SERVICE & RESOURCE SHARING IN RURAL SETTINGS: A PERSPECTIVE REPORT

Overcoming Common Barriers Faced by Rural Local Health Departments

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Background

Rural local health departments (LHDs) are charged with protecting and promoting the health of their communities. For more than a decade, the Center for Sharing Public Health Services (the Center) was committed to helping health departments do this job efficiently and effectively through service and resource sharing arrangements (SRSAs). The Center transitioned from the Kansas Health Institute to the Public Health Accreditation Board Center in 2022 and SRSA efforts are now housed under the PHAB Center for Innovation. While this guide uses the term service and resource sharing arrangements, previous publications by the Center utilize the terminology of cross-jurisdiction sharing.

SRSAs allow rural LHDs to solve problems that cannot be solved — or easily solved — by a single health department. When rural LHDs and their partners share staff, expertise, funds, and programs across their respective boundaries (e.g., population served, service area, district, or governmental jurisdictions), they can accomplish more together than they could do alone. This practice can increase effectiveness (enhancing the quality of existing services or increasing capacity) and efficiency (maximizing the value of each dollar invested in delivering public health services). It can generate economies of scale and enable rural LHDs and their partners to offer programs that otherwise would not be feasible. It can also be a powerful tool to advance health equity and improve the access to and delivery of public health services in the community.

This resource is intended to accomplish three things: 1) Describe the unique benefits that SRSAs can bring to rural public health services, 2) identify the key roadblocks rural public health departments may face in developing and implementing service and resource sharing arrangements, and 3) show how existing strengths and assets within rural communities can be leveraged to overcome barriers to developing SRSAs and improve public health. The perspectives shared below are intended to support by those doing and leading public health work in rural communities across the United States.

About the Authors

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The Kansas Health Institute is KHI is a nonprofit, nonpartisan educational organization that supports effective policymaking through nonpartisan research, education and engagement. Wyatt, helps lead rural health focused projects as a senior analyst at KHI, and served as an analyst for the Center for Sharing Public Health Services (CSPHS) when it was housed at the Kansas Health Institute, prior to moving to the Public Health Accreditation Board.

The Center for Rural Health Research at ETSU works to improve health and well-being at the community, state, regional and national levels through community engagement, research and innovative solutions that contribute to the expanding evidence base of what works in rural America. Haleigh, Olivia and Nneoma are graduate level public health students supporting rural health projects at the Center for Rural Health Research. Christen, a Research Assistant Professor within the Department of Community and Behavioral Health at ETSU, serves as Director of Operations for the Center for Rural Health Research.

Methods

Twelve case studies of service and resource sharing arrangements in rural communities across the U.S. supported were qualitatively analyzed. The case studies were developed by the CSPHS and published between 2019 and 2022 but drew from experiences of CSPHS grantees from the past decade. Prior to coding the case studies, the project team reviewed the foundational literature for service and resource sharing arrangements published by the CSPHS. Additionally, the project team reviewed and discussed select research on rural health disparities, rural classification schemes, and rural governmental public health workforce to build foundational and shared understanding of key terminology, concepts, and challenges in rural public health.

The 12 case studies were double coded, and thematic analysis was used to identify common factors that influence shared service arrangements in rural communities. The project lead reviewed and synthesized the codes to identify common themes and coding discrepancies were jointly discussed and resolved by the project team. Draft summaries describing the major themes of the analysis were developed and relevant case studies examples were included. Where helpful, supplemental examples, literature and data were included to support deeper understanding of the themes and approaches being described. While these supplemental examples and perspectives were not systematically identified, they were informed by the deep understanding of SRSAs and rural contexts among the authors. Finally, leading experts in governmental public health service delivery and modernization at PHAB provided review and quality assurance.

The Value of Service & Resource Sharing for Rural Public Health

In the absence of dramatic changes to the way local public health is funded and supported, SRSAs offer a way to maximize limited resources to provide public health services more effectively and efficiently for all communities. Put simply, SRSAs are a valuable tool for addressing some of the greatest challenges rural health departments face. Rural health departments are oftentimes asked to “do more with less.” At the state or systems level, changes in laws and policies can place new demands on rural health departments, requiring they “do more” while ongoing capacity limitations mean they are working “with less.” While SRSAs will not, on their own, change these realities, they can help rural public health departments do more with less, better.

