Center for Sharing Public Health Services
Rethinking Boundaries for Better Health

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SHARED SERVICES LEARNING COMMUNITY

COMMON THEMES

Introduction

Several themes have emerged from the Center's work to date with the Shared Services Learning Community (SSLC). This document will be updated over time as nuances related to these issues and additional themes emerge.

Addressing Change

Change occurs during all phases of developing cross-jurisdictional sharing (CJS) initiatives. For example, individuals might move in and out of key positions: a local public health official or government administrator might resign, an election might result in different policymakers, or new members might be appointed to a board of health. Moreover, the CJS arrangement itself can impact agency policies and procedures, leadership, governance and staff responsibilities.

Deliberately tending to all aspects of change appears to facilitate the process of transition. Some intuitive examples are the new policies and procedures needed to support a CJS arrangement; modified lines of communication and decision-making under different leadership and governance structures; orientation to the work at hand for new individuals who assume key positions; and orientation of key staff to all changes that are made. In the case of newly elected policymakers, it is important to recognize that orientation is more than just *"bringing them up to speed."* Rather, it must include incorporating *their* policy direction, even if it differs from the previous work. Two less intuitive examples involve explicit attention to group dynamics and change management.

Tuckman's model of group dynamics[1] describes predictable stages of how a group functions, emphasizing that it takes time for group members to trust each other and learn how to be productive in performing the necessary tasks. When members leave or are added to a group, the dynamics shift, often resulting in lower productivity or slower progress as the group adjusts to the change. Employing strategies that support the team's progression to the next stage in Tuckman's model can help to ease difficulties otherwise encountered in this type of transition.

Within a CJS context, change management is focused on engaging affected individuals in informing, understanding and supporting the changes that will result from a new CJS arrangement (see the archived webinar related to this topic on the Center's website[2]). Lessons learned by the Center have revolved around change management strategies aimed at staff. Keeping the *"why"* in the forefront of discussions about the effort — i.e., why a CJS arrangement is being pursued — has been reported as extremely beneficial by a number of SSLC teams. Moreover, eliciting staff perspectives about the impending change and, as appropriate, articulating how the perspectives have been utilized, also has been cited as a valuable strategy to help decrease resistance by staff. Finally, providing ongoing updates, even when there is little or no new

information, has been identified as a way to build trust among staff. Providing regular communication is also a way to demonstrate transparency in the process — another strategy to managing change.

Assessing Current Capacity

Most of the SSLC teams have completed assessments of capacities and basic programs currently shared between and among the participating jurisdictions, and sometimes also have included assessments of capacities and programs offered only within a single jurisdiction.[3] The results of these assessments typically are eye-opening for policymakers and government administrators, many of whom have voiced a greater understanding of public health and, in some instances, surprise at the magnitude of what is being shared. Although local health officials are already aware of the nature and extent of what is being shared, the comprehensive view provided by the assessment results have helped them appreciate their collective capacity and are often described as a very valuable basis for moving forward in their work. The Center's survey tool developed for this purpose and the Public Health Accreditation Board (PHAB) standards[4] most frequently serve as the basis for these assessments.

Financing

Many sites are addressing financial issues associated with CJS. These issues include calculating the cost of providing a particular service, the cost of providing that service when it is shared, determining how to distribute costs across jurisdictions, and describing the value of public health services.

Simply calculating the cost of the service that will be shared, while straightforward, can be quite tedious. Even more difficult is presenting the cost of the service in terms that are readily understood by the participating jurisdictions and their public administrators. In some cases where there are public fees associated with the services to be shared, there is also a need to determine the fee structure and how it will be administered for all participating jurisdictions. Moreover, it is sometimes necessary to develop and present the cost for each jurisdiction to provide the service by itself compared to the cost of providing it as a shared service to assist in illustrating the cost benefit potential of CJS.

Developing a plan or formula for the distribution of the shared service costs across the participating jurisdictions is a very challenging issue needing to be addressed by most teams. Generally, this is not as simple as adopting a per capita approach or dividing costs evenly across the number of jurisdictions.

Finally, while not exclusively a financing issue, teams also are seeking guidance on how to describe or quantify the value of public health services. Many policymakers on the SSLC teams are seeking to understand the value proposition of public health, i.e., how public health capacities and basic programs align with and/or help further their policy goals.

Due to the wide variety of sharing arrangements being considered, as well as differences in state and local law, public health practice, taxing authorities, etc., it appears that most of the solutions generated by the SSLC teams will be fairly unique. That stated, the Center is developing technical assistance to address these issues, and plans to provide resources that are developed and lessons learned. Further, the Center will analyze all financial issues that emerge to identify approaches and solutions that are likely to be applicable in other settings.

Policymaker Engagement

All of the teams have policymakers who are dedicated to serving as team members, and an emerging theme is how to effectively engage policymakers from all participating jurisdictions as one group.

As described above related to change management for staff, keeping the *"why"* in the forefront of discussions about the effort is also an important strategy for engaging policymakers. The *"why"* is the reason for engaging in the work. It is an important foundation that drives the effort and should be restated often to help orient policymakers when discussing issues and making decisions about the CJS arrangement.

