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Public Health Services
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COLLABORATION BETWEEN LOCAL HEALTH DEPARTMENTS AND COMMUNITY HEALTH CENTERS

Prepared for the National Association of County and City Health Officials

AUGUST 2018

CSPHS/34-VI

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Acknowledgements

The authors would like to thank Peter L. Holtgrave, M.P.H., M.A., Senior Director, Performance Improvement, and Melissa Mayer, M.P.H., Program Analyst, Performance Improvement, with the National Association of County and City Health Officials. The authors also would like to thank colleagues from the Center for Sharing Public Health Services who provided feedback on the report: Jason Orr, M.P.H., Patrick E. Lowry, M.B.A., and Cathy McNorton.

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BACKGROUND

The Center for Sharing Public Health Services ("Center") was created in 2012 to explore and encourage best practices on resource sharing among health departments in different jurisdictions. Over the course of its work, the Center has interacted repeatedly with staff at the National Association of County and City Health Officials (NACCHO). A NACCHO representative sits on the Center's advisory group.

In 2017, NACCHO approached the Center to discuss options to collaborate in a project funded by the Health Research and Services Administration (HRSA), as part of the National Organizations of State and Local Officials (NOSLO) program, and the two organizations signed a contract covering joint activities from September 2017 to August 2018. The contract stipulated that the two organizations would conduct key informant interviews with staff from local health departments (LHDs) and from community health centers (CHCs) to identify resources that could support LHD-CHC sharing of services. The objective was to use this information in a future project phase to identify and help inform the development and piloting of service sharing tools between LHDs and CHCs.

PROCESS

Survey

The first step in the project was the development and deployment of a survey targeting LHDs and CHCs throughout the nation to identify instances of collaboration. The survey asked questions about the nature of the agreement (if one existed) between the LHD and the CHC, as well as the area or program covered by that agreement. NACCHO issued a Call for Information in November 2017 for LHDs and CHCs that currently or recently (within the past 2-3 years) either formally or informally partnered in the provision of services. The Center also circulated the Call for Information through its distribution channels. Project staff classified the responses received as follows:

1. Nature of the agreement:
    a. Collaboration only; the agreement does not include any written document or memorandum (for example, referral of clients, joint participation in community coalitions).
    b. Formal agreement; a written document exists describing the activities and resources being shared.
2. Area of the agreement:
    a. Clinical services (for example, immunizations, sexually transmitted disease treatment).
    b. Population-based services (for example, community health fairs, community health assessments).

A different category was created for respondents who reported the LHD and the CHC were part of the same organization.

Interviews

Ten pairs of LHDs and CHCs were selected for follow-up interviews. All CHCs were Federally Qualified Health Centers (FQHC), except one that operated on a similar model. Respondents were selected to represent different types of sharing arrangements, diverse geographical locations and settings (including rural and urban), variable sizes of population served, and staffing. Of these, representatives from nine pairs agreed to participate. Following the development of an interview protocol, (see **Appendix A**), from May to June 2018 project staff completed interviews with 14 individuals (eight from LHDs and six from CHCs), all of whom were agency or organizational leaders (i.e., health officials and CEOs). The agency whose leaders were interviewed served populations in eight states (Missouri, Maryland, Michigan, Nebraska, North Carolina, North Dakota, Oregon and Texas). Interviewees represented six medium and three large health departments, as well as four rural, one suburban and four urban population densities. A breakdown of interview sites is available in **Appendix B**.

Each call, which lasted 45-60 minutes, was led by NACCHO staff with additional questions posed by Center staff. Conversations were recorded with participant consent to clarify notes taken by Center staff.

FINDINGS

Survey

A total of 125 responses to the Call for Information were submitted. Of these, 96 came from LHDs and 29 from CHCs. *Table 1* shows the distribution of respondents across categories representing the nature and area of the agreement.

Table 1. **Nature and Areas of Agreement Between Local Health Departments and Community Health Centers***

Collaboration only	47 (38%)
Sharing clinical services	46 (37%)
Sharing nonclinical services	36 (29%)
Merged	8 (6%)
Unknown	8 (6%)

*Respondents could answer that they shared both clinical and nonclinical services.

In some cases, project staff had difficulty classifying survey responses into the categories that had been preset, due to incomplete or unclear information about the nature and scope of the agreement. In those cases, project staff assigned the response to the category that seemed to fit best, with the understanding that for the selected sites more details could be gathered during the interviews. In other cases, discussion during the interviews identified a different categorization than initially assigned, most often when it was determined there was an agreement in place when the case had been initially categorized as collaboration only.

Interviews

Types of Service Agreements

Of the nine sites interviewed, four shared clinical services, one shared nonclinical services, and four shared both clinical and nonclinical services. Seven locations had one or more formal agreements in place, with two having only informal arrangements.

Themes From the Interviews

Duration and Nature of the Sharing Agreements

A majority of sites indicated that they had a long-term history of sharing services (seven or more years), although most agreements were reviewed and renewed yearly. Several interviewees reported the nature of their agreements had changed over time, and that the success of early agreements had led to strengthened organizational relationships and increased collaboration. Interviewees said this resulted in improved, integrated models of service provision and better ability to attract external funding.