The dynamic of doing more with less can be organized into two broad areas – limited capacity, and the impact of state laws and systems on local public health. In the sections that follow, the unique potential for SRSAs to help overcome both challenges will be described, starting with the challenge of limited capacity and resources.

Limited Resources & Capacity

While capacity is a broad challenge for the entire public health system, the challenges that are associated with limited capacity can be especially acute for rural LHDs. Rural public health capacity is regularly stretched thin in three areas: funding, workforce, and technical expertise. These three capacity issues are oftentimes interconnected – with each influencing the other. Scarce funding makes hiring and retaining workforce difficult and smaller staff sizes may require team members to manage multiple programs and services at once. These challenges can prevent staff from developing deep technical expertise and potentially limit the services the health department can provide. Oftentimes this means rural LHDs provide fewer services, even when there are additional service and program needs, which can erode the perceived value of, and investment in, local public health.

Service and resource sharing can help address and unwind these interconnected challenges to help rural local health departments build and sustain their capacity.

Funding

Rural local health departments often face a dual challenge for funding: efficiencies of scale and perceived impact based on smaller population size. First, while urban jurisdictions can benefit from efficiencies of scale and concentrated populations for service delivery, rural health departments often must spend more resources to provide the same service to a more geographically dispersed population. For example, conducting lead exposure screening for residences of 2,000 people in an urban area could mean visiting a single apartment complex. For a rural health department, accomplishing the same number of screens could necessitate driving across an entire town or county. In short, there is an *efficiency* challenge.

Secondly, despite the unique health needs of rural populations, rural health departments are oftentimes not as competitive for external grant funding and pass-through dollars because they serve smaller populations compared to other jurisdictions. Funders and state leaders, who also work with limited resources, may often seek to maximize the impact of their investments, which is oftentimes defined by the number of people served. Even though a rural LHD may address a critical issue that is greater in severity of need compared to an urban population, funders may measure the impact in number of people impacted. This competitive disadvantage is often written in funding opportunities, with required minimums for population served, but can be effectual even when not explicitly written, which does not consider the unique challenges of rural public health. This can be thought of as a problem of perceived lack of *reach*.

SRSAs can be a tool for overcoming both challenges. SRSAs are designed to maximize both efficiency and effectiveness. By sharing administrative functions for a program with a neighboring jurisdiction, for example, both health departments may be able to provide the service more efficiently than on their own. For external grant funding, combining resources and populations when applying for a grant can expand the reach of the application and make rural jurisdictions more competitive.

Workforce

The public health services and protections local health departments provide are dependent upon adequate workforce and staff. In October 2021, the de Beaumont Foundation and the Public Health National Center for Innovations (PHNCI), **found** that local health departments would need to increase the number of workforce FTEs by 70 percent to provide a minimum set of public health services. For health departments serving a population of less than 25,000, the workforce would need to increase 230 percent. Unfortunately, the impacts of limited staff and workforce have impacts beyond the type and amount of services health departments can provide.

Staffing encompasses a variety of challenges for rural LHDs. If demands increase, but the workforce remains constant, those staff who remain must take on more work and responsibilities. Over time, this can contribute to burnout departures, further exacerbating the challenges. Additionally, staff taking on new and higher-level responsibilities without more support are left with little time to pursue continuing education, leaving the departments at a disadvantage compared to more fully staffed LHDs.

While local SRSAs will not directly change the broad workforce challenge facing the public health system, it can be a valuable tool for supporting the existing workforce, maximizing the limited resources, and bringing new staff capacity to a community.

