.)
- ❑ Communications (including the ability to work with media outlets, the ability to develop and implement a strategic communications plan, the ability to communicate in culturally and linguistically appropriate formats, etc.)
- ❑ Policy Development & Support (including the ability to identify evidence-based public health policy recommendations, the ability to utilize health in all policies (HiAP), the ability to enforce public health mandates, etc.)
- ❑ Community Partnership Development (including the ability to develop a community health improvement plan, the ability to convene a broad-sector assembly of partners to promote public health, the ability to work with community members and organizational partners to identify community assets and resources, etc.)
- ❑ Organizational Competencies (including the ability to serve as the face of governmental public health in the community, the ability to develop a strategic plan, the ability to conduct quality improvement and maintain a performance management system, the ability to keep protected health information confidential, the ability to recruit and retain a competent public health workforce, etc.)
- ❑ Health Equity and the Social Determinants of Health (including the ability to recognize and understand the determinants of health disparities within the community, the ability to coordinate programming to reduce health disparities, etc.)
- ❑ Other (please describe) _____

Q2.3 Which of the following Foundational Areas (programs or services) do you share, in part or entirely, with another organization? (check all applicable)

- ❑ Communicable Disease Control (including laboratory services, disease investigations, immunizations, communicable disease screening/treatment, etc.)
- ❑ Health Promotion and Chronic Disease and Injury Prevention (including health promotion, population-based primary prevention programs, identifying evidence-based interventions, working to reduce rates of tobacco use and substance abuse, working to increase rates of healthy eating and active living, promotion of mental health and well-being, etc.)
- ❑ Environmental health (including child care inspections, blood lead case management, nuisance abatement, participation in land use planning and sustainable development, etc.)
- ❑ Maternal and child health services (including interventions to lower infant mortality and pre-term births, and to optimize lifelong health and social-emotional development, etc.)
- ❑ Access to Clinical Care (including the assurance of access to family planning services, STD and HIV testing and treatment, linking community members to care, etc.)
- ❑ Other (please describe) _____

Q3.1 Do you anticipate developing new/additional cross-jurisdictional shared services in the next two to three years?

- ❍ Yes
- ❍ No
- ❍ Unsure

Q3.2 If yes to Q3.1, which of the following Foundational Capabilities (skills and capacities) might you consider sharing, in part or entirely, with another organization? (check all applicable)

- ❑ Assessment (including the ability to develop a Community Health Assessment, the ability to collect primary and secondary data, the ability to identify patterns of disease (epidemiology), the ability to evaluate programs, etc.)
- ❑ All Hazards Preparedness/Response (including the ability to develop and rehearse emergency response strategies and plans, the ability to promote community preparedness and resilience,

the ability to issue emergency health orders, the ability to be notified and respond to emergencies on a 24/7 basis, etc.)

- ❑ Communications (including the ability to work with media outlets, the ability to develop and implement a strategic communications plan, the ability to communicate in culturally and linguistically appropriate formats, etc.)
- ❑ Policy Development & Support (including the ability to identify evidence-based public health policy recommendations, the ability to utilize health in all policies (HiAP), the ability to enforce public health mandates, etc.)
- ❑ Community Partnership Development (including the ability to develop a community health improvement plan, the ability to convene a broad-sector assembly of partners to promote public health, the ability to work with community members and organizational partners to identify community assets and resources, etc.)
- ❑ Organizational Competencies (including the ability to serve as the face of governmental public health in the community, the ability to develop a strategic plan, the ability to conduct quality improvement and maintain a performance management system, the ability to keep protected health information confidential, the ability to recruit and retain a competent public health workforce, etc.)
- ❑ Health Equity and the Social Determinants of Health (including the ability to recognize and understand the determinants of health disparities within the community, the ability to coordinate programming to reduce health disparities, etc.)
- ❑ Other (please describe) _____

Q2.4 If yes to Q3.1, which of the following Foundational Areas (programs or services) might you consider sharing, in part or entirely, with another organization? (check all applicable)

- ❑ Communicable Disease Control (including laboratory services, disease investigations, immunizations, communicable disease screening/treatment, etc.)
- ❑ Health Promotion and Chronic Disease and Injury Prevention (including health promotion, population-based primary prevention programs, identifying evidence-based interventions,

working to reduce rates of tobacco use and substance abuse, working to increase rates of healthy eating and active living, promotion of mental health and well-being, etc.)