The interviews allowed a deeper exploration of the benefits and challenges of informal and formal agreements. Some respondents expressed reservations about executing formal contracts due to their complexity and reduced flexibility, cautioning that not all sharing agreements should be formal. Other challenges to making informal arrangements more formal included the time-consuming nature of executing agreements and having contractual processes that do not capture the nuances of each partnering organization. Conversely, other respondents described how having formal agreements helped define roles, activities and space sharing, and ensured fiscal and service accountability. Other possible benefits of formalizing agreements mentioned during the interviews included minimizing liability risks, increasing commitments to each other in providing shared services, and better continuity of services when staff turnover takes place.

Characteristics of the Shared Services

Clinical and nonclinical services were shared with roughly the same frequency (as expected due to the selection system adopted to identify interviewees).

When clinical services were shared, the CHC was more often the provider, except for diagnosis and treatment for tuberculosis and for immunizations for beneficiaries of the Vaccines for Children Program. Clinical services more often shared included family planning, dental screening, behavioral health, breast cancer screening, and screening and treatment services for the homeless. Shared nonclinical services mentioned more often included emergency preparedness, disease surveillance and substance use disorders (including needle exchange programs).

Some interviewees stated there were instances in which the LHD would be the more appropriate provider for a given service, such as family planning and screening for certain infectious diseases

(e.g., sexually transmitted infections, human immunodeficiency virus, and hepatitis C), because the health department was perceived by clients as a more private setting that could better protect confidentiality. Other functions identified as more appropriate for LHDs were following-up on animal bites and responding to outbreaks. On the other hand, one respondent said that it was more economically feasible for the CHC to provide clinical services than for the health department to do so.

Service sharing was described as taking multiple forms. In some cases, one partner would do screening and intake activities (for example, family planning) and refer the clients to the other partner for service. In other cases, one of the partners would provide staff and the other would host the service. And in some cases, one partner would take full responsibility for the service being shared, sometime in exchange for a payment from the other partner.

Some interviewees reported that they would share space for the other partner to provide services. For example, one LHD made space available at no cost in its facilities for the CHC staff to deliver substance abuse services. Other interviewees mentioned the importance of sharing guidance, expertise and data with their partners. For example, a CHC could rely on the LHD staff for support in identifying health trends, new or emerging issues, or informing pilot projects. While not exactly a service sharing model, several interviewees mentioned these forms of partnership were advantageous for both parties and made integration and delivery of services smoother for clients.

All sites indicated there were both interest and opportunities for further service sharing, with some indicating current, active engagement they could pursue. In addition, several sites stated that they shared services with multiple LHDs and CHCs.

Collaborating on Community Health Assessments

Five interviewees indicated that the CHC participated in the LHD's community health assessment process (CHA), in some cases with the involvement of the local hospital. In at least one instance, the joint CHA process resulted in more services being shared. Another site stated that integrated assessment and planning efforts helped support the LHD's accreditation readiness efforts. In one case, the CHA was conducted by the CHC, with the LHD providing support.

Facilitating Factors

For most sites, having a history of collaboration, both informal and formal, was key to making any service sharing possible and successful. A success element often cited was building relationships, both at the program and leadership levels, which was done through joint participation in advisory groups, coalitions and governing boards. In addition, having leaders of one organization participate in the governing or advisory board of the other was cited as a helpful element to promote good relationships. Positive relationships over time resulted in increased trust, which was frequently cited as an essential element for the success of sharing agreements.

Additional facilitating factors mentioned included:

- Having complementary competencies among LHD and CHC staff.
- A shared awareness of the community's health needs.
- Access to and utilization of effective academic, organizational and leadership skills.
- Having shared values, such as advancing population health, improving access to care, and achieving the Triple Aims of improving clinical care and population health while containing costs.
- A shared interest toward innovative approaches to population health service delivery.
- The role of the Affordable Care Act and the Public Health Accreditation Program as an impetus for shifting clinical services from LHDs to CHCs and for fostering a commitment to address population health and health equity.
- The benefits of having a close geographic proximity to each other's offices.
- Political support from local elected officials for the programs and services being shared.

Barriers

Most sites reported some challenges negotiating and executing services sharing agreements. These included:

- Staff apprehension related to job security and potential role changes.
- Concern about duplication of services by multiple providers with overlapping service areas.
- Provider availability (e.g., continuing services when service providers are unavailable).

- Funding, including cost for the shared services and cost to track the information necessary to support the shared programs.
- Incompatible and inconsistent data systems. In some cases, indicators and metrics to demonstrate service effectiveness and efficiency vary between partners and with funders (e.g., Health Resources and Services Administration in the case of FQHCs and the Centers for Disease Control and Prevention or State Health Departments in the case of LHDs). In other cases, the system in which the LHD and CHC information is collected and stored are not compatible with each other.

Most sites indicated that the legal aspects of entering into service agreements were, for the most part, not a problem. A noted exception were more complex arrangements, such as those requiring mutual confidentiality agreements. Having boilerplate legal templates was helpful, and some respondents had access to local legal expertise. However, complex and cumbersome city contractual processes and the absence of available legal counsel for small, rural agencies also were cited as persistent challenges to executing legal agreements.

Tools

Most sites with formal sharing agreements indicated that they used legal templates, sample agreements and checklists to create documents such as Memorandums of Understanding. In one state, having a Joint Powers Agreement to streamline resource sharing also was mentioned as a helpful tool, although it required staff training to understand the process. In another state, a functional organizational chart was used, delineating people and programs across entities, as a means of getting away from siloes and sectoral identities and achieve agency priorities in a more integrated fashion.