Example from the Field

Like many rural-serving health departments, when staff retired from Genesee and Orleans Counties' local health departments, they took an immense amount of historical knowledge and expertise with them. The two counties would then compete over the limited workforce in the area. Building on an established relationship, the two counties began exploring more formalized SRSAs to share critical staff and workforce, beginning with administration. Over time, the two health departments gradually began sharing more staff positions, finding ways to add new staff and services to both counties, without losing positions. Read more here: **Bringing Counties Together to Create Stronger Health Departments at a Lesser Cost in Rural Western New York**

Technical Expertise

At the intersection of funding and staffing often lies technical expertise. As with specialist physicians in healthcare, some public health positions, such as epidemiology, grant-writing, or environmental health, require advanced training or experience. The aspirations of public health, to advance and protect the health of all communities, runs into the perceived lack of need for advanced services in rural communities.

Even when there is support for seeking out and building capacity in the services that require more advanced technical expertise, rural LHDs can face challenges funding the position. The additional training and experience levels translate to higher salary costs, making recruitment and retention challenging for low-resourced rural LHDs. Rural LHDs may not be able to compete with urban LHDs for positions that require advanced degrees and higher wages if urban LHDs are better able to justify the value to boards of health and offer a more competitive salary.

Ultimately, for many rural LHDs, there are neither the resources nor the buy-in for supporting a full-time position in some technically advanced positions. In these situations, SRSAs offer a way for bringing the benefits of those technical skills to a health department, while allowing all those involved to design an arrangement that shares the costs and benefits appropriately. For the very small health departments, this can make services and technical expertise – and all the associated benefits they provide – available, whereas doing so individually would not be feasible.

Example from the Field

In California's San Joaquin Valley, in the middle of the COVID-19 pandemic, multiple local health departments and regional partners came together to bring technical expertise to partner jurisdictions in the region. Two counties financially supported an epidemiologist that, in turn, created epidemiologic reports for seven counties in total. However, this SRSA extended beyond this additional technical expertise; meetings to identify and discuss results of these reports also provided an opportunity for multiple LHDs to share capacity during a pressing public health emergency. Read more here: **Shared Epidemiology Services in the San Joaquin Valley**

Changing Laws & Policies

Modernizing and updating public health law is important in protecting and promoting the overall health and well-being of communities served. Nevertheless, the changes often present unique challenges and opportunities for rural LHDs.

Responding to New Mandates

While changes to local public health mandates, rules, and expectations can help move the system forward, they can add additional requirements to rural LHDs, placing further strain on already stretched resources, capacity, and staff. When these changes come, SRSAs can be a mechanism for distributing the new costs associated with meeting new requirements.

Example from the Field

In 2008, Colorado updated state public health laws to protect and promote health across the state. Several rural and remote LHDs, which were already struggling to meet some of the state requirements due to staffing and funding shortages, were concerned about how they were going to meet the new mandates. From previous working relationships, two regional partnerships evolved: West Central Public Health Partnership and San Luis Valley Public Health Partnership. These partnerships were supported by the Colorado Department of Public Health and Environment and the Center for Sharing Public Health Services through grants and strategic partnership development. As these partnerships developed, they were able to collaborate on grants to expand services, share data across counties, and implement a regional system to address public health concerns to not only meet state requirements but better meet the growing needs of the communities in the region. Read more here: **Strengthening Public Health in the Mountains of Colorado** & **Working Together to Improve Environmental Health in Colorado**

Seizing New Opportunities

In addition to adding new requirements for local health departments, federal and state governments can also remove laws and policies that limit the ability of LHDs to collaborate. When these laws change, SRSAs can support rural local health departments in designing innovative approaches to elevating the level and breadth of services they provide or address existing cost and efficiency challenges.

Additionally, SRSA's can be a valuable tool for maximizing new funding and resources that come into the public health system, such as the **Public Health Infrastructure Grant (PHIG)** from the Centers for Disease Control and Prevention. Through this grant, many local health departments will receive some pass-through funding from their state health departments. The amount of funding each local health department receives, however, will be influenced by the total population they serve. For some rural LHDs, the amount received will not be enough to hire a new staff member or offer a new service on their own. Service & resource sharing arrangements could be a way to capitalize on this funding, making the impact of the funding for local communities both greater and more sustainable.