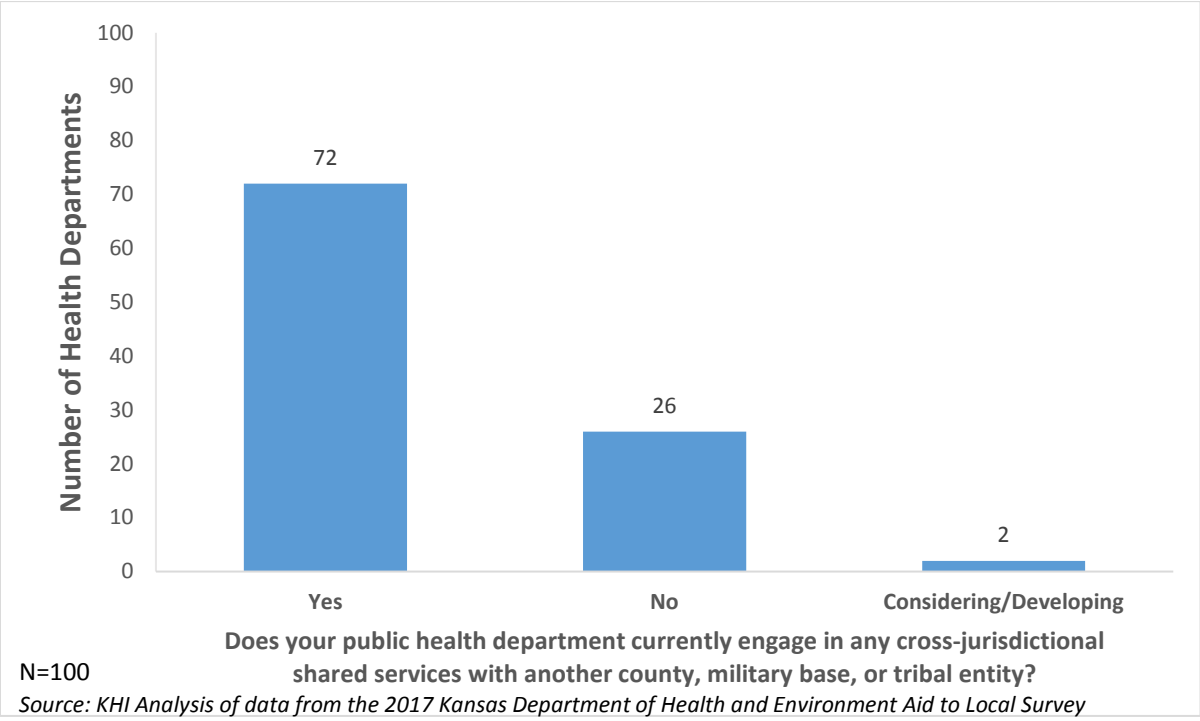
- ❑ Environmental health (including child care inspections, blood lead case management, nuisance abatement, participation in land use planning and sustainable development, etc.)
- ❑ Maternal and child health services (including interventions to lower infant mortality and pre-term births, and to optimize lifelong health and social-emotional development, etc.)
- ❑ Access to Clinical Care (including the assurance of access to family planning services, STD and HIV testing and treatment, linking community members to care, etc.)
- ❑ Other (please describe) _____

Appendix E: Full Results of Kansas Aid-to-Local Survey CJS Questions, 2017

Does your public health department currently engage in any cross-jurisdictional shared services with another county, military base, or tribal entity?

Seventy-two local health departments (LHDs) out of 100 total LHDs currently have a shared service agreement while twenty-six do not. Two respondents reported that they were currently considering or developing a shared service agreement *(Figure E-1)*.

Figure E-1. **Does your public health department currently engage in any cross-jurisdictional shared services with another county, military base, or tribal entity?**



Source: KHI Analysis of data from the 2017 Kansas Department of Health and Environment Aid to Local Survey

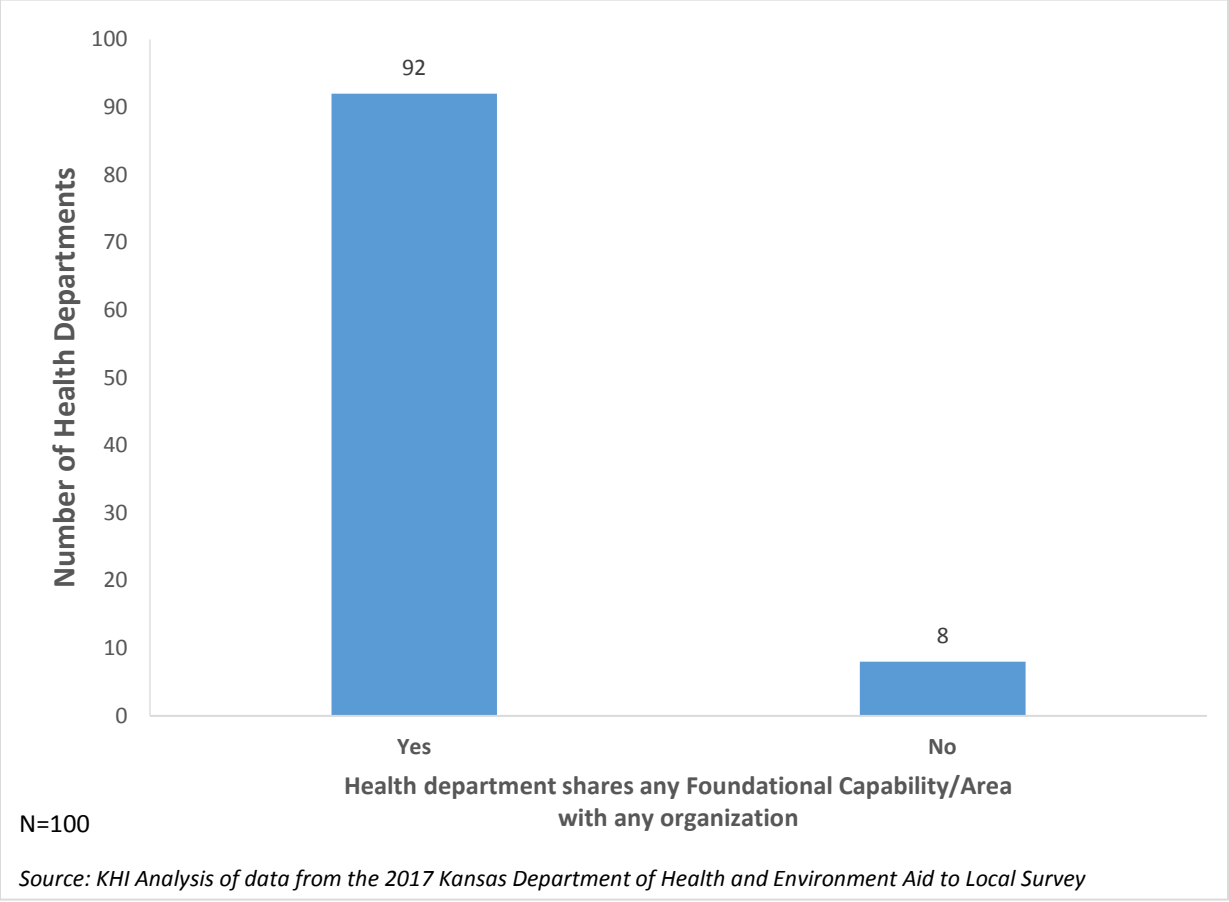
Based on the question wording, we believe that this question was interpreted as: Does the LHD have a shared service agreement with only the political entities listed? Indeed, respondents subsequently reported having more shared services when asked about specific Foundational Capability (FC) and Foundational Area (FA) categories.

