PHAB
Center for Innovation

SERVICE AND RESOURCE SHARING AGREEMENTS

Guidance for State Health Departments

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INTRODUCTION

State public health transformation efforts provide an important platform for much-needed improvements, and several state health agencies in the United States are incorporating systemwide strategies to share services and expertise as a means of maximizing available resources. Service and resource sharing arrangements (SRSAs) (also known as "cross-jurisdictional sharing" or "CJS" arrangements) are when partners share services and/or other resources across their respective jurisdictions to improve organizational capacity, address public health issues more effectively and efficiently, advance health equity, or otherwise address problems that cannot be easily solved by a single organization or jurisdiction. SRSAs have been a well-established feature in some states for many years (especially for state health departments with centralized or mixed governance structures). The 2019 National Profile of Local Health Departments indicated that 55% of local health departments are already engaged in some type of sharing arrangement (see examples in the following section). In addition to enhancing the efficiency and effectiveness of providing the Foundational Public Health Services (FPHS), sharing arrangements may also better prepare both state and local health departments to meet the Public Health Accreditation Board (PHAB) accreditation Standards (either by providing new FPHS or strengthening existing ones).

Drawing from a decade of work, previously housed at the Center for Sharing Public Health Services, this guide is intended to equip state health agency staff to support all SRSAs, whether they are designed and implemented at the systemwide, regional/district, or local level. The state health department has an important and unique role to play in this arena, as it is positioned both to design statewide efforts to promote SRSAs and to directly assist groups of local health departments that are generating SRSAs independent of state actions.

State health departments may find it helpful to adopt or adapt existing approaches to sharing, and equally (if not more) importantly, states may be best served by crafting an innovative approach to service and resource sharing to meet their public health goals. The PHAB Center for Innovation stands ready to assist state health agencies in promoting and facilitating SRSAs for the provision of Foundational Public Health Services.

EXAMPLES OF SERVICE AND RESOURCE SHARING ARRANGEMENTS

Service and resource sharing arrangements can take many different forms. The PHAB Center for Innovation categorizes SRSA arrangements into three levels, as follows:

STATE LEVEL/SYSTEMWIDE

State level/Systemwide approaches refer to models and strategies that are designed to enhance a state's whole governmental public health system. Several states are implementing SRSAs as part of their public health transformation efforts.

REGIONAL/DISTRICT

Regional/District approaches are intentionally developed to share services and resources in an area smaller than the state. They may be developed by the state health department, local health departments, or a combination of both. These approaches can take the form of state satellite offices, structured partnerships, council of governments, nonprofit organizations, or other collaborations with a formal oversight body.

LOCAL

Local approaches are developed between and among two or more local health departments, generated entirely by their own volition or as part of a state's direction or incentive

The levels of arrangements are intended to help conceptualize variations among them, and articulate some differences in how SRSAs originate and the range of geopolitical areas that may be included in the approach. The levels intentionally do not contain specific numbers of participating health departments. In fact, many SRSAs could be characterized in more than one approach. For this reason, it can be helpful to keep in mind that these categories are meant to be descriptive and not definitive.

Resource: Approaches to Service and Resource Sharing

The following examples illustrate different levels and provide additional information.

State Level/Systemwide Examples

Massachusetts

Since 2010, the Massachusetts Department of Health's Office of Local and Rural Health (OLRH) has incentivized locally driven SRSAs through grants. The MA Public Health Excellence Grant Program is designed to help local public health departments comply with the state's statutory and regulatory mandates and to expand the public health protections and services they offer residents. OLRH staff provide technical assistance to grantees in their exploration, planning, and implementation of SRSAs.

Washington

Washington also has been hard at work over the past 10 years to transform its public health system. Part of their effort supports pilot tests of different public health service delivery models that take a regional or district approach to ensuring the same level of service delivery across the state. View more examples from Washington.