Sites that did not already have standardized legal language, templates or checklists indicated such resources would be helpful to execute a shared service agreement. Other resources of interest that were mentioned during the interviews:

- Examples of executed agreements, case studies/best practices, and standard operating procedures/protocols pertaining to service sharing.
- Guidelines or tips to ensure agreements have clear deliverables and shared performance metrics.
- Shared job descriptions for multi-agency positions.

- Toolkits for helping CHCs and LHDs understand their governing structures and legal/statutory requirements and constraints.
- Training modules on how to manage service integration processes.

Sustainability

A majority of the agency leaders interviewed felt that sharing of services would continue if they left their position. However, the strength of this assurance varied depending upon the type of agreements and the nature of the work. In some cases, specific policies will help ensure the continuity of the shared service agreements, especially for longer-terms agreements and when clear succession planning is in place. Interviewees from one state said while shared service delivery would likely continue, the policy advocacy efforts currently led by each agency's leaders may become more difficult when those leaders, who developed trustworthy, positive relationships, no longer are available. Some people stated shared services would likely continue even in the presence of leadership turnover, but it would require additional time and effort, given the integral role of the LHD and CHC leaders in the process.

In the case of the one organization that combined LHD and CHC, the gradual integration of leadership and staff, along with having one governing body responsible for the overall organization (county commissioners), make sustaining the sharing process after changes in leadership more likely.

Lessons Learned

Based on their experience, interviewees listed the following elements as important considerations when undertaking sharing agreements.

- Be aware of other partners who may have goals aligned with the service sharing agreement and establish relationships with them.
- Clearly define the primary points of contact, roles and responsibilities in the agreement for those from participating organizations responsible for the planning, implementation and other key activities.
- Assure support from the agencies' top executives.
- Clearly define which services each agency currently provides, and which services could be provided through sharing agreements.

- Be committed to serving communities and having community partners support the shared work.
- Be willing to work together amicably and build trust – remember no one entity can do alone what the sharing agreement tries to achieve.
- Recognize it is critically important to consider strengths and challenges of each partner while working together, and plan accordingly.
- Recognize that benefits of partnering are much greater than any "turf" issues.
- Ensure the goals for each participating agency are clear and aligned.
- Have the same definition for what "health" means.
- Recognize that CHCs also may have skills and tools to measure population health that can be helpful for the success of the sharing agreement.
- Piloting or practicing integration on a small scale first may be critical for agencies considering merging.
- Be willing to take some risks to achieve the shared goals.
- Be willing to work in more integrated and less traditional siloed approaches.
- Understand that government agencies might have specific constraints when collaborating with nongovernment partners.

DISCUSSION

One of the goals of this project was to understand the extent to which the Center experience supporting LHDs that share resources across public health jurisdictional boundaries was applicable to partnerships between LHDs and CHCs. In the course of the project, staff explored the possibility of applying the *Spectrum of Cross-Jurisdictional Sharing Arrangements*—one of the key documents developed by the Center—to resource sharing projects between LHDs and CHCs. Project staff realized during the interviews that the models used in the Center's *Spectrum* could not always be matched to the forms of collaboration that take place between LHDs and CHCs. This confirmed one of the assumptions of this project, which was that while the tools developed by the Center to describe resource sharing among LHDs can serve as a starting point to describe collaborations between LHDs and CHCs, there are some differences that require an adaptation of the tools. Later in this report we discuss some key Center tools that could be adapted to LHDs-CHCs collaborations.

Another key tool developed by the Center describes certain key *Success Factors* for resource-sharing activities among LHDs. Overall, we found a good level of agreement between the Center *Success Factors* and the facilitating factors mentioned in the interviews. For example, trust, a pre-requisite for success identified by the Center, was mentioned by several respondents. Some commented that developing positive relationships (also a Center success factor), especially at the leadership level, often comes before trust can be developed. Other facilitating factors mentioned by interview respondents that have similar corresponding *Success Factors* in the Center's tools are a history of successful collaborations, a clear definition of roles and responsibilities, and senior leadership support.

Although the Center does not have a specific document describing challenges for resource sharing projects, several barriers mentioned by the interviewees match findings from the Center experience. For example, change management (the ability to support individuals and organizations while they go through important changes) was identified by the Center as an important element of successful sharing projects and is included in the Center's *Success Factors*. Several respondents mentioned the difficulty related to staff apprehension due to potential role changes and the need for change management efforts.

ASSESSMENT OF USEFULNESS OF EXISTING SHARING TOOLS

Center staff reviewed most of the main tools developed in support of cross-jurisdictional sharing (CJS) with the goal of identifying tools that could be adapted to support partnerships between LHDs and CHCs. For that purpose, the following tools were reviewed:

1. *A Roadmap to Develop Cross-Jurisdictional Sharing Initiatives.*
2. *Determining and Distributing Costs of Shared Public Health Services.*
3. *Guide for Developing Legal Documents Governing Cross-Jurisdictional Sharing Arrangements.*
4. *Success Factors in Cross-Jurisdictional Sharing Arrangements.*
5. *Spectrum of Cross-Jurisdictional Sharing Arrangements.*
6. *COMPASS – Comprehensive Assistance for Shared Services.*
7. *Measuring the Impact of Cross-Jurisdictional Sharing in Public Health.*
8. *Cross-Jurisdictional Sharing Agreements Collaborative Trust Scale.*
9. *Cross-Jurisdictional Sharing Readiness Factors.*
10. *Self-Assessment of Progress Along the Cross-Jurisdictional Sharing Roadmap.*

Each of the 10 tools reviewed was rated on two dimensions:

1. *Importance*. Based on the results of the interviews, would the tool be helpful to facilitate partnerships between LHDs and CHCs? Was the tool (or something functionally close to it) mentioned often during the interviews?
2. *Feasibility*. How much adaption would be required to make the existing tool fit the partnerships models between LHDs and CHCs?