New Variable: For the shared FC/FA questions, the language shifted to sharing with another organization instead of the political entities outlined in Question 1 with the following language:

"Which of the following Foundational Capabilities (skills and capacities)/Areas (programs or services) do you share, in part or entirely, with another organization?"

This shift in language led to more respondents saying they shared FCs and FAs with other organizations than the number of respondents reporting they had a cross-jurisdictional sharing agreement in Question 1. A new variable was developed to capture if a health department had any shared services (FC or FA) with any organization *(Figure E-2).*

Figure E-2. **Local Health Departments Indicating any Kind of Sharing with any Organization**



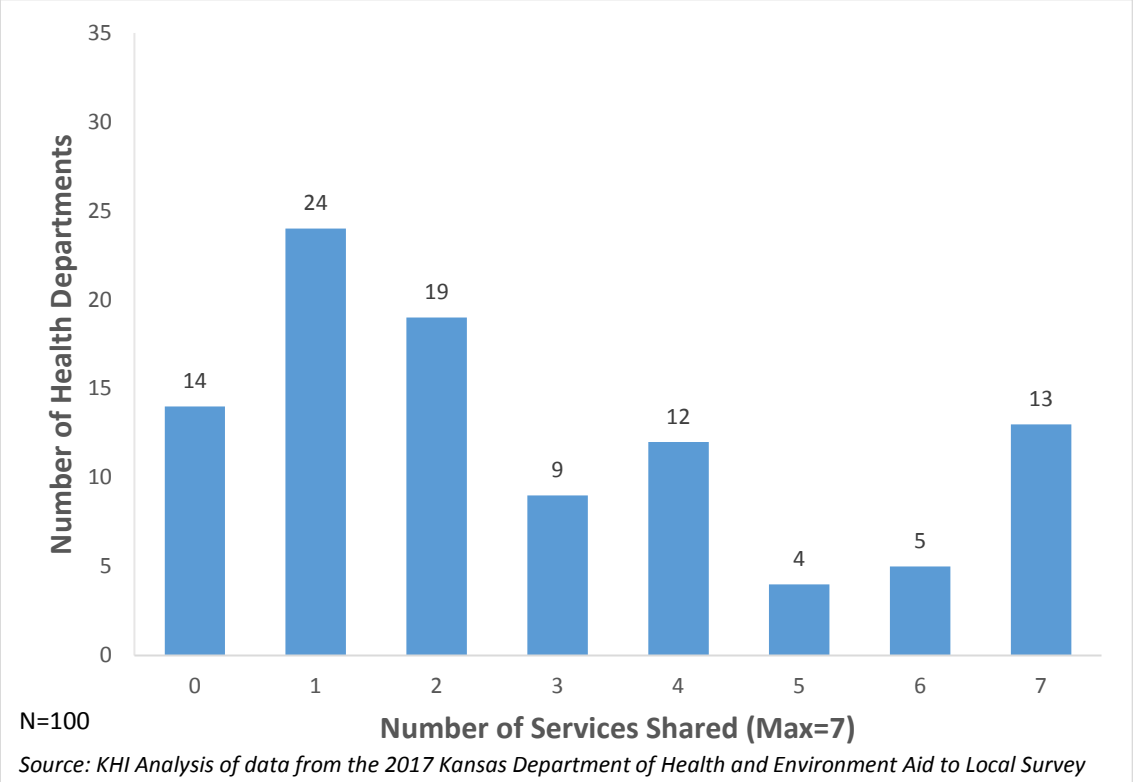
Source: KHI Analysis of data from the 2017 Kansas Department of Health and Environment Aid to Local Survey

Which of the following Foundational Capabilities (skills and capacities) do you share, in part or entirely, with another organization?