Oregon

Oregon's decade-long public health transformation work includes strategies to consecutively ensure the equitable provision of Foundational Public Health Services across the state, beginning with a focus on communicable disease services. The Oregon Public Health Authority issued small grants to local health departments to incentivize local health department SRSAs to improve their ability to address the full range of high-quality communicable disease services.

Regional/District Examples

San Luis Valley, CO

The seven counties that comprise the geographically isolated San Luis Valley serve jurisdictions ranging from approximately 900 to 16,000 people. The capacity of individual communities is somewhat limited, and therefore residents have a collective mindset of "we're in this together" that is demonstrated, in part, by a long history of local governments assisting one another in a variety of ways. The San Luis Valley Public Health Partnership was formed to facilitate sharing arrangements between and among the valley's health departments, resulting in a more robust set of FPHS available to each community.

Nebraska Association of Local Health Directors

Communications capacity in the local health departments across this rural state is very limited. To help address this issue, the NE Association of Local Health Directors worked with health directors to design a website template that contains relevant statewide information and is easily customizable for local information. This is an excellent example of how a single entity can provide a valuable, virtual, efficient, and effective service.

San Joaquin Valley, CA

This vast agricultural region of central CA is home to 13 counties, each with its own health department. Although jurisdictional size and culture vary widely among them, the departments also face many of the same challenges that are difficult to adequately address on their own. The San Joaquin Public Health Collaborative, which for years served mainly as a connection point, recently added staff who will engage in epidemiology, health equity, and communications activities on behalf of the member counties, with plans to expand their offerings over time. Read the description of their shared epidemiology capacity.

Public Health Services Council of OH

Seven local health departments in the rural northwestern corner of Ohio collaborated for many yeas on a number of different initiatives to address public health issues that otherwise would go unaddressed. Eventually, the group developed a council of governments to facilitate sharing services as a means of increasing their respective capacities. In the process, an unexpected benefit realized was a stronger voice for public health throughout the region.

Local Examples

Marion and Polk Counties, OR

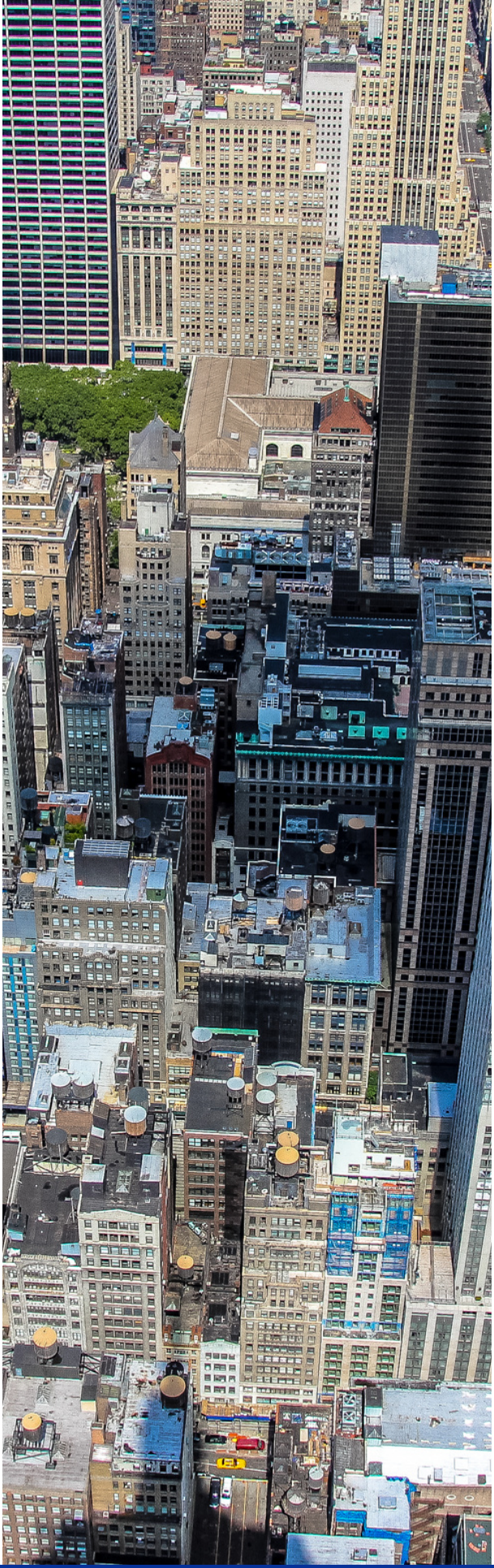
Marion and Polk Counties received a grant from the Oregon Public Health Authority (described above) to develop a shared communicable disease program. Marion County is the home of Salem, the state capital, and neighboring Polk County is much smaller and mostly rural. Program enhancements for both counties have resulted due to the implementation of identical communications, prevention measures, and program procedures.