Example from the Field

In western New York, when the state law changed to allow health departments to share public health directors, two rural local health departments discussed how they could expand their current collaborations to meet the changing needs of their communities. Each of the local health departments were facing challenges with cost effectiveness and sustainability of current operations. They had collaborated previously, and with the change in state law, they saw an opportunity to formalize their collaboration to better meet community needs and support staff. Through an SRSA, the local health departments were able to align response plans and increase capacity during emergencies, reduce personnel costs because of shared management, share staff, and recruit a CDC public health associate. Read more here: **Bringing Counties Together to Create Stronger Health Departments at a Lesser Cost in Rural Western New York**

Changes to Existing Arrangements

Local health departments, which may have long-standing agreements with regional or state partners to provide services, may be forced to respond to dramatic changes in the scope or costs associated with those arrangements. When these challenges arise, exploring new SRSAs can provide an alternative to the previous service arrangement that is more efficient and effective.

Example from the Field

In Nevada, when environmental health inspection costs for the inspection services the state had been providing were set to increase for the Douglas County Health Department, a two-jurisdiction agreement was developed with Carson City to keep costs at previous rates and improve local environmental health services. By establishing this partnership, costs were kept down, scheduling was easier and timelier to serve the vast geographic region of these counties, and it was easier for the public to get their questions answered because the environmental health services were now consolidated. The partnership development required strategic planning between the counties and the state to ensure the partnership would meet all state and local environmental health requirements and it is now expanding to provide other services and a quality assurance component to the environmental health work. Read more here: **Enhancing Environmental Health by Sharing Services in Nevada**

Planning for Potential Roadblocks to Developing SRSAs

Having described how service and resource sharing arrangements can be a valuable tool for addressing common and pressing challenges faced by rural local health departments, the next section focuses on the barriers public health administrators and leaders may face when working to develop and implement SRSAs in rural communities. Like the broad challenges of cost and policy changes, these potential roadblocks to SRSAs may be present in urban LHDs, but they may impact rural LHDs differently.

Leadership and Planning

Required Planning Time & Resources

Conceptualizing, developing, and implementing effective SRSAs requires thoughtful planning, time, and resources. While the **Center for Innovation has numerous tools and resources** to support this work, there is no avoiding the time and resource investments needed. Rural local health departments may acutely feel the lack of time and resources for this planning time and investment. In the absence of a dedicated staff member for grants, partnerships, or similar work, the effort may fall to the administrator – who likely already has a full task and obligation list.

To prevent the lack of planning time and resources from becoming a barrier to exploring and developing SRSA, rural local health administrators may need to find ways to justify or otherwise cover the time and costs of SRSA development. In some cases, state health departments or other funders will provide flexible funding that includes time for strategic planning in which SRSAs can fit. Some of these funding opportunities may also be accompanied by technical assistance. If offered, this technical assistance can help supplement limited staff time for planning. While applying for these funding opportunities comes with its own set of costs, if received, those funds can provide the time and resources to strategically plan and develop SRSAs.

In the absence of external funding and technical assistance, LHD administrators may need to advocate and justify using their own time and resources to explore the SRSA. In these situations, communicating to other staff and policymakers about the potential benefits and value the SRSA may bring is important. Additionally, in justifying the use of time and resources for exploring SRSAs, leaders may need to address concerns about loss of control and a lack of buy-in, which are further discussed below.

Lack of Champion

Even when rural local health departments have the staff time and resources to explore and plan an SRSA, the work will likely stall without a dedicated leader and champion for the effort. In the early stages of developing SRSAs, the involved jurisdictions will need to build enough trust and clarity of objectives to proceed. This will require meetings, conversations, and follow-ups. Without a dedicated leader and champion, the SRSA may never get through those important steps.

While a health department administrator is well-positioned to champion and lead this work, that may not be feasible or most advantageous in all communities. In some cases, another staff member may be interested in and connected to the challenge being addressed through an SRSA. The health department staff member who conducts environmental health inspections, for example, may be a strong champion for an SRSA with a neighboring jurisdiction to add a new shared inspection service in both counties. Those staff who are close to the service and challenge being discussed may be best situated to articulate the potential benefits of exploring the arrangement and help justify the costs and time to do so. Another potential champion for SRSAs beyond health department administrators are local policymakers. For many rural local health departments, the county commissioners serve as the local board of health. While this dynamic can present challenges, if a county commissioner sees the potential of an SRSA to improve the services offered in a community or more efficiently utilize tax dollars and funding, they can become a powerful champion for SRSAs.

