**FAQs Work Plan (Webinar 3-28-2017)**

**Q: *If a milestone has been reached since the start of 2017, how is that to be denoted?***

**A:** Incorporate your current status as of April 30, 2017. In this case, it may be marked as ‘Not Started’ or ‘In Progress’ in 2016, and ‘Complete’ in April 2017.

***Q: Will we be required to submit an updated work plan every 6 months until completed, or will we follow the timeline outlined by Wally [April and October 2017, April 2018]?***

**A:** At this time, there are three reporting periods. It is expected that agencies may wish to continue to use the template/milestones to track progress beyond the initial three report periods.

***Q: Can we get this work plan template even if we already applied for accreditation, just for our own use?***

**A:** The work plan template will available to anyone who wishes to use it.

***Q: Please provide an example of “economies of scale: for shared services.***

**A:** Economies of scale exist when “per unit costs of production decline with increasing amounts of output” (Santerre, Health Services Research, 2009). This occurs as a result of the ability to “spread fixed costs of public health infrastructure over larger populations of beneficiaries and taxpayers” (Mays et al, American Journal of Public Health, 2006).

In a local health department context, we can use immunization services as an example: A department would need to establish public health “infrastructure”, such as equipment, supplies, clinical office space, and perhaps a full time staff member to provide immunizations to the public (Note: definitions of public health “infrastructure” may vary. In this example, we assume that a full time person would be a part of this public health “infrastructure”). By establishing this kind of capability, the department would then spread the costs of this “infrastructure” across the persons served. If there were 100 persons seeking immunizations over a particular period of time (say, a week), this would reduce the per person costs of supplying immunizations in comparison to the costs of serving only 25 individuals over that same period of time. With this larger volume of work to be done (and perhaps paid for by, or on behalf of, those receiving the service), the department would be more likely to be able to pay for the services at a lower per person cost and sustain them into the future.

Those interested in the application of economies of scale to public health services may want to look at Bernet and Singh, “Economies of Scale in the Production of Public Health Services: An Analysis of Local Health Districts in Florida”, American Journal of Public Health, Supplement 2, 2015, Vol 105, No S2, as well as the work by Santerre (2009) and Mays and colleagues (2006) referenced above.

***Q: It seems that many consolidations in Ohio have been between cities and the counties in which they are located. Has anyone looked at the feasibility of one LHD serving 100,000 people spread across three counties? It seems that the benefits would be diminished in this scenario.***

**A:** We are not aware of any feasibility studies on a county-to-county consolidation in Ohio. However, multi-county health departments do exist in other states. The cost of providing services to dispersed populations across a multi-county jurisdiction would have to be weighed against potential cost savings from other aspects of a consolidation. This is one reason why it is important to complete a feasibility assessment to assist the decision-making process related to consolidation. Check out the Center for Sharing Public Health Services’ website ([www.phsharing.org)](http://www.phsharing.org)) for more information on consolidation and shared services issues being explored in other states.

***Q: Are there any examples of departments with health levies merging or consolidating with one that does not?***

**A:** One example can be drawn from our experience with the City of Ravenna – Portage County Health District consolidation that was finalized a couple of years ago. The city health department did not have a levy to support its operations, while the county had an existing levy in place, and during consolidation discussions, had an increase to that levy approved by the voters of the county health district. The fact that Ravenna residents did not vote for the levy increase was a topic of discussion during the negotiations between the two jurisdictions. Ultimately, the city decided to move forward with the consolidation in order to achieve savings to its general fund and to receive services from the county health department, which had greater capacity than Ravenna’s small city department. Ravenna residents, now as members of the county health district, will participate in future votes to reauthorize the levy.

It is also important to note that the method of consolidation is relevant to the issue of health levies existing in jurisdictions considering consolidation. Ravenna and Portage County, in the end, sought a full union of their health districts. However, if they chose to implement a contractual consolidation (3709.08), the city residents would not be subject to the Portage County Health District’s property tax levy. Instead, the City would be obligated to pay for the services received from the county health department through other means, likely the city’s general fund. In this scenario, Ravenna taxpayers end up funding the public health services received; however, the means through which they pay changes depending on whether a full union of the health jurisdictions occurs or if there is a contractual consolidation between two existing health districts.

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