GO Health, NY

Genesee and Orleans Counties, located in in the western part of the state, are served by a quasi-merged agency specifically configured to meet the state requirement that each county has its own health department governed by a board of residents. What began as a pilot test for both county health departments to share a health officer (as positions are difficult to fill in this rural area) gradually expanded to an arrangement in which one executive team serves both departments, some new staff are hired specifically to provide services in both counties, and all staff in both departments are equipped to provide services in either county. GO Health has also analyzed the quantitative and qualitative impacts of the new model. View more information about their work.

Washington-Ozaukee, WI

When the county commissioners in Washington and Ozaukee Counties made the decision to merge their health departments, the health director used this opportunity to transition the health department from a traditional model to one that embodies Public Health 3.0 principles. Read their story.



Guidance for States Promoting or Developing Service and Resource Sharing Arrangements

When states are designing SRSAs – whether through the establishment of regional/district offices, funding requirements, or incentives –the following guidance can facilitate effective planning and implementation of new strategies.

1. Understand concerns and drawbacks of sharing from the local perspective.

Because local SRSAs will have a significant impact on how local health departments do business, it is critical to include the local perspective in all planning efforts to change service delivery models and strategies. Political, financial, strategic, and other issues specific to the local context may not be apparent from a state perspective, so it is important to elicit information for planning purposes from those who will be directly affected. Feedback could be gathered through meetings with a state association of county and city health officials; key informant interview; focus groups; or other mechanisms.

2. Identify and apply characteristics of Foundational Public Health Services that make them good candidates for sharing.

Washington State Department of Health funded demonstration projects that pointed to several characteristics of services and resources (noted below) that are well-suited for sharing. Applying these characteristics as criteria when considering how best to maximize the efficiency and effectiveness of Foundational Public Health Services across the state can be a useful strategy when making decisions about resource allocation.

- Infrequent or sporadic need for services that cost a significant amount of money. For example, surge disease investigations.
- Expensive or rare skill set or expertise that is easily transferred or deployed in a time of need and/or does not need to live locally/can be provided from a distance. For example, data collection and analysis and epidemiological expertise for TB cases.
- Services with significant up-front capital and resource investment. For example, online resource development.
- Services with little marginal cost to increased participation and/or expanding a service to additional agencies. For example, a video conferencing platform that can serve more people at very low marginal costs.
- Services that are or can be delivered “virtually.”

3. Ensure equitable sharing across all communities in the state.

Health equity often is considered in the context of race and ethnicity. In rural areas, health equity may involve different issues. For example, health disparities could occur due to differences in income, culture (e.g., with migrant farmworkers), and access to funds (relative to non-rural parts of the state). From the state perspective, it is critical to consider how to ensure equity across all communities and understand that SRSAs that could benefit one part of the state may not be designed in a way that addresses inequities in other parts of the state.

4. Work with divisions throughout the state health agency.

Each division in the state health department may have its own processes and policies that could impact local SRSAs (e.g., funding formulas, technology issues, reporting requirements, etc.). Identify, understand, and address these impacts in advance to ensure that state plans to promote sharing are aligned with program practices.