Building Support for Service & Resource Sharing Arrangements

While a capable champion can drive the development and planning of an SRSA, the long-term success of any arrangement will suffer if there is not broad support and buy-in for the arrangement. Buy-in and support for SRSAs must be present within and between all collaborating organizations and the policymakers for the jurisdiction. Additionally, the governing boards for local health departments often control or heavily influence the agreements and broad financial decisions local health departments can make.

While a rural LHD director may see the potential for SRSAs to meet mandates or improve the services they provide in their community, gaining the crucial support for these arrangements can be challenging. These leaders must convey their broad understanding of operations to persuade both staff and community leaders of the benefits of sharing arrangements. By focusing on community benefit and cost savings from SRSAs, public health leaders can alleviate potential concerns of staff and collaborate with local policymakers for win-win solutions.

Buy-in from Staff

While an administrator may be able to lead the development of an SRSA, they are unlikely to implement and maintain the service on their own – other health department staff will need to support the arrangement as well, and their potential concerns need to be heard and addressed. Staff commitment to any SRSA can only be secured if their concerns are promptly and adequately addressed. One major concern is the possible elimination of positions and loss of jobs to create a shared position or service. The staff who currently provide immunizations, for example, may have reservations about the impact of developing a new expanded immunization program with the neighboring jurisdiction. This can instill fear of job insecurity among the workers who predict their position would be impacted by the SRSA. Managing and accounting for these concerns is particularly important for SRSAs that result in more dramatic changes to the structure of a health department, such as a full merger. Establishing clear parameters for adding new shared positions or services only when it does not negatively impact current staff is one approach for proactively addressing these concerns.

Example from the Field

Reflecting on the concern of lost positions for current staff, the leadership of the Genesee and Orleans County SRSA in Western New York *said*: *For a long time, the main challenge in this effort was the anxiety expressed by existing staff members. Staff were concerned that a position in one department would be eliminated to create a shared position for both departments. As envisioned, and to date, positions shared by the health departments have been created only when an opportunity presents itself (e.g., through retirement, resignation, and new funding opportunities) and when it is mutually beneficial to have a shared position.* Read more here: **Bringing Counties Together to Create Stronger Health Departments at a Lesser Cost in Rural Western New York**

Support from Local Policymakers

For many rural health departments, governance of resources is managed by locally-elected leaders, often in the form of a board of commissioners or a board of health. These leaders may not prioritize public health funding due to limited financial resources and competing priorities from other governmental departments. This can lead to a lack of capacity for public health agencies, leaving LHDs unable to meet crucial public health and safety needs. In this common scenario, SRSAs could be an option to partner with neighboring communities and meet public health needs by sharing staffing and service delivery resources. However, gaining buy-in from those who hold power can present another challenge.

One particularly salient concern for local policymakers can be funding and resource allocation. Like public health departments, other segments of local government may face limited funding and resources – particularly in rural communities. Service arrangements that are seen as extracting local tax dollars to fund services in another jurisdiction may be non-starters. Furthermore, declining populations and tax bases may make local policymakers especially cautious when considering adding new services or positions. When building support for an SRSA, administrators should emphasize that the arrangement would be structured to be mutually beneficial for all jurisdictions, with funding and cost-sharing approaches ensuring local funds stay within the jurisdiction. While the intricacies of distributing costs are best addressed after clarifying the goals and objectives of the SRSA, acknowledging, and overcoming this concern early on will likely be necessary to move forward. When ready to discuss the details of distributing costs, leaders can use this **resource** on to determine a mutually beneficial and fair approach.

A related, but more generalized, concern public health leaders may encounter is a loss of control. Rural communities may have recent or ongoing experiences that negatively influence how they view collaboration and partnership with external entities. This can be particularly true for SRSAs between a very small, less resourced community and a larger, more resourced one. Communities that have seen employers leave for larger cities, critical access hospitals close, or schools consolidate may rightly be sensitive to changes that are perceived as removing the control and autonomy they have over their community. This concern is best encapsulated in many policymakers negative perceptions of “regionalization” and “consolidation.”