Based on this question, the team derived a sum of health departments (N=100), by number of shared foundational capabilities. Fourteen respondents reported not sharing any FCs and forty-

three respondents reported sharing only 1 or 2 FCs with another organization. Thirteen respondents indicated they shared all seven foundational capabilities *(Figure E-3).*

Figure E-3. **Number of Foundational Capabilities Health Departments Currently Share with any Organization (Max =7)**



Source: KHI Analysis of data from the 2017 Kansas Department of Health and Environment Aid to Local Survey

**Does not include "Other" category. Respondents were given the opportunity to list other shared services, but these were not considered "Foundational".*

The most shared FC was *All Hazards Preparedness and Response* with 80 respondents reporting they shared this FC *(Figure E-4).* 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.*

Figure E-4. **Number of Health Departments that Report Sharing each Foundational Capability**

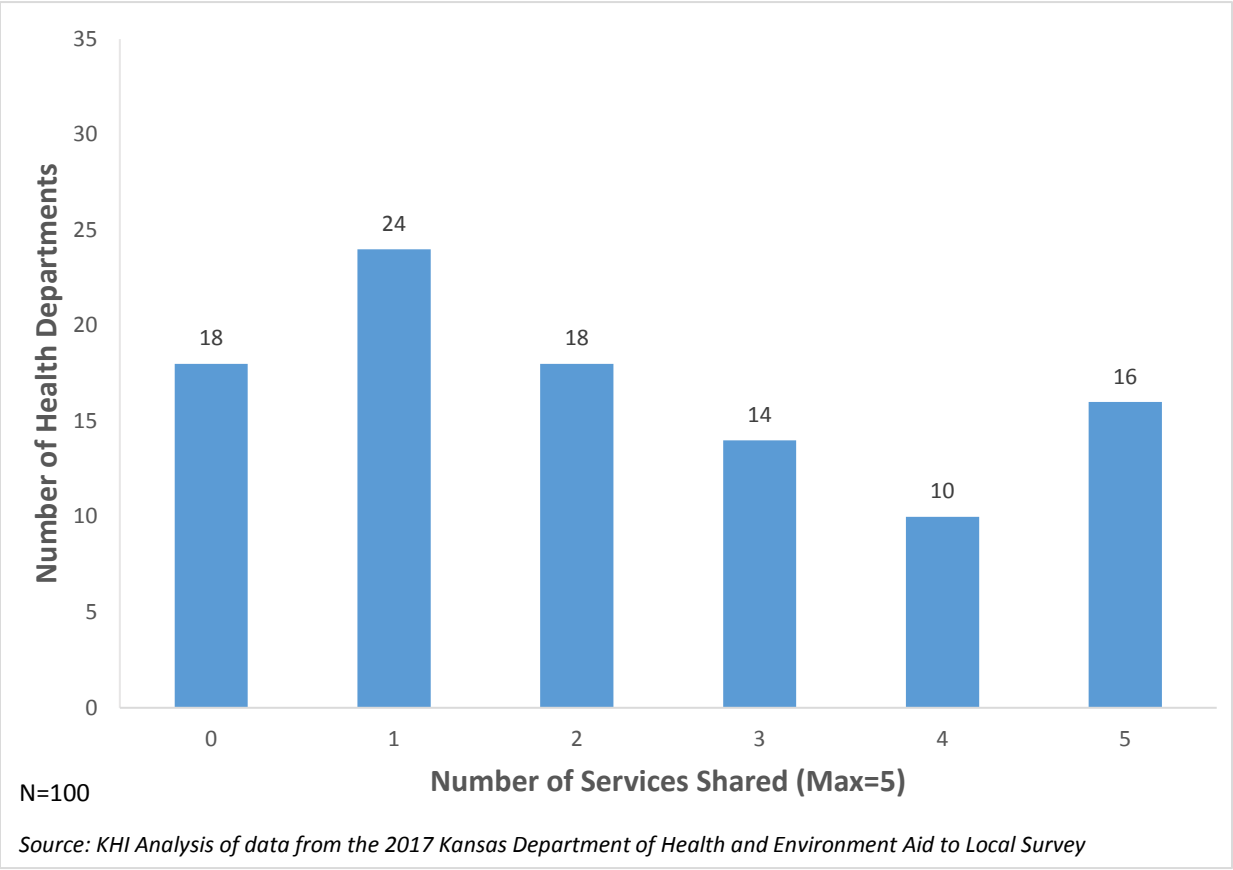
Foundational Capability	Health Departments
All Hazards Preparedness/Response	80
Assessment	41
Communications	40
Community Partnership Development	40
Policy Development & Support	27
Health Equity and the Social Determinants of Health	27
Organizational Competencies	23
None	14

Originally, two respondents reported sharing for WIC and Environmental Services under the "Other" category. Examination of these responses by the team led to agreement that they were not FCs, but were instead determined to be FAs. For these LHDs, the responses were imputed for FAs if they had no response in the relevant subject under FAs. The FAs were updated based on the FC "Other" category response, then these FC "Other" responses were removed.

Which of the following Foundational Areas (programs or services) do you share, in part or entirely, with another organization?

Based on this question, a count of LHDs sharing FAs, by number of FAs, was derived from the 100 LHDs responding. Eighteen respondents reported not sharing any FAs, while forty-two respondents reported sharing one or two FAs with another organization. Sixteen respondents reported sharing all five FAs *(Figure E-5).*

Figure E-5. **Number of Foundational Areas Health Departments Currently Share with any Organization (Max = 5)**



Source: KHI Analysis of data from the 2017 Kansas Department of Health and Environment Aid to Local Survey

Note: Does not include "Other" Foundational Areas category. Respondents were given the opportunity to list other shared services, but these were not considered "Foundational".

The most shared FA was *Environmental Health* with 52 respondents reporting they shared this FA *(Figure E-6).* About half of the respondents (49) reported sharing *Maternal and Child Health*, and less than half reported sharing any other FA. Forty-two respondents reported that they shared *Access to Clinical Care*, forty respondents reported sharing *Communicable Disease Control*, thirty-nine reported sharing *Health Promotion and Chronic Disease and Injury Prevention*. Eighteen respondents reported sharing no FAs.