For each of the two dimensions staff assigned a score between 1 to 5, with 1 representing the lowest and 5 representing the highest levels of importance and feasibility, respectively.

The detailed results of this assessment for each tool reviewed is shown in **Appendix C**.

RECOMMENDATIONS

Modifications of Existing Tools Produced by the Center

Based on the results of the interviews and the assessment of existing tools (see **Appendix C)**, Center staff has prioritized and recommends the following tools be modified to support partnerships between LHDs and CHCs in a subsequent cycle.

1. *A Roadmap to Develop Cross-Jurisdictional Sharing Initiatives* (http://phsharing.org/Roadmap). The revised *Roadmap* should reflect sharing and collaboration between LHDs and CHCs. Revisions to Phases One and Two could provide higher initial utility value, though revising Phase Three would be worth doing so that a complete tool could be finalized.

2. *Guide for Developing Legal Documents Governing Cross-Jurisdictional Sharing Arrangements* (http://phsharing.org/LegalChecklist). For the most part the topical areas and specific issues raised in the current checklist could be applicable to agreements between LHDs and CHCs. Some modifications to the section about governance would be necessary.

3. *Success Factors in Cross-Jurisdictional Sharing Arrangements* (http://phsharing.org/SuccessFactors). The factors and characteristics described in the current document are not unique to public sector organizations and should be applicable across both public and private sectors as well as across different service

sectors. There are two items that may need more detailed review and possible revision for inclusion in an LHD-CHC *Success Factors* document: Balanced Approach under Prerequisites and Sense of Regional Identity under Facilitating Factors.

4. *Spectrum of Cross-Jurisdictional Sharing Arrangements* (http://phsharing.org/Spectrum). The types of sharing arrangements identified in the current *Spectrum* document are more generic in terms of organizations than specific to governmental public health or even public sector entities. As such they should be easily adapted to LHD-CHC sharing and collaboration. However, the examples used to illustrate the types would need to be revised accordingly. It also should be noted that the Center's *Spectrum* title speaks to sharing arrangements. There might be types of collaborations where a formal sharing of services or assets is not taking place. In addition, further exploration of possible sharing areas other than services should be discussed, e.g., sharing space or back-office functions such as administration or billing. It might be necessary after further review to change the title and content accordingly.

5. *Cross-Jurisdictional Sharing Agreements Collaborative Trust Scale* (http://www.phsharing.org/wp-content/uploads/2014/01/PDFTrustScaleV1.pdf). Most instruments used to measure organizational trust have been developed to measure trust *within* individual organizations. The Center's *Collaborative Trust Scale* is aimed at measuring trust *among* partners from different organizations who come together with a common goal. The trust elements that surfaced from the interviews align closely to the five dimensions of trust in the Center's tool, with particular emphasis on a shared vision and concern for community well-being. It also was noted in most cases that the mutual organizational trust was predicated first on trust between organization leaders, often as a result of several years of interactions and working relationships.

   The dimensions of trust measured in the *Trust Scale* are not unique to public health organizations; they would serve other organizations such as CHCs as well. However, the tool does not examine interpersonal trust between organization leaders. Knowing the nature of inter-leader trust might be a necessary precedent to fully understanding the level of trust between organizations. Revisions to the *Trust Scale* incorporating this would

be helpful to both LHD-CHC collaborations and sharing as well as public health cross-jurisdictional sharing arrangements.

6. *Cross-Jurisdictional Sharing Readiness Factors* (http://www.phsharing.org/wp-content/uploads/2013/05/2012-PD17-CSPHS-Guiding-Questions1.pdf). The Center's *Readiness Factors* assessment is a set of questions related to readiness for a CJS effort. It is not a scored instrument; rather, it is more of a dialogue guide for those considering a collaborative or sharing arrangement to develop a sense of how ready they are to proceed. LHDs and CHCs interested in a collaborative or sharing arrangement effort might find it useful to explore as a group the *Readiness Factors* questions to better understand the strengths and challenges to be faced by a collaboration effort. This information can be used to identify key issues and possible obstacles needing to be addressed in the planning process for a collaborative or shared arrangement. While the document is organized around sharing projects for public health departments, the *Readiness Factors'* seven domains and questions are not specific to public health organizations. Language would need to be expanded to reflect cross-sector collaboration and sharing inclusive of LHDs and CHCs rather than just public health cross-jurisdictional sharing as in the current document.

Development of New Tools

Based on the results of this project, Center staff recommends that the following new tools be considered for development. Some resources could be developed directly by Center staff, some jointly between the Center and those working with or within LHDs and CHCs, and others could benefit from being developed by those most knowledgeable and/or experienced in the particular issue under consideration.

1. *Basic structure and obligations for LHDs/CHCs*. Multiple interviewees mentioned the benefits of each partner acquiring a better understanding of the governance, legal requirements, financing, constraints and general scope of each other's organization. It might be beneficial to develop a resource which describes features of governmental public health and CHCs (with particular attention to FQHCs).