5. Aim for a balance of enhanced effectiveness and efficiency.

The goal of enhanced efficiency is to maximize the value of the available funds; it is important to understand that does not always equate with cost savings. Efficiency can take many forms, e.g., increasing the scope and reach of services and capacities in a way that would not be possible without shared costs. Moreover, without an intentional balance between efficiency and effectiveness, costs savings can come at the expense of effectiveness. For example, a decrease in funds could result in a corresponding decrease in the scope and reach of services and capacities. Therefore, it is critical to ensure that funds directed toward shared services specifically seek a balance of improved efficiency and effectiveness.

Reporting requirements often present a burden to local health departments and can even dissuade them from accepting certain funding sources. Easing reporting requirements can make funding sources more attractive SRSAs present an opportunity to decrease the burden of reporting if only one health department is required to report on a grant that serves multiple health departments. This is an example of another way to achieve greater efficiency, as more time can spent on service provision if less time is spent on reporting.

6. Address data and technology issues.

Data sharing can be a very important component in successful SRSAs, and therefore data sharing agreements ideally will be in place before a new SRSA is launched. State health departments can play a critical role in ensuring needed access to data by facilitating the development of data sharing agreements before SRSAs are launched.

Moreover, security measures for information management systems can unintentionally limit access to these systems by staff shared between health departments (e.g., when virtual access is tied to physical location). Assessing security measures and addressing any issues that would inhibit full implementation of resource sharing early in the planning stage can prevent significant problems and delays with implementation of new arrangements.

7. Support SRSA preparation efforts.

The creation of SRSAs entails robust exploration and planning phases. The exploration phase is devoted to considering conceptual feasibility of sharing, and it relies on strong relationships among all partners. If good relationships do not already exist, their establishment is a critical outcome of the exploratory phase; otherwise, subsequent planning efforts will not get far. Relationships are built over time, through candid conversations, and with the development of trust. The use of contracted facilitators or other parties who do not have a vested interest in the outcome can be a tremendous asset in navigating issues during exploratory conversations.

Moreover, a number of operational issues must be carefully considered during the planning phase, which is devoted to ensuring the operational feasibility of an SRSA. Details regarding governance, human resources, technology, legal issues, and more require discussion and agreement. Proceeding without the full consensus of the group will significantly derail attempts to implement the SRSA.

For these reasons, it is necessary to find ways to financially support the ability of SRSA partners to plan with intentionality. Designated funds could include completion of the steps in Phase 1 or Phase 2 of the Roadmap; exploratory conversations; team-building retreats; and other activities that result in a comprehensive process to build a successful SRSA. Furthermore, consider the value of allowing existing programmatic grants to support SRSA planning. Because service and resource sharing efforts are intended to enhance both efficiency and effectiveness, an argument can be made that a SRSA will yield strong program outcomes and therefore effort dedicated to establishing a SRSA should be an allowable expense.

8. Allow local health departments to choose their partners for SRSAs.

Any state-level actions to promote local approaches to SRSAs must be built on the premise that local health departments will select their partners. Taking a “bottoms-up” approach ensures that the partners feel they can work together and avoids potential problems that might not be readily apparent (e.g., poor relationships, history of difficult collaborations, culture clashes, etc.).

9. Train Staff to support the process of exploring, planning, implementing, and monitoring SRSAs.

State employees are uniquely positioned to provide support to SRSA efforts, and offering technical assistance to the degree possible can provide a significant benefit for local health departments. If the state decides to require or incentivize SRSAs, it is important to ensure that staff are available to help. The section below illustrates ways that the state can help local partners pursue SRSAs, and the PHAB Center for Innovation is available to provide training on and offer technical assistance for its SRSA tools and guidance documents.