Other shared FAs responses were reported by several respondents. WIC (8), Family Planning (6), and Public Health Emergency Preparedness (PHEP) (5) were the most commonly reported and one respondent reported Child Care Licensing.

After discussion amongst the team, WIC was classified under *Maternal and Child Health* and Family Planning was classified as *Access to Clinical Care* under shared FAs. Public Health Emergency Preparedness was reclassified to *All Hazards Preparedness/Response* under shared FCs to match the Kansas FPHS list. For these LHDs, the responses were imputed for shared FAs or FCs if they had no response in the relevant subject in each section. The shared FAs and FCs were updated based on the shared FA "Other" category response then these shared FA "Other" responses were removed. Child Care Licensing was left as an "Other" response under shared FAs.

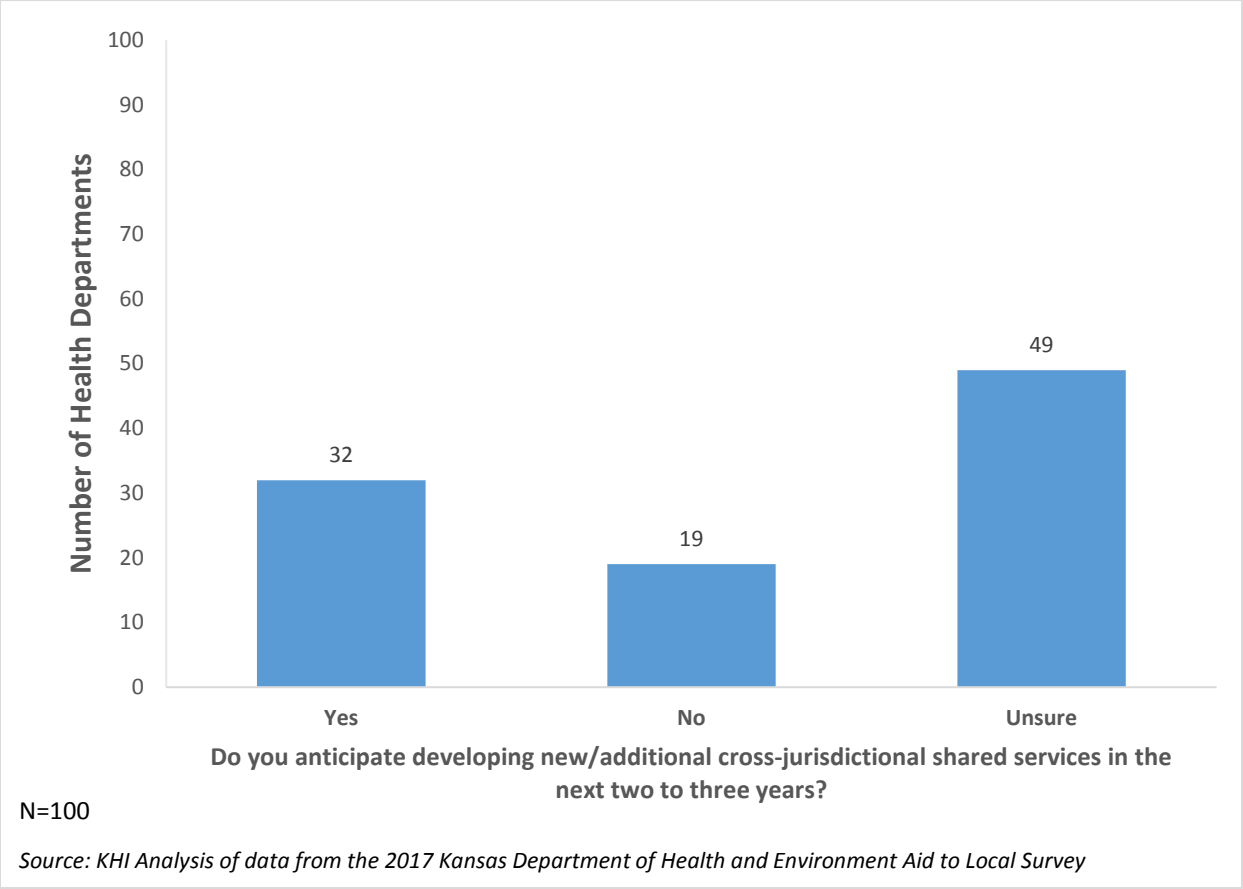
Figure E-6. **Number of Health Departments that Report Sharing Each Foundational Area**

Foundational Area	Health Departments
Environmental Health	52
Maternal and Child Health Services	49
Access to Clinical Care	42
Communicable Disease Control	40
Health Promotion and Chronic Disease and Injury Prevention	39
None	18
Other	1

Do you anticipate developing new/additional cross-jurisdictional shared services in the next two to three years?

Thirty-two respondents said they anticipated developing new or additional cross-jurisdictional shared services in the next two or to three years, while nineteen respondents said they did not *(Figure E-7).* Forty-nine respondents indicated that they were unsure if they anticipated sharing services in the next two to three years.