2. *Resource to Assist in Formalizing Arrangements*. This tool would discuss steps to consider for formalizing arrangements, including describing the respective benefits and drawbacks of formal and informal relationships. This might work alongside the *Roadmap* phases and areas as well as the integration continuum from the *Spectrum*.

3. *Resource to Support Success of LHD-CHC Arrangements*. Separate from what is included within the *Success Factors* tool and the *Roadmap* (centered primarily on processes and activities in sharing projects between governmental health departments), a new tool could be developed outlining features specific to the success of public-private partnerships. Some important factors were mentioned in the interviews and could be considered for inclusion in the new document, after additional validation research. Examples include CHC top executives being appointed into jurisdictional Boards of Health and/or their advisory bodies and for health officials to be included on CHC governance and/or advisory bodies; the need for understanding differences in each other's governance, legal restrictions, authorities, services, scope and ability to adapt quickly to changes in the political/economic landscape; and piloting recommendations on a small scale prior to full-scale arrangement.

4. *Tool to Assist in Identifying Optimal Arrangement*. Many of the interviewees mentioned partnerships forming organically without much use of tools to support the exploration of different arrangements and logistics. There might be a benefit in developing a new tool to support the identification of available alternative arrangements and to assist in the selection of an optimal arrangement.

APPENDIX A: KEY INFORMANT INTERVIEW PROTOCOL

Call Date and Time:

Participants:

- (name, title, org name, city, state)
- (As above)

Protocol (NACCHO leads):

1. Dial # and ID on Outlook invite
2. Ask everyone for permission to record session for note checking (not to be shared). If OK, press: * 2, 1
3. Introductions and roles (see below)
4. Purpose of call
    a. HRSA-funded project to identify what resources would be helpful to support LHD-CHC services sharing (Year 1), develop and disseminate those resources + provide TA (year 2) and assess impact (Year 3)
    b. Partnership between NACCHO and CSPHS (and WCPHP/PHI for clinical calls)
5. How we will use information: Anonymous – not to be published; also interested in potentially developing case studies/stories from the field, for which we would ask permission
6. Conversation should last between 45 and 60 minutes and anyone can decline to respond to any questions.
7. Any initial questions about the purpose of the call?

Facilitators:

- Peter Holtgrave or Melissa Mayer, NACCHO (lead)
- Pat Libbey and/or Gianfranco, CSPHS (assist)
- Suzanne Ryan-Ibarra, Public Health Institute (assist) – for clinical calls

Note Taker:

- Jason Orr, CSPHS

Questions:

1. When did you start a resource sharing agreement with the community health center (CHC)/local health department (LHD)?
   a. What MOUs or MOAs have you had within the past few years?

2. What is the purpose of the agreement?
   a. Can you briefly describe how it came to life, and what prompted its development? – See above
   b. Is it for a specific time period, ongoing or renewable?
   c. Is it for clinical services, nonclinical services, or both?

3. (Based upon the responses to #1 and #2, confirm what type of agreement they have by saying:)

   Based upon what you have shared, is sounds like your agreement is _____ (see the following options and paraphrase).

   a. A general informal agreement to collaborate with each other as needed through sharing information and expertise and/or providing assistance during emergencies, or through referrals for services, with no ongoing or routine formal resource sharing;
   b. An agreement for one of the parties to provide service(s) for the other party, usually through a contract that may include a remuneration for the specific service(s) provided; or
   c. An agreement to share the funding, governance and responsibility for a service, program or function

4. Has the nature of your agreement changed over time? How so?

5. Do you share services with other (e.g., neighboring) LHDs/CHCs? If so, why and what services?

6. During the development or implementation of your sharing agreement, did you use any tools or resources to assist you in establishing the agreement? Those could include logic models, legal templates, checklists, etc.
   a. (If Yes:) Did you create them from scratch or obtain them from another source?

7. What challenges have you experienced in negotiating or executing this sharing agreement?

8. What characteristics of both the LHD and the CHC have made this agreement successful?

9. What do you feel are the benefits and challenges to making informal agreements more formal?

10. What tool or resources do you think would have been (or could still be) helpful to you to assist you with your sharing agreement?

11. How do you feel that the services you share could continue or be sustained in the event that one of you as a partner leaves or is no longer able to fulfill that role?

12. What do you wish you had known when beginning a partnership with your local CHC (LHD)? What advice would you give to an LHD/CHC) that is considering partnering with their local CHC/LHD)?

APPENDIX B: SUMMARY OF INTERVIEW SITES AND ARRANGEMENTS

Table B-1. **Interview Sites by State with Site Features**

State	Local Health Department	Community Health Center	Services Shared	Agreement Type	Health Department Size (pop.)	Rurality
Missouri	**Cape Girardeau County Public Health Center, Cape Girardeau**	**Cross Trails Medical Center**	Clinical	Formal	Medium (78,000)	Rural
Maryland	**Cecil County Health Dept., Elkton**	**West Cecil Health Center (3 locations)**	Nonclinical	Informal	Medium (100,000+)	Rural
Michigan	**Western Upper Peninsula Health Dept., Hancock**	**Upper Great Lakes Family Health Center, Hancock**	Both	Informal	Medium (72,000)	Rural
North Carolina	**Guilford County Health Dept., Greensboro**	**Evans-Blount CHC** **Triad Adult and Pediatric Medicine**	Clinical	Formal	Large (518,000)	Urban
North Carolina	**Catawba County Public Health, Hickory**	**Livewell Catawba**	Clinical	Formal	Medium (151,000)	Urban
North Dakota	**Grand Forks Public Health Dept., Grand Forks**	**Valley Community Health Center, Grand Forks**	Both	Formal	Medium (67,000)	Suburban
Oregon	**Benton County Health Department, Corvallis**	**Community Health Centers of Benton and Linn Counties**	Both (merged/ integrated orgs)	Formal	Medium (82,000)	Urban
Texas	**City of Houston Health Dept.**	**Healthcare for the Homeless, Houston**	Clinical	Formal	Large (2,300,000)	Urban
Nebraska	**Elkhorn-Logan Valley Public Health Department**	**Midtown Health Center**	Both	Formal	Medium (56,000)	Rural