10. When offering incentive grants for local approaches to sharing, design them in partnership with local health departments

State agencies are well-served by working alongside local health officials when designing incentive programs for SRSAs as this approach can avoid legal and operational problems down the road. For example, it is important to understand how local codes, regulations, and ordinances can impact SRSAs, and therefore planning efforts should accommodate any needed time to address potential impacts on local policy when they are developed.
The local political climate can greatly influence the trajectory of SRSAs. Understanding anticipated sticking points and resistance due to local politics and co-creating funding strategies with local health departments can reduce or avoid barriers specific to local contexts. For example, some local health departments need specific directives from the state or specific earmarks in order to accept the funds.

Many grants are structured with a focus on tangible deliverables, and yet when it comes to developing SRSAs, many intangible outcomes are critical to developing a sustainable model. Examples include developing strong relationships, building trust among all partners, and getting buy-in from governing entities and boards of health. For this reason, grants should allow partners sufficient time to tend to these issues before engaging in more tangible planning efforts.

If possible, structure grants in a way that allows partners to determine that proceeding with a SRSA is not a viable alternative. Discussions in the exploratory phase may lead partners to conclude that they do not have mutually-agreeable goals or that they share goals but a SRSA is not the best way to achieve them. Moreover, even in the planning phase there are factors that can derail the process (e.g., compromised trust, elections, contention due to other cross-governmental issues, etc.), so it is possible that further activity is not possible even when partners have been committed to the SRSA.

11. Evaluate improvements in the state‘s public health system.

Assessing state level/systemwide efforts promote efficiency and effectiveness can provide important insights to the value of different strategies. State health departments are encouraged to consider process indicators for these purposes. For example, efficiency may be measured in terms of program costs (e.g., more funds could be devoted to service provision and fewer funds devoted to administrative costs when a grant serves a group of local health departments) or additional revenue for local health departments (e.g., from fees collected as a result of improved IT systems/expertise). Effectiveness may be measured in terms of an increase in the number of clients served by a program or the number of health assessments generated by a newly shared epidemiology position. Measuring the Impact of Cross-Jurisdictional Sharing in Public Health (link) includes a host of validated measures for local approaches to sharing that may be adapted for use at the state level.

Guidance for States Assisting Local Health Departments with Local Service and Resource Sharing Arrangements

Even when the state health department is not formally advocating SRSAs, it can play an important role in facilitating successful sharing arrangements generated by and for local health departments. In addition to considering the following guidance, state health departments are encouraged to reference the Roadmap to Develop Sharing Initiatives in Public Health and to contact the PHAB Center for Innovation to learn about technical assistance for state agency staff supporting local efforts.

1. Stress the importance of pre-requisites at the outset.

The Factors for Successful Sharing Arrangements notes several pre-requisites that set the stage for SRSA planning efforts. The document also includes facilitating factors and project characteristics that have been shown to pave the way for a productive process and outcome. The importance of taking a structured and strategic approach to SRSAs cannot be overstated; therefore, it is helpful to point local health department partners to this tool at the outset of their work.

2. Promote trust.

It has been said that work occurs at the speed of trust. Indeed, trust is one of the "prerequisites" described in Factors for Successful Sharing Arrangements. Trust can be hard won and is easily lost, and therefore it is critical to take the time needed for potential partners to build trust (even if this results in a delay in exploring conceptual feasibility, the first phase in the Roadmap). Otherwise, planning efforts could be derailed, with the worst-case scenario being that an otherwise promising partnership will not be pursued further and the best-case scenario being lost time and momentum later on while partners work to surface and address issues that have affected trust. Sharing partners can be directed to the Collaborative Trust Scale to assess and address aspects of trust that require attention.

3. Encourage taking the time needed for a full exploration.

A group discussion of all items in the first, exploratory phase of the Roadmap will yield a conceptual feasibility analysis, equipping the group to ensure they are in agreement regarding important foundational issues. Even if partners have progressed past an exploration and are in the midst of planning (Phase 2 of the Roadmap), encourage them to go back and ensure that all of the issues in the first phase have been addressed. Otherwise, a lack of agreement on very basic matters may well surface later and stymie further progress.