Figure E-7. **Do you anticipate developing new/additional cross-jurisdictional shared services in the next two to three years?**

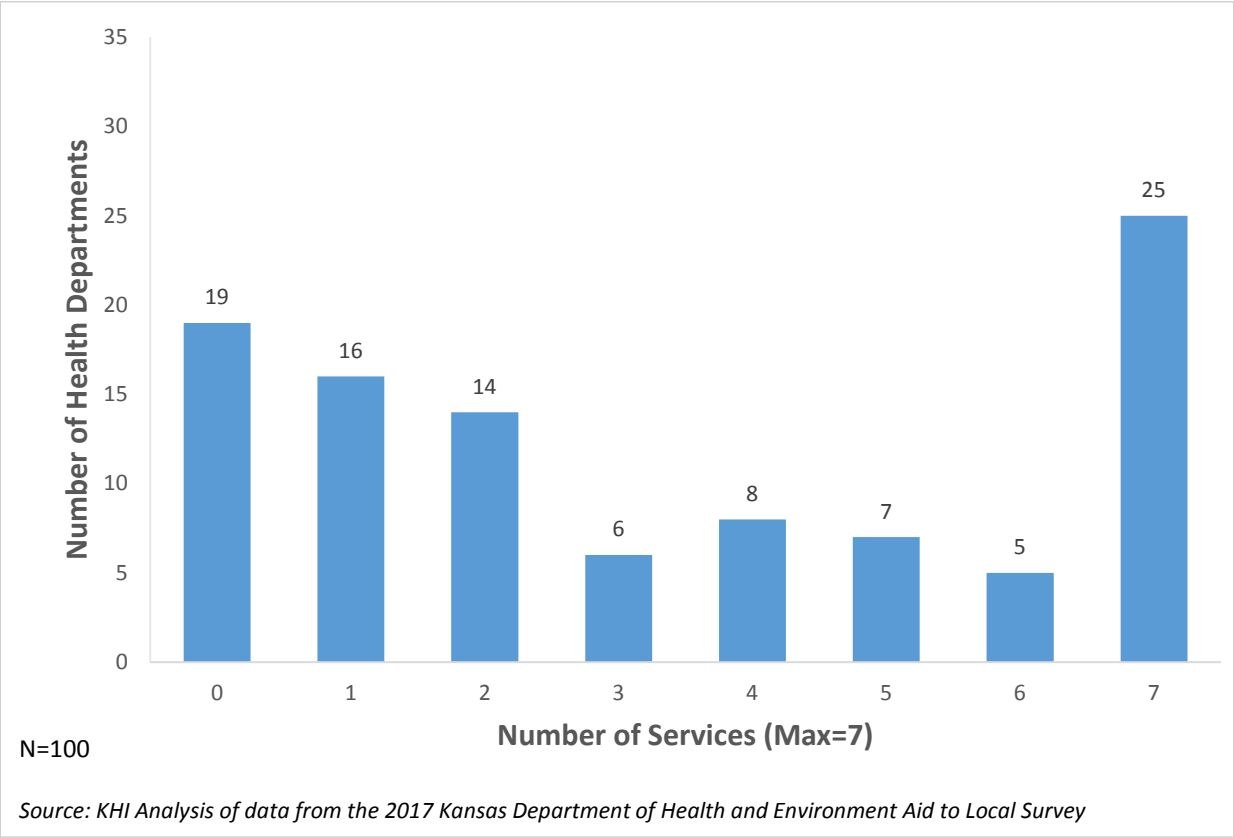


Source: KHI Analysis of data from the 2017 Kansas Department of Health and Environment Aid to Local Survey

Which of the following Foundational Capabilities (skills and capacities) might you consider sharing, in part or entirely, with another organization?

Nineteen respondents indicated that they would not consider sharing any FCs. Thirty respondents reported that they might consider sharing in 1-2 of the FCs while twenty-five respondents reported that they would consider sharing in all seven of the FCs *(Figure E-8).*

Figure E-8. **Number of Foundational Capabilities Health Departments Might Consider Sharing (Max = 7)**



Source: KHI Analysis of data from the 2017 Kansas Department of Health and Environment Aid to Local Survey

Note: Does not include "Other" Foundational Capabilities category. Respondents were given the opportunity to list other shared services, but these were not considered "Foundational".

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). Forty-five departments might consider sharing *Policy Development and Support*, forty-three might consider sharing *Organizational Competencies*, and forty-one departments might consider sharing *Communications.* Nineteen departments would not consider sharing FCs *(Figure E-9).*

Several respondents also provided responses for the Other response for FCs they might consider sharing. Two responses were identified as related to FAs or FCs. One respondent listed WIC and Child Care Licensing and another respondent listed Brain Health Intervention.

WIC was classified under *Maternal and Child Health* and Child Care Licensing was classified as an "Other" response under shared FAs the department might consider. Brain Health Intervention was not easily reclassified and was left as an "Other" response for an FC that LHDs might consider sharing. The shared FAs and FCs were updated based on the shared FC "Other" category response then these "Other" responses for FCs departments might consider sharing were removed.