Source: *Local Health Department-Health Center Services Sharing Project: Key Informant Interview Summary Findings*, NACCHO 2018.

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APPENDIX C: REVIEW OF KEY EXISTING TOOLS

A Roadmap to Develop Cross-Jurisdictional Sharing Initiatives

http://phsharing.org/Roadmap

Importance: Relevance to LHD-CHC collaboration and sharing High 5

Feasibility: Ability to modify the tool for LHD-CHC collaboration and sharing High 4

Discussion:

The Center's *Roadmap* guides readers chronologically through the three distinct phases of cross-jurisdictional sharing: Exploration, Preparation and Planning, and Implementation and Improvement. It covers a broad range of topics to address and poses specific questions to answer to answer for each phase. The *Roadmap* also offers links to a host of other tools and resources specific to the particular topics and questions.

Overall, the *Roadmap* appears to be very relevant and potentially helpful to LHD-CHC collaboration and sharing efforts. The three phases identified in the *Roadmap* basically parallel the development and implementation of LHD-CHC partnerships. Based on the information from the interviews, many—if not most—of the collaborations evolved in more unstructured or organic ways to address specific community issues or opportunities. A revised *Roadmap* could provide a more structured and potentially more thorough approach in undertaking a sharing relationship.

The current *Roadmap* would need to be edited or rewritten to reflect sharing and collaboration between LHDs and CHCs. In many—if not most—instances, this would be fairly straightforward, ensuring the language reflects both LHDs and CHCs rather than just the current LHD public jurisdiction language. In other instances, different areas and examples of issues may be needed to reflect unique needs of LHD-CHC collaboration and sharing. The linkages to other tools and resources would need to be reviewed and determinations made as to whether they are appropriate to an LHD-CHC *Roadmap*. It should be noted that a *Roadmap* without linkages, at least initially, could still be a useful tool and one to which linkages could be added over time. Revisions to Phases One and Two would appear to provide higher utility value at least initially. Revising Phase Three is worth doing in time for a complete tool, from exploration through implementation.

Determining and Distributing Costs of Shared Public Health Services

http://phsharing.org/Costs

Importance: Relevance to LHD-CHC collaboration and sharing Mid 3

Feasibility: Ability to modify the tool for LHD-CHC collaboration and sharing Low 2

Discussion:

This Center tool helps identify all costs associated with a service being shared across local health jurisdictions. It also presents options for allocating those costs across the jurisdictions participating in the shared arrangement.

The methodologies for determining service costs as well as options for allocating those costs are developed on a public financial management framework. Some but not all elements could be applicable to a public–private sharing arrangement such as might occur between a local health department and a community health center. The guide would likely be most helpful for determining costs in instances where one party, LHD or CHC, is purchasing a specific service from the other. Of the eight identified cost allocation methodologies, only the fee for service and possibly the cost plus fixed fee approaches would likely be applicable.

The Center document describes several possible cost sharing models that could not be matched easily with the financial arrangements described during the interviews. The LHD-CHC service sharing examples observed for the most part did not rely on individual or unit-based costing or charging arrangements, and reliance on third-party payments or service reimbursements were cited more often in the interviews. Reworking the entire tool and reconciling differences in fiscal management and funding approaches does not appear to be warranted. Rather, those portions of the tool addressing specific service unit costing could be used when needed.

Guide for Developing Legal Documents Governing Cross-Jurisdictional Sharing Arrangements

http://phsharing.org/LegalChecklist

Importance: Relevance to LHD-CHC collaboration and sharing High 4

Feasibility: Ability to modify the tool for LHD-CHC collaboration and sharing High 5

Discussion:

This Center *Guide* is basically a checklist of items specific to cross-jurisdictional sharing agreements to be considered in any legal agreements governing those arrangements. It is not a template or prototype of an entire legal agreement nor of elements within an agreement. The *Guide* was developed by the Center for Sharing Public Health Services in collaboration with the Network for Public Health Law.

For the most part the topical areas and specific issues raised in the checklist could be applicable to agreements between LHDs and CHCs. The only exception would be the topical area and issues associated with the Form of the Agreement under Governance where several of the items are unique to government–government arrangements. It is important to remember that as a checklist, rather than an example agreement, it simply raises issues to consider and determine how, if at all, they would need to be addressed in an agreement. This makes the checklist more or less generic and applicable beyond cross-jurisdictional sharing arrangements, including LHD and CHC arrangements.

In most of the interview cases there was a written agreement between the LHD and the CHC for their sharing or collaboration. Many of the interviewees stated it would have been helpful to have had examples when their agreements were being developed. This checklist guide should prove helpful, as would actual examples of executed agreements, for future sharing or collaborative arrangements.