4. Ensure that form follows function.

Although it may be tempting to identify a sharing model as a first step towards a SRSA, the most appropriate model will emerge as partners agree on what they are seeking to accomplish and how to operationalize that. Therefore, it's helpful to take a thorough and systematic approach to identifying operational considerations of a SRSA. The Roadmap takes users through a series of questions, with accompanying resources, to help design a resource sharing model that supports all partners' needs.

5. Offer coaching and technical assistance throughout the planning phase.

State health department staff can familiarize themselves with various resources and otherwise discuss planning and implementation issues with local health department partners working on SRSAs. For example, the Roadmap strongly recommends that sharing partners develop plans to guide project management, change management, and communications, and it includes resources for all of these plans. In addition, local partners may need a sounding board for managing group dynamics, developing meeting agendas, structuring potentially contentious discussions, or addressing unanticipated barriers. State health department agency staff can provide a forum for discussions about these and other issues, call upon trusted colleagues to provide advice, or otherwise provide support and guidance. The Center for Innovation is available to train state staff on the Roadmap and offer technical assistance to equip state staff to support exploring, planning, and implementing SRSAs.

6. Serve as a liaison with other divisions in the state health agency.

Local health departments may get through a great deal of planning before the state health department division responsible for the shared program is notified that plans are afoot. It's advisable to take a "no surprises" approach when assisting at the local level, and state staff are ideally positioned to be liaisons between local health departments and the state health department. Deliberate and routine communication with affected division provides an opportunity for all parties to work out any issues before they become major problems.

7. Assist with managing risks/legal ramifications.

Some issues that arise may be legal in nature, and state counsel can be uniquely qualified to assist. For example, there could be administrative rules dealing with local boards of health, services and programs, legal agreements between local agencies, or personnel that would have a bearing on SRSAs. Even if legal issues have not arisen, proactively notifying the state attorney general that local health departments are developing an SRSA can be very helpful in the event s/he is contacted by a county or city attorney with questions about any state barriers or facilitators for this work.

8. Help identify impact measures that align with state reporting requirements.

Impact measures help health departments and decision-makers understand the degree to which an SRSA is achieving its goals. Wherever possible, it is useful to use impact measures that align with existing reporting requirements as a means of streamlining evaluation efforts. States are encouraged to refer to Measuring the Impact of Cross-Jurisdictional Sharing in Public Health for guidance on establishing impact measures.

9. Craft strategies.

Even with a comprehensive and thoughtful planning process, SRSAs may not work as intended, a political decision may end the arrangement, a funding shift could have an impact on its effectiveness, or other circumstances could arise that lead to ending the arrangement. Sharing agreements should incorporate guidelines to dissolve an SRSA that take the following items into account:

- State statutes that affect transition issues and times
- Process for a party to make a notification of the intent to dissolve the agreement
- Communication plan that assures the people receive it in a timely manner
- Transition steps
  - Length of time between the decision to dissolve and the initiation of the dissolution process
  - Disposition of shared space, equipment, materials, grant funds, etc.
  - Process for making decisions and communicating with staff about staff retention, reassignment, and layoffs
  - Provisions for a mediator should one be needed

Having guidelines in place helps ensure a smooth process, which is particularly useful during what could be a situation fraught with distrust and resentment.

For more information

SRSAs hold a great deal of promise for public health practice and can be an important tool for public health transformation. When developed and implemented with strategies that have proven to be effective, these arrangements can drive much-needed efficiencies and effectiveness throughout the nation's public health system. Visit the Service and Resource Sharing webpage for additional resources, view our Tools for Transformation webpage for additional tools for transformation, and contact the PHAB Center for Innovation for technical assistance to help guide your efforts and prepare your staff to support SRSAs.