Engaging policymakers at *existing* regional meetings, as opposed to initiating new regional meetings or forums focused solely on CJS arrangements for public health, appears to be extremely effective for several reasons. Most significantly, using existing regional venues has the potential effect of raising their awareness of public health issues to the same level as other issues they discuss, like transportation, regional planning, etc. In addition, these venues are likely to attract greater participation of policymakers. Finally, from a purely logistical standpoint, this approach means that public health officials spend less time and effort coordinating meetings with policymakers.

Team leads reported that the Center's 2013 second quarter archived webinar, *A Unified Voice: Policymakers and Public Health Officials Working Together for the Community's Health*, was very valuable to their efforts.[5] The Center anticipates learning more about policymaker engagement moving forward. Examples are high-level issues of interest to keep policymakers generally engaged throughout CJS work, issues requiring more intensive engagement, efforts of local health officials to keep policymakers within their own jurisdictions engaged in-between regional meetings, etc.

Existing Regional Identity

Those teams that are operating in an area in which a sense of regional identity exists seem to progress more efficiently overall with CJS discussions. This regional identity reflects a general sense of togetherness and affinity shared among citizens, organizations and programs in a certain geographical area regardless of geopolitical borders. Examples are counties that are situated in a valley, as is the case in San Luis Valley, Colorado, and counties that comprise a specific part of the state, such as Horizon Community Health Board's location in West Central Minnesota. Intuitively, this makes a great deal of sense. For example, as referenced above, Tuckman's model[6] dictates that newly formed teams go through predictable stages before they can begin the work at hand; therefore, groups that already work together are more likely to maintain a high level of productivity while addressing new issues. Groups that have worked together in the past may stay in the performing stage of Tuckman's model, or otherwise adapt more readily as members join and leave the group. Additionally, elected officials from different political jurisdictions are much more likely to be on board with CJS efforts when they share some of the sentiments that have been expressed, such as *"We're in this together"* and *"We need to help each other out."*

Emerging Public Health Collaborative Identity

In the absence of a broad sense of regional identity, teams working on CJS arrangements appear to be well-served when they shed the individual health department *"hat"* and don a group *"hat."* This requires approaching population health from a broader geographic perspective, and consciously working to better the broader area while understanding that each individual jurisdiction stands to benefit in the process.

Team leads are predicting and/or observing that as health departments work as a multi-jurisdictional entity, they are more of a force when working with the state health department and community partners serving the area. When an individual health department views itself as part of a broader collaborative entity and approaches public health issues from a broader geographical perspective,

there is much greater power to attract a qualified workforce and effectively tackle population-based health problems. This process can promote or nurture a sense of regional identity that is not yet well-defined and is likely to go a long way in sustaining CJS efforts after the project funding ends. In that sense, *"the whole is greater than the sum of its parts"* when thinking about CJS arrangements. Although this has been self-evident for smaller health departments working with larger ones, it is also proving to be true for larger health departments working with smaller ones.

Size Variations

Many issues need to be resolved when entities serving jurisdictions of varying sizes work together, particularly (but not exclusively) when there are great disparities in size. As noted above, and not surprisingly, health departments typically have specific concerns related to financing shared arrangements. Other issues relate to changes that may be required to governance structures, and determining what comprises *"equal"* representation in authority and decision-making. The culture of service provision is another issue, in that very small jurisdictions sometimes have a more personal tie to their communities that could be impacted with the implementation of a shared arrangement. Moreover, staff in smaller health departments may be more *"generalists"* and those in larger health departments may be more *"specialists;"* this distinction could have many implications for staff when a service model is changed. These issues, and others related to the differing sizes of participating jurisdictions, will continue to be monitored, analyzed and shared.

Time

Several of the sites expressed surprise at the length of time it takes for those at the table to reach decisions about various matters. For some, this proved largely to be reflective of key stakeholders not sharing an understanding of the value of a robust public health system and/or the reason to engage in the proposed CJS efforts (i.e., the *"why"* as described previously). These sites modified their strategies accordingly and have been able to progress more readily as a result. For others, the reason seems to be that the team members did not already have established relationships, and therefore more time was needed to get through the predictable stages of team development[7] before CJS work could be accomplished. Regardless, sites consistently report that any team engaging in CJS efforts should anticipate that it is likely to take more time than initially estimated.

Trust

Trust is an essential element in all successful CJS arrangements. It is important to consider the existing trust between parties when determining the feasibility of sharing services. The Center is developing a tool to assist in measuring the level of trust among partners from different organizations and jurisdictions.

Footnotes:

1) Tuckman, Bruce (1965). "Developmental sequence in small groups." Psychological Bulletin 63 (6): 384–99.
2) Available online at www.phsharing.org/technical-assistance/webinars/managing-change.
3) Available online at www.phsharing.org/assessment_tools.
4) Available online at www.phaboard.org/accreditation-process/public-health-department-standards-and-measures.
5) Available online at www.phsharing.org/technical-assistance/webinars/a-unified-voice-policymakers-and-public-health-officials-working-together-for-the-communitys-health.
6) Tuckman, Bruce (1965).
7) Tuckman, Bruce (1965).

CENTER FOR SHARING PUBLIC HEALTH SERVICES

The Center for Sharing Public Health Services helps communities learn how to work across jurisdictional boundaries to deliver essential public health services. The Center serves as a national resource on cross-jurisdictional sharing (CJS), building the evidence and producing and disseminating tools, methods and models to assist public health agencies and policymakers as they consider and adopt CJS approaches. The Center is funded by the Robert Wood Johnson Foundation and is managed by the Kansas Health Institute.

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