As with concerns around costs and funding, public health leaders should speak directly to concerns about control, emphasizing that SRSAs are built to be mutually beneficial for all sides and that decision-making processes within the arrangement can be designed to protect against these concerns. Those involved in the arrangement have the power to determine what is and what is not shared, and regionalization or consolidation is only on the table when all parties believe it to be the best solution. Furthermore, administrators should point to the potential benefits the SRSA may provide to residents through new or higher-quality services and protections.

Ultimately, local leaders are vested members in their communities, as are public health leaders. This shared value can often be the starting point in moving toward a successful SRSA. Health department leaders must be ready to alleviate the concerns of local leaders regarding funding, governance, and control, while speaking to the potential benefits the SRSA may provide.

Example from the Field

The West Central Public Health Partnership is an excellent example of garnering broad support. Those involved summarized the concerns of policymakers, saying: *Even when public health directors or environmental health managers were enthusiastic, some county commissioners (who generally served as a county's board of health) were lukewarm about the idea of participating. Fears that this could be the first step to the "regionalization" of public health services surfaced, and some of the smaller counties were concerned that local control over public health would erode, and that their departments would be taken over by the partnership.* Using positive peer pressure from early adopters of the idea, public health leaders were able to provide local leadership with a detailed approach to strengthening public health infrastructure across multiple communities. This included evidence of a potential return on investment and an opportunity for cross-training staff. Existing mutual respect among involved communities and an improved understanding of the process led to an intergovernmental agreement outlining roles and responsibilities and a successful SRSA. Read more here: **Strengthening Public Health in the Mountains of Colorado**

Leveraging Assets and Strengths

Rural public health leaders work tirelessly to protect and promote the health of their communities. SRSAs can be a valuable tool to support these efforts, but exploring, planning and implementing SRSAs come with their own challenges and potential obstacles. Even amidst these challenges, rural communities are rich in strengths, assets, and ingenuity – and many aspects of rural culture and context can be an advantage to SRSAs and protecting community health.

Having described the potential value of SRSAs and the potential roadblocks to navigate, this final section highlights how rural public health leaders can leverage the unique strengths of their rural communities to advance SRSAs and support public health.

Lean into Proximity & Informality

While rural communities may be isolated and geographically distant from the resources and decision-making powers in large cities, those *within* the community are often closer to the people and places of influence, with fewer formal barriers blocking communication and access. For example, leaders and policymakers may serve on volunteer boards together, participate in the same school district activities with their families, or have similar places of worship. While it's an exaggeration to say that everyone knows everyone in a small town, the relational distance between individuals is often smaller and more easily bridged.

Sustainable SRSAs *move at the speed of trust* and trust can be built and nurtured within and outside of professional roles. Public health leaders should lean into the relationships they may have with policymakers, even if they originate outside of work. Where those relationships are not developed or strong, health administrators can take advantage of the access to policymakers.

Build on Shared Identities and Experiences

Like all communities, the populations served by rural local health departments have unique histories, goals, and aspirations. Even so, many rural communities share common challenges and identities with their neighbors. Rural regional contexts, such as the mountains of Appalachia, the wheat- and corn-lined fields of the Great Plains, and the arid deserts of the Southwest, can impart shared norms, traditions, and experiences to their communities. The communities may serve similar populations and face common challenges. These commonalities can be powerful facilitating factors for conceptualizing SRSAs. Leaning into shared identities can create a shift from competing for the same limited resources to collaborating to accomplish a shared goal, resulting in better public and fiscal health for rural communities.

Conclusion

Service and resource sharing arrangements can help leverage the strengths, relationships, and creativity of rural local health departments to address the changing public health needs of the jurisdictions they serve. Through intentional planning and relationship building - both within and across collaborating jurisdictions - rural local health departments can design SRSA's that increase both the efficiency and effectiveness of the services they provide. Ultimately, SRSA’s are a powerful tool rural public health leaders can utilize to advance the health of their communities.