Success Factors in Cross-Jurisdictional Sharing Arrangements

http://phsharing.org/SuccessFactors

Importance: Relevance to LHD-CHC collaboration and sharing High 5

Feasibility: Ability to modify the tool for LHD-CHC collaboration and sharing High 4

Discussion:

The Center's *Success Factors* document describes 10 elements that can increase the likelihood a cross-jurisdictional sharing arrangement will be successful. The factors were identified and categorized by the Center based primarily on its work with its initial Learning Community projects (75 different health departments serving 125 separate geo-political jurisdictions), subsequent small grantees, and from the provision of technical assistance. *Success Factors* are divided into three categories:

- Prerequisites—three factors that need to be in place before starting to work on a shared arrangement;
- Facilitating Factors—three factors that, if present, can contribute to sharing arrangement success; and
- Project Characteristics—four characteristics associated with successful development and implementation of shared arrangements.

A description of *Success Factors* for LHD-CHC collaboration and sharing would be helpful in raising awareness of the factors and characteristics that contribute to successful arrangements. Sharing the Center's *Success Factors* early on with jurisdictions considering sharing arrangements has been useful to their efforts.

Overall it appears the Center's *Success Factors* for cross-jurisdictional sharing could be applicable to LHD-CHC sharing and collaboration efforts with minor modifications. Throughout the case interviews nearly all the *Success Factors* were mentioned by the participants in describing the development and operation of the different arrangements. The factors and characteristics described in the Center's document are not unique to public sector organizations and should be applicable across both public and private sectors as well as across different service sectors. There are two items that might need more detailed review and possible revision for inclusion in an LHD-CHC *Success Factors* document: Balanced Approach under Prerequisites and Sense of Regional Identity under Facilitating Factors. The rest will need to be reviewed and revised primarily to ensure language fits or relates to LHD and CHC arrangements.

Spectrum of Cross-Jurisdictional Sharing Arrangements

http://phsharing.org/Spectrum

Importance: Relevance to LHD-CHC collaboration and sharing High 4

Feasibility: Ability to modify the tool for LHD-CHC collaboration and sharing High 5

Discussion:

The Center's *Spectrum* identifies four main types of sharing arrangements across public health jurisdictions. These include: As-Needed Assistance, Service-Related Arrangements, Shared Programs or Functions, and Regionalization/Consolidation. These types are different than the categorization used to sort potential interviews based on services and nature of agreements. The *Spectrum* has been useful in increasing the understanding of health officials and policymakers that there are several different ways in which a shared arrangement can be structured. The *Spectrum*, updated and revised in 2017, was adapted to reflect public health specifically from the 2006 public administration research of J. Ruggini and A. Holdsworth.

A uniform description or standard classification of the types of arrangements possible between LHDs and CHCs could help ensure the full range of options and opportunities are considered from the outset. It was not clear from the interviews that a range of options were systematically considered when the collaborations or sharing arrangements were being developed. A common or uniform description of the types of arrangements also would be useful in collecting and disseminating examples and building a common reference base for other LHDs and CHCs considering sharing or collaborating.

The types of sharing arrangements identified in the Center's *Spectrum* are more generic in terms of organizations than specific to governmental public health or even public-sector entities. As such, they should be easily adapted to LHD-CHC sharing and collaboration. However, the examples used to illustrate the types would need to be revised accordingly. It also should be noted that the Center's *Spectrum* title speaks to sharing arrangements. There might be types of collaborations where a formal sharing of services or assets would not be necessary. It might be

necessary after further review to add a type(s) of sharing arrangement(s) to reflect this in developing an LHD-CHC spectrum.

COMPASS – COMPrehensive Assistance for Shared Services

https://COMPASS.phsharing.org

Importance: Relevance to LHD-CHC collaboration and sharing Low 2

Feasibility: Ability to modify the tool for LHD-CHC collaboration and sharing Low 1

Discussion:

COMPASS is an online interactive tool for those working on developing and/or implementing a cross-jurisdictional sharing arrangement among public health agencies. It includes self-guided tours—including targeted questions, interactive multi-media elements, and linkages to other online Center resources—through the three main phases of the CJS *Roadmap*.

It is not clear from the interviews conducted and general working knowledge of the field whether there is enough activity to warrant creation of a similar tool specific for LHD-CHC collaborative and sharing relationships. Nor is it clear whether the breadth of potential arrangements would lend themselves as readily to a common tool as was the case with *COMPASS* and public health cross-jurisdictional sharing.

Given its specific focus on public health sharing, *COMPASS* could not be easily modified or edited to be of much use to LHD-CHC sharing or collaboration. Rather, it would require building a new tool targeted for such arrangements.

Measuring the Impact of Cross-Jurisdictional Sharing in Public Health

http://phsharing.org/wp-content/uploads/2018/04/Measuring-Impact-CJS.pdf

Importance: Relevance to LHD-CHC collaboration and sharing Low 1

Feasibility: Ability to modify the tool for LHD-CHC collaboration and sharing Low 1

Discussion:

The Center's *Measuring the Impact* tool describes a specific methodology for developing and implementing a plan for measuring the effect in terms of changes in efficiency and effectiveness resulting from a cross-jurisdictional sharing arrangement among public health agencies. The tool also contains a set of specific efficiency and effectiveness measures for select public health program, service and function areas.