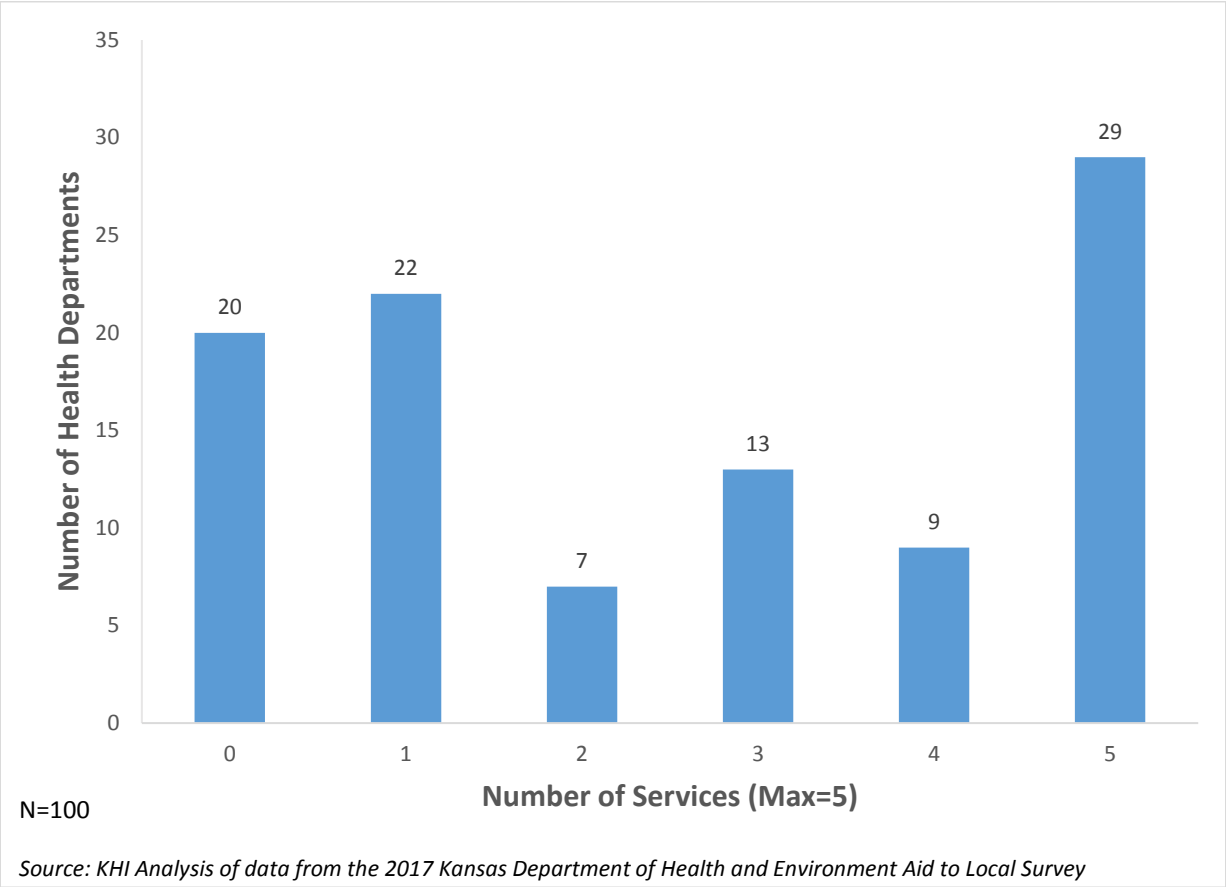
Figure E-9. **Number of Health Departments that Might Consider Sharing Each Foundational Capability**

Foundational Capability	Health Departments
All Hazards Preparedness/Response	59
Community Partnership Development	51
Assessment	48
Health Equity and the Social Determinants of Health	47
Policy Development & Support	45
Organizational Competencies	43
Communications	41
None	19
Other	1

Which of the following Foundational Areas (programs or services) might you consider sharing, in part or entirely, with another organization?

Twenty respondents reported they would not consider sharing FAs. Twenty-nine respondents reported they would consider sharing 1 to 2 FAs and twenty-nine respondents reported the would considering all five FAs. *(Figure E-10).*

Figure E-10. **Number of Foundational Areas that Health Departments Might Consider Sharing**



Source: KHI Analysis of data from the 2017 Kansas Department of Health and Environment Aid to Local Survey

**Does not include "Other" Foundational Areas category. Respondents were given the opportunity to list other shared services, but these were not considered "Foundational".*

Of FAs that LHDs might consider sharing *(Figure E-11),* the highest responses were for *Health Promotion and Chronic Disease and Injury Prevention* (58), *Environmental Health* (55), *Access to Clinical Care* (52), and *Maternal and Child Health Services* (50). Forty-one LHDs might consider sharing *Communicable Disease Control.* Twenty respondents reported that they would not consider sharing any FPHS services. One respondent listed that they might consider sharing Child Care Licensing under "Other" FAs.

Child Care Licensing was identified as more related to FAs based on the previous reclassification from the FCs.

Figure E-11. **Number of Health Departments that Might Consider Sharing Each Foundational Area**

Foundational Area	*Health Departments*
Health Promotion and Chronic Disease and Injury Prevention	58
Environmental Health	55
Access to Clinical Care	52
Maternal and Child Health Services	50
Communicable Disease Control	41
None	20
Other	1

Other Comments

Respondents also provided several comments that were not related to FCs or FAs currently shared or that LHDs might consider sharing. Discussion amongst the team identified several responses of note.

- 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, a general theme across multiple non-FC/FA related comments from respondents was a general interest in sharing services and agreements to better serve their communities.

Appendix F: Key Informant Interview Questionnaire

Pre-Interview Questions

1. Review list of shared services/functions arrangements that were indicated on survey (see attachment). Are there any that are listed but shouldn't be on the list? Are there any not on the list that should be?

2. FOR EACH SHARED SERVICE/FUNCTION: How is this arrangement structured in your community?

    - i.e. Another LHD provides the functions or services for our constituents, we provide services for another LHD's constituents, our LHD shares staff with another LHD, our LHD shares equipment with another LHD, or other

3. During the in-person interview, we will want to ask a series of questions to gather more information about the following shared services/functions at your organization:

    - What was the first shared service/function arrangement that was developed at the HD? Were you at the HD then? If not, is there someone who participated that we could talk with?

