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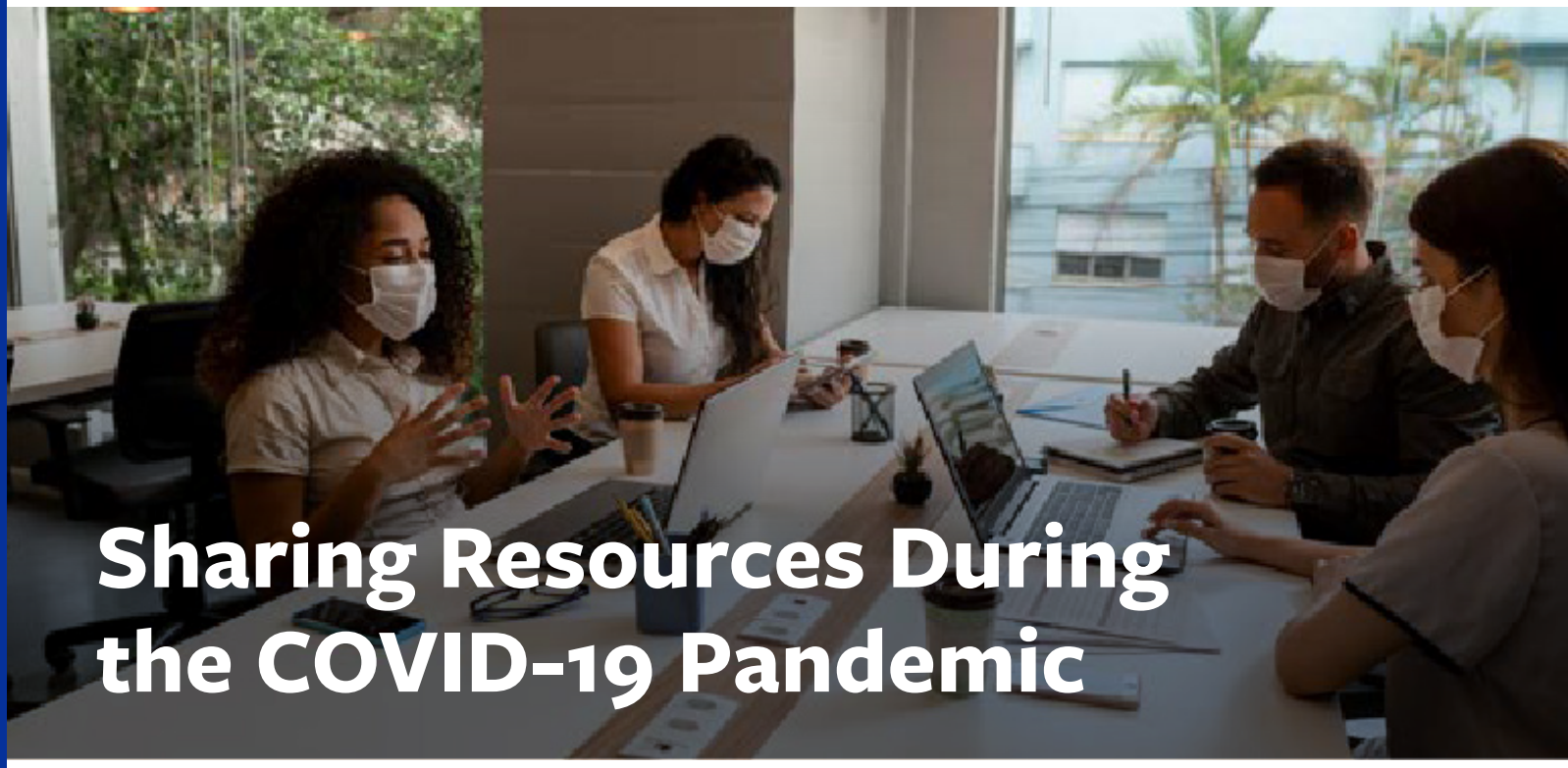

Sharing Resources During the COVID-19 Pandemic

Starting in 2020, the COVID-19 pandemic — an event that by definition has no jurisdictional boundaries — became the ultimate example of an emergency that could not easily be solved by a single organization. Resource sharing among partners became a powerful tool to address the challenges brought by the pandemic. Many local health departments shared resources through partnerships that had been developed well before the pandemic, while in other instances new partnerships were forced by rapidly evolving circumstances. While resource sharing supported health departments as they weathered the pandemic, practical challenges also arose.

This brief highlights examples of resource sharing during the COVID-19 response and discusses challenges and benefits associated with sharing resources during this public health emergency. The analysis draws on 12 informal interviews with public health professionals across the U.S., the findings from 20 responses to a short survey of local health departments and the experience of the Center for Sharing Public Health Services in assisting dozens of partnership initiatives across the country before and after the start of the pandemic.