It's important to note this tool focuses on measuring the effect of sharing, not the outcome per se of the program, service or function being shared. There did not appear to be a strong need or interest expressed in the interviews for a formal measurement process of differences or effects resulting from the LHD-CHC collaboration or sharing.

The current tool measures were derived from work done by the Centers for Disease Control and Prevention and work from the University of Washington specific to public health. If there was sufficient interest in measuring the impact of LHD-CHC collaboration and sharing new measures beyond the tool's current public health focus, it would need to be developed. Short of that, if an LHD-CHC collaboration or sharing arrangement was interested in measuring the effect of that arrangement, the Center's tool could be helpful at least in describing the measurement methodology.

Cross-Jurisdictional Sharing Agreements Collaborative Trust Scale

http://www.phsharing.org/wp-content/uploads/2014/01/PDFTrustScaleV1.pdf

Importance: Relevance to LHD-CHC collaboration and sharing High 5

Feasibility: Ability to modify the tool for LHD-CHC collaboration and sharing High 5

Discussion:

The Center's *Trust Scale* was developed early in the Center's work to help those considering entering into a sharing arrangement evaluate levels of trust between partner organizations. The tool is designed to capture the following five dimensions of trust: Trust in Partner Knowledge

and Skills; Trust in Partner Integrity; Trust in Partner Investment in Community Well-Being; Trust in Partner Behavior (Predictability); and Trust in Communication. The *Trust Scale* is intended to help people explore together their differing expectations and experiences of one another. Most instruments used to measure organizational trust have been developed to measure trust within individual organizations. The *CJS Collaborative Trust Scale* is aimed at measuring trust among partners from different organizations who come together with a common goal.

High levels of trust were seen by those interviewed as being key to successful collaborations and sharing arrangements between LHDs and CHCs. The elements described align closely to the five dimensions of trust in the *Trust Scale*, with particular emphasis on a shared vision and concern for community well-being. However, it was noted in most cases that the mutual organizational trust was predicated first on trust between organization leaders. Most often that personal trust between leaders resulted from several years of interactions and working relationships.

The dimensions of trust measured in the *Trust Scale* are not unique to public health organizations; they would serve other organizations such as CHCs as well. However, the tool does not examine interpersonal trust between organization leaders. Knowing the nature of inter-leader trust might be a necessary precedent to fully understanding the level of trust between organizations. Revisions to the *Trust Scale* incorporating this would be helpful to both LHD-CHC collaborations and sharing as well as public health cross-jurisdictional sharing arrangements.

Cross-Jurisdictional Sharing Readiness Factors

http://www.phsharing.org/wp-content/uploads/2013/05/2012-PD17-CSPHS-Guiding-Questions1.pdf

Importance: Relevance to LHD-CHC collaboration and sharing	High 5
Feasibility: Ability to modify the tool for LHD-CHC collaboration and sharing	High 5

Discussion:

The Center's *Readiness Factors* assessment is simply a set of questions related to readiness for a CJS effort. It is intended for use by those groups and individuals exploring the possibility of or preparing for a CJS process. It asks a set of questions in seven domains related to motivation for

change, trust between partners, identified and effective leadership, commitment to CJS efforts/ change, effective collaboration, common policies and procedures, and financial and capital resources. It is not a scored instrument; rather, it is more of a dialogue guide for those considering a collaborative or sharing arrangement to develop a sense of how ready they are to proceed.

LHDs and CHCs interested in a collaborative or sharing arrangement effort might find it useful to explore the *Readiness Factors* questions as a group to better understand the strengths and challenges to be faced by a CJS effort. This information can be used to identify key issues and potential obstacles needing to be addressed in the planning process for a collaborative or shared arrangement.

The *Readiness Factors* seven domains and questions are not specific to public health organizations. Language would need to be revised to reflect cross-sector collaboration and sharing inclusive of, but not limited to, LHDs and CHCs rather than just public health cross-jurisdictional sharing in the current language.

Self-Assessment of Progress Along the Cross-Jurisdictional Sharing Roadmap

http://phsharing.org/2015/03/20/self-assessment-of-progress-along-the-cjs-roadmap/

Importance: Relevance to LHD-CHC collaboration and sharing	Mid 3
Feasibility: Ability to modify the tool for LHD-CHC collaboration and sharing	High 4

Discussion:

The Center's *Self-Assessment of Progress* can be used in estimating the extent to which planning for and/or implementation of a cross-jurisdictional sharing arrangement has addressed those issues key to success as described in the three phases of the *Roadmap*. The assessment contains a series of statements to which respondents describe their level of agreement on a four-point Likert scale. The assessment can be taken individually or as a team. The assessment requires calculation of a score.

The scores derived from the assessment could help the organizations involved in understanding the extent to which important issues have been identified and discussed and to examine the level of agreement regarding the planning and implementation process. The scores are not meant to be used as a "pass-or-fail" threshold. They are just a way to point out potential areas of disagreement among team members and organizations and to show a comparison of the strength of each phase of the collaborative or sharing initiative. In its entirety, the *Self-Assessment of Progress* is probably best suited for more complex or sensitive arrangements often involving several key players. Most of the collaborations and sharing arrangements discussed in the interview were developed more organically over time and did not rely on as highly structured an approach.

As the *Roadmap* is revised to reflect other sector and LHD-CHC collaborative and sharing arrangements it would be fairly easy to update the *Self-Assessment of Progress* accordingly.

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Rethinking Boundaries for Better Health