

Staff Sharing Arrangements for Local Public Health



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Rethinking Boundaries for Better Health

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Introduction

Just as residents might commute from one jurisdiction to another, public health challenges also travel freely, whether stemming from food poisoning, substance abuse, environmental exposures, or communicable diseases. Rather than take an insular approach to addressing just the issues in one singular area, local public health officials have considered, and in some cases implemented, partnerships as an effective means of containing existing and potential problems, expanding organizational capacity, and effectively managing public health expenditures. Such cross-jurisdictional sharing arrangements generally take one of four forms, or a combination thereof: (1) as-needed assistance; (2) service-related arrangements; (3) shared programs or functions; and (4) regionalization/consolidation.² All of these arrangements require decisions regarding maintaining in-house staffing expertise for the range of essential local public health roles³ relative to sharing staff among multiple jurisdictions or contracting for staffing services with other public, private, or nonprofit entities.

Purpose of the Report

It might seem beneficial to share staff between jurisdictions, but on a practical level, when exploring the concept, there can be a natural hesitation related to existing governance structures, the history between and culture of the jurisdictions, the equitable provision of services, and underlying fiscal arrangements, among other factors.⁴ To help inform these considerations, this report offers a series of case studies on shared staffing arrangements in local public health organizations. These cases were selected for study based on a national environmental scan of arrangements in place and with attention to variation in location, size of jurisdictions, and type of local government. The shared positions covered in these case studies run the gamut from health directors to physicians, nurses, inspectors, social workers, and administrative staff.

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Summary of Results

While there is no one-size-fits-all solution to public health staffing needs, shared staffing approaches may be helpful in filling gaps, or in some cases, enabling the provision of services that would not have been feasible in the absence of the partnered approach, including the following examples:

- More effective planning and response for common infections like influenza, or rare, tropical diseases like Zika and Ebola
- Qualification for grant funding that may not have been available to an individual health department on its own, whether due to the smaller population served or a lack of in-house capacity and resources
- Addition of call-in assistance lines and other services that would not otherwise be economical
- Dependable backup coverage and coordinated scheduling for skilled clinical positions.

Regular communication among the parties has brought both the opportunity to address challenges as they've been encountered and a path to continue improving services as the contractual arrangements grow and evolve.

Case Studies in Partnership, Not Consolidation

As effective as staff sharing can be in providing public health services, none of these case studies represents full regionalization of the services being provided. From Melrose, Massachusetts, to Multnomah County, Oregon, to Webster County, Iowa, each lead agency bears a certain amount of the administrative, budgetary, and human resources responsibility of managing the shared staff programs. In each of these cases, however, each of the partner agencies working with the lead agency still retains its own autonomous board of health and ability to set local policies and procedures. Each jurisdiction also has the option to alter, expand, or discontinue its involvement as agreements come up for annual reauthorization. While sharing staff arrangements might not be optimal, or even an option, for all local health departments across the United States, the case examples offered in this report serve as informative, longer-term (eight-plus years in place) models for other jurisdictions considering similar approaches.

Case Study: The City of Melrose and Town of Wakefield⁵

Since June 2009, the city of Melrose, Massachusetts (population estimate, 2016: 27,928⁶), and the town of Wakefield, Massachusetts (population estimate, 2016: 26,753), have had a formal agreement to share local health department staff.⁷ Under this agreement, one health director, one senior health inspector, two part-time health inspectors, and one part-time public health nurse are shared between the two jurisdictions, while both have one administrative assistant dedicated to the arrangement. Melrose is the formal employer of all the shared staff included in the arrangement and is responsible for the provision of compensation and benefits. Wakefield reimburses Melrose for the staff time dedicated to its public health needs, such as food establishment, farmers market, pool, hotel, summer camp, and tanning inspections; immunization clinics; communicable disease reporting and tracking; sharps kiosk and medication take-back program; substance abuse prevention programs; and management and administrative duties.

Initial Challenges and Concerns

Prior to the arrangement being established, the Town of Wakefield's elected and appointed officials acknowledged that they did not have the staffing capacity, technical expertise, or internal ability to train staff to offer the range of public health services that their residents needed or that the state required be provided. In Wakefield, among other concerns, health inspections were not being conducted in a timely and thorough manner, immunization programs were not adequate for its population and demographics, and there were no time or financial resources being dedicated to strategically planning programming on topics such as substance abuse, health education, and maternal health.

More broadly, from a historical perspective, while there are only five counties in Massachusetts, there are 53 municipalities and 298 towns or townships, each with its own boards of health, that have the primary responsibility for providing and funding

local public health services.⁸ Given this decentralized approach and the tradition of very localized governance, regionalization and/or programmatic sharing of resources is not always well-received by public officials and the residents they serve.

Process and Implementation

Wakefield and Melrose cover a small combined geography (< 13 square miles total), have similar resident demographic profiles; are in the same congressional district; and the local government officials, both elected and appointed, traditionally have often communicated and collaborated on various initiatives across multiple government business lines. Examples of other collaboration categories include emergency response and public safety, veterans programs, and special education programs, among others.⁹ Given these jurisdictional attributes, the idea of a shared staffing arrangement was developed jointly by the Wakefield town administrator (with the approval of the Wakefield Board of Selectmen) and Melrose mayor, underpinned by the technical advice of the long-tenured Melrose health director who held the confidence and trust of the leadership of both entities. At the same time, there was an ongoing effort by the commonwealth of Massachusetts to encourage the regionalization of local health services. This state initiative had been in existence (in some form) over three gubernatorial administrations (that spanned both parties) and included a district incentive grants component through the Massachusetts Department of Public Health.¹⁰ It was via this regionalization program and the Metropolitan Area Planning Council¹¹ that the two jurisdictions received technical assistance to establish the formal, shared staffing arrangement.