A MARRIAGE OF CONVENIENCE

The COVID-19 pandemic created a "marriage of convenience," in which health departments, given the scale of effort required to respond to the pandemic, often had no choice but to work together. Working together allowed partners to scale up their response efforts more quickly and to secure needed resources and skills that may not have been available internally (e.g., data analysis and epidemiology capacity). Local health departments shared resources with other local health departments, state

Why Resource Sharing?

By working together — pooling resources, sharing staff, expertise, funds and programs — across organizational boundaries, public health departments can accomplish more than they could do alone, both during and outside a public health emergency.

health departments and other community partners including health care providers and systems, emergency medical services, fire departments, law enforcement, schools, chambers of commerce, local government agencies, faith communities, media outlets, social service organizations, long-term care providers, local tribal governments and more.

While some of these partnerships leveraged existing relationships, the urgency of the emergency led some new relationships to develop rapidly, a process not without challenges. Rapid partner development left little time to understand respective missions and operations, align shared values around centering equity in decision-making, articulate mutually reinforcing goals and strategies, and develop trust. In one example, a large, cross-sector group of entities convened to coordinate response efforts, and conflicts emerged when the local health department issued a mask mandate but the chamber of commerce did not encourage their member businesses to comply with enforcing this requirement. This group of partners did not have a history of working together and the conflict disrupted the group dynamic.

EXAMPLES OF SHARED RESOUCES

The resources that local health departments shared most frequently were communication materials, knowledge/technical assistance, data, programs and services, and policies, as described in *Figure 1*, with different health departments being both recipients and providers of resources. Sharing of funds or staff was less frequent, apart from staff support supplied by state health departments to assist local operations. Given existing public health workforce shortages and the widespread need for intense response efforts, some health departments did not have additional staff capacity to offer to other partners outside of administering some joint initiatives.

LESSONS LEARNED

In many ways, the pandemic (like any large emergency) acted as an accelerator — speeding up relationship development, expanding longstanding arrangements, and amplifying existing tensions.

Political Nature of COVID-19

The political nature of the COVID-19 pandemic created challenges for health departments that partnered with other agencies in responding to it. Many health departments are governed by elected officials who are responsible for directing public health activities in their jurisdiction, and some elected officials were not very keen to engage in shared efforts that crossed jurisdictions, often out of concern that their responsibility is focusing on the emergency within their boundaries.

RESOURCES THAT LOCAL HEALTH DEPARTMENTS SHARED MOST FREQUENTLY DURING THE COVID-19 PANDEMIC (*Figure 1*)

SHARED RESOURCES	EXAMPLES	NOTES
Knowledge, technical assistance	Holding regular conference calls and webinars. Sharing information via email with groups of health departments. Sharing information with health care partners.	Some of these regular convenings have continued, and interest has been expressed in developing longer-term mentorship opportunities between health officials as a means of continuing the valuable knowledge sharing.
Communications	Sharing a public information officer, holding joint media events, sending joint press releases and sharing communications targeted to specific populations.	A benefit of this work is consistent messaging across jurisdictions, some of which were included in the same media market.
Contact tracing	Sharing investigators, conducting joint investigations and exchanging information.	This type of sharing facilitated investigation of sources of infection, cases, and their contacts spanning multiple jurisdictions.
Data, epidemiology capacity	Sharing epidemiologists (new hires or existing) to serve multiple jurisdictions.	Larger health departments (including some created through mergers prior to the pandemic) were able to boost their epidemiologic capacity more easily than smaller agencies.

Political differences created tensions that affected even longstanding, multi-county sharing arrangements when local officials in different jurisdictions disagreed on the adoption of public health containment measures (e.g., mask mandates). In some cases, the pandemic amplified differences already present among sharing partners prior to the pandemic. These challenges highlight the need to secure the support of elected officials for agreements to share public health services and reinforce the importance of developing a shared identity among partners to assure the success of a sharing agreement.

Need for Advance Planning

While many new partnerships emerged during the pandemic, working with new partners during such a large emergency response was not without challenges. Shared goals needed to be defined, and trust had to be built, before the new partnerships could produce the desired results. When no formal sharing agreement existed before the pandemic, staff from some health departments did not have the bandwidth to consider what sharing could look like. Because of how quickly things changed on a day-to-day basis, some indicated that not sharing resources was one way for their jurisdiction to remain nimble and feel a greater sense of control over their scarce resources.

Pre-existing partnerships could manage these challenges using the experience accumulated prior to the pandemic. In interviews with public health officials, it was evident that having strong relationships and trust prior to the pandemic facilitated the ability to expand existing CJS arrangements, by adding new partners or new programs and services to existing arrangements.

Sharing Agreements Models and Structure

The Center for Sharing Public Health Services has identified four main types of sharing arrangements, as depicted on the *Spectrum of Sharing Arrangements* (*Figure 2*). Generally, moving from left to right along the spectrum, the level of service integration increases, the level of jurisdictional autonomy decreases, and implementation and governance may become more complex.