    - Is there a service that is most helpful for other health departments to know about? (i.e. highest-performing, most impact on population health, cost-saving, going the smoothest)

4. List all health department/county/community organization employees that we should talk to for these interviews. (Are there any individuals who would have specific knowledge of the development of shared services/functions identified in Q3?)

5. Do you share a medical consultant?

    - If so, please describe how the arrangement is structured and how well the arrangement is working?

Possible Cues: What is or is not going well? What would you like to improve? What would you recommend to another organization thinking about a similar arrangement?

6. How would you describe the work you do with the other counties in your public health preparedness region?
    - Would you characterize this work as a shared service? Why or why not?

Interview Questions

Interviewee Role

1. Please describe your role here at [insert organization], and what is your relationship with the local health department?
2. How long have you been in this position?
3. *Here is a list of all the shared services/functions we know of at the health department. Are you aware of these shared services/functions? Are there any that we didn't list?*

Question Block: Ask for each selected service

Impetus

4. What was your position and role when [Agreement 1, 2, …] was developed?
5. Please describe what circumstances led to [insert organization]'s shared services/functions arrangement?
6. What specifically was the shared-service agreement intending to change? (i.e. eliminate duplication, cost-savings, efficiency, improved health)
7. Who initiated the conversation about this shared service or function and why?

Development

8. Which organizations were involved in developing the plan? What were their roles?
9. How was it decided who the partners (counties) would be?
10. How was the issue presented to the public, if at all? (How frequently do you revisit the public feedback on this arrangement, or do you?)

11. Please describe the political climate (support or opposition) around developing this shared services agreement?

12. What were other arguments for or against developing this shared services arrangement, if any?

13. Describe the process the planning organizations used to decide on a shared services agreement.

Implementation

14. What type of agreement was put into place? (handshake, MOU, interlocal agreement etc.)

15. Did you use another shared service agreement example as guidance? Please describe.

16. Please describe any obstacles encountered during implementation of the shared services agreement.

17. Have any details about the shared service arrangement changed since it was put into place?

Results

18. Earlier, you mentioned x was/were the goals of the shared service. In what ways have those goals been met?

19. What were any additional unforeseen benefits or outcomes that the shared service produced?

20. What costs are associated with the shared service agreement? Have there been any cost savings?

21. How are outcomes measured? Please describe your evaluation process, if any.

22. Do you evaluate for internally-motivated (i.e. quality improvement) or for externally-motivated purposes (i.e. grant funding)?

23. Describe how you would like to evaluate the shared service arrangements and any barriers toward achieving your desired form of evaluation.

Lessons learned

24. Please describe the negative consequences to developing the shared services arrangement, if any.

25. What, if any, information do you wish stakeholders in this arrangement had before beginning this effort?

26. What lessons have you learned as a result of this arrangement? What advice would you give others considering a similar arrangement?

27. If you were to develop a shared service in the future, who would be an essential member of the team, and why?

Now we're going to a different service. Does anyone have any final thoughts about this service? Is there anything that came up for you that you can think of that we haven't talked about yet? Anything these questions sparked for you? (Ask the following questions just once, after the block of questions above.)

28. Looking toward the future, are there plans to increase, decrease or keep the same level of shared services? If more sharing arrangements are made, what do you see as the driving factor(s) behind the changes?

29. Have you had any shared services arrangements in the past that are no longer being implemented? What are they and why did they stop?

30. Is there anything else you would like to share with us?

Appendix G: Endnotes

1. Center for Sharing Public Health Services. (2013). *A Roadmap to Develop Cross-Jurisdictional Sharing Initiatives.* Retrieved March 29, 2017, from http://phsharing.org/wp-content/uploads/2015/04/RoadmapBrochure.pdf
2. In September 2015, the Kansas Association of Local Health Departments adopted a vision statement which included the provision of the Foundational Public Health Services (FPHS) for all Kansans. Since then, Public Health Systems Group (PHSG) members have been supporting this vision through a variety of activities to explore the adoption of FPHS. More information can be found at: http://www.kalhd.org/kansas-public-health-practice-program/.
3. Hartsig, S., Chapman, S., & Boden, J. (2015). *Case Study: Public Health Shared Services-Southeast Kansas (SEK) Multi-County Health Department.* Retrieved from: http://www.khi.org/policy/article/ks_cjs_sek
4. Hartsig, S., Chapman, S., & Boden, J. (2015). *Case Study: Public Health Shared Services-Northeast Kansas (NEK) Multi-County Health Department.* Retrieved from: http://www.khi.org/policy/article/ks_cjs_nek
5. Hartsig, S., Chapman, S., & Boden, J. (2015). *Case Study: Public Health Shared Services-South Central Kansas Coalition for Public Health.* Retrieved from: http://www.khi.org/policy/article/ks_cjs_skcph
6. Madamala, K., Young, N., Young, D., Lieske, G., Brandenberg, T., & Zahner, S. (2014). Current and Planned Shared Service Arrangements in Wisconsin Local and Tribal Health Departments. *Journal of Public Health Management and Practice, 14*(6).
7. Center for Sharing Public Health Services. (2014). *Assessment Tool for Public Health. Existing CJS Arrangements: Abbreviated Survey.* Retrieved from: http://www.phsharing.org/wp-content/uploads/2014/01/PDFAssessmentOfCJSArrangementsAbbreviatedV1.pdf

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