SPECTRUM OF SHARING ARRANGEMENTS (*Figure 2*)

LOOSER INTEGRATION ← → TIGHTER INTEGRATION

As-Needed Assistance

Information sharing (e.g., infectious disease testing protocols, health education messaging)

Equipment sharing

Assistance for surge capacity (e.g., assisting with food delivery during a crisis, providing temporary contact tracing capacity)

Assisting with enrolling in public benefit programs

Service-Related Arrangements

Service provision agreements (e.g., contract to provide immunization services, providing grants to community members to implement population health strategies)

Purchase of staff time (e.g., environmental health specialist)

Shared Programs or Functions

Joint programs and services (e.g., shared HIV program, shared data platform)

Joint shared capacity (e.g., epidemiology, communications)

Group purchasing/ procurement processes

Joint management and governance of grants

Regionalization/ Consolidation

New entity formed by merging existing local public health agencies

Consolidation of one or more local public health agencies into an existing local public health agency

Consolidating health and human services into one agency

Consolidating public health and behavioral health services into one agency

2021 Updates: The Center updated the Spectrum in April 2021 to reflect lessons learned about CJS and other recent advances in the field of Public Health Systems and Services. The Center's original 2013 Spectrum was adapted from previous versions produced by J. Ruggini (2006), A. Holdsworth (2006) and N. Kaufman (2010).

In general, agreements falling in the as-needed, more informal model on the left side of the spectrum were more difficult to implement and manage during the pandemic, particularly for sharing capacity. Those agreements are often developed to support surge capacity in one jurisdiction affected by a local emergency. When all the partners are experiencing the same emergency, especially one as large as a pandemic, such agreements proved to be less helpful, since there was little surge capacity across all the partners that could be shared.

The structure of the arrangement also matters. One health department in this analysis participates in two regional partnerships that are structured differently. One of the partnerships was led by staff from a single county, who struggled to effectively coordinate activities among the participating counties. In that situation, partners were more reluctant to share resources, like epidemiological capacity. Recognizing how their structure hindered regional response efforts during the pandemic, the partnership is considering hiring regional staff not tied to an individual county.

Leaders from some health departments that had merged prior to the pandemic (i.e., had sharing agreements falling on the right side of the spectrum) noticed how those mergers promoted the availability of additional capacity needed during the pandemic — including data analysis, epidemiological capacity, communications expertise, and the overall number of staff. On the other hand, leaders of merged agencies were responsible for a larger workforce and jurisdiction, and in some cases were accountable to multiple boards of health. This caused some management challenges, especially when different parts of their jurisdiction experienced the pandemic differently (e.g., case rates were higher in one area).

LOOKING FORWARD

As the intensity of response efforts has decreased, some health departments have begun planning for what resource sharing could look like after the pandemic. For those who initiated ad hoc arrangements during the pandemic (e.g., hiring a shared epidemiologist to support multiple jurisdictions), this includes assessing the impact of their sharing agreement and the feasibility of continuing it past the acute response phase.

Some health departments that experienced challenges in their COVID-19 response efforts have begun considering sharing arrangements as an opportunity to improve capacity and performance in the future. This includes potential partnerships between small health departments, as well as state agencies considering the addition of regional staff support. Others have sought out advice for restructuring their departments or exploring a merger. Resources like the ***Roadmap to Develop Sharing Initiatives in Public Health*** and ***Factors that Contribute to a Successful Sharing Arrangement*** can support health departments developing long-term arrangements.

Some health departments hope to leverage new relationships developed during the pandemic to increase partnerships in other health department activities after the pandemic subsides, such as community involvement and input during the community health assessment (CHA) / community health improvement plan (CHIP) process.

CONCLUSION

The scope of the COVID-19 pandemic led many to share resources in ways they had not previously, often with new partners. The ability to share knowledge, communication materials, contact tracing and vaccination efforts, and data and epidemiological capacity was particularly vital, although sharing resources was not without challenges. Health departments with formal sharing agreements in place before the pandemic were often in a better position to share resources during the pandemic. Despite these challenges, some health departments are already looking ahead to the future to find ways to leverage the new relationships created by the pandemic to continue to effectively, efficiently and equitably serve their jurisdictions.

November 2021 – PHSharing/21-2-V1

These resources were created under the original language around cross-jurisdictional sharing. As we've learned more about this work over time, we've broadened our language to service and resource sharing. However, the documents reflect the term 'CJS' for this reasons. They were created to provide guidance for two ore more health departments developing a shared arrangement.

We will be updating these resources and adding new resources to describe the broader types of service and resource sharing models based on learnings.

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The Center for Sharing Public Health Services provides access to tools, techniques, expertise and resources that support better collaboration and sharing across boundaries. We help public health departments across the country work together to protect and promote the health of the people they serve.

The Center is funded by the Robert Wood Johnson Foundation and is managed by the Kansas Health Institute.