The shared staffing agreement has been in place since July 1, 2009, and is effective until either party decides to conclude the arrangement. It is reviewed every year by both jurisdictions, and both boards of health evaluate the performance of the health director and staff. Under the agreement, Melrose staff provide public health services jointly to both communities and Wakefield

reimburses Melrose, on a quarterly basis, for staff wage, FICA, and insurance costs. This reimbursement is variable, based on the level of effort required by Wakefield for its health services. Table 1 offers an estimate of the level-of-effort time allocations.

Table 1. Staff Time Allocations - Estimates

Time percentage allocated to	Melrose	Wakefield
One health director	75%	25%
One senior health/sanitary inspector	25%	75%
Two part-time health/sanitary inspectors	50%	50%
One part-time public health nurse (24 hours a week)	50%	50%

Note: Each jurisdiction has one administrative assistant assigned to the arrangement.

Melrose and Wakefield have also coordinated certain information technology assets to minimize the organizational challenges related to sharing staffing across jurisdictional lines. For example, prior to the establishment of the staffing agreement, Melrose did not have the storage capacity for a new electronic inspection program. To address this and related needs, under the sharing arrangement, Wakefield's department of information technology provides server capacity for file and record storage related to public health services for both communities, provided in-kind to Melrose. Also, while staff have individual email addresses for each jurisdiction, their emails go to one inbox. Health inspectors use the same tablet-based, paperless records system for inspections in both jurisdictions.

External Stakeholders

With the same health department staff engaging residents, businesses, nonprofits, and other stakeholders, Melrose and Wakefield have been able to maintain a standardized level of service and communications. For example, when coordinating with the local Melrose-Wakefield Hospital¹² regarding public health community events, educational programs, and individual patient cases, the hospital staff has one set of local public health professionals to coordinate with,

not two. Similarly, the one core set of shared public health staff can more easily coordinate with the two separate police departments on a variety of programs, including those focused on opioids. Also, the increased health inspection capacity, especially in Wakefield's case, has enabled inspectors to (more consistently) maintain on-time inspection schedules for business management and owners.

Financial Considerations

All the interviewees for this case study noted that financial considerations were not a driver in developing the shared staffing arrangement. While both jurisdictions' health departments track ongoing expenditures specifically for Wakefield-Melrose staffing expense reimbursement and for broader budgetary reasons, neither jurisdiction has identified a material change to local health staffing costs since the implementation of the arrangement, nor do the governing boards involved require cost savings to occur in order to justify the continuation of the arrangement. Also, both jurisdictions use the staffing time/cost allocations (Table 1) as general guidelines, not static figures that must be adhered to every day or month. The agreement itself and management of the agreement were specifically designed to be flexible so that staff time can be allocated to meet temporary changes in demands for services. The trust and continuous communication among the two boards of health, Wakefield town administrator and Board of Selectmen, Melrose mayor and Board of Aldermen, and joint health director enable this flexibility to work.

Outcomes

Neither jurisdiction maintains a formalized system for assessing customer satisfaction, service quality, timeliness, or other factors. With this noted, since the arrangement's inception, both local health staff and the elected and appointed leadership of the two jurisdictions overall have received positive anecdotal feedback from residents regarding the quality of services and educational programs, and business owners (especially in Wakefield's case) have seen improvements in the timeliness and thoroughness

of inspections. In addition, programs popular with residents, such as health counselor call-in phone lines and opioid misuse and abuse prevention programs, would not be financially possible without the collaboration. Local leadership believes the shared staffing arrangement and the co-provision of health services better position both jurisdictions to receive state and federal grant funding, given the ability for the entities to speak with one voice on local public health matters and offer a standardized level of health service delivery across two communities.

Lessons Learned

The shared staffing arrangement between Melrose and Wakefield, which was implemented in 2009, has continued for a range of programmatic and policy reasons. Many of these considerations are generalizable for other jurisdictions weighing similar approaches.

- **Governance:** Each jurisdiction maintains its own board of health, which oversees the shared staffing arrangement while ensuring that both communities' interests and concerns are represented in the provision of health services. Although this structure is a requirement of state statute and regulation,¹³ it ultimately enables the New England tradition of strong, local control¹⁴ to continue, while at the same time allowing for the implementation of innovative shared staffing.
- **Discretion:** The health director is given a wide range of management flexibility by both jurisdictions. This was a prerequisite of the health director before entering into the arrangement. The staffing level of effort and time allotments for each jurisdiction are considered guidelines and are adjustable depending on service needs.
- **Technology coordination:** The sharing of information technology resources is essential. The arrangement works because the same or similar information and communications technology systems are used by both jurisdictions for public health services, health records are maintained in one place, and the duplication of assets is reduced or eliminated, where possible, through coordination by the respective IT departments.
- **Trust and communication:** The leadership of both jurisdictions works closely on a range of initiatives (not just public health), so they know each other well and communicate often. This underpins the trusting relationship that enables the continuation and ongoing adaptation of the staffing arrangement, an arrangement that must be evaluated and renewed every year.
- **Transparency:** Through the provision of health programs by staff and communications of elected and appointed officials, residents and businesses are made aware that the same public health staff serves both communities and must provide the same quality of services to both jurisdictions. The arrangement is described, in detail, in annual reports, in board documents, and during board meetings.
- **The bottom line:** The arrangement does not focus on cost savings or quantified metrics; instead it is centered around increasing the capacity and expanding the programs that both jurisdictions believe would not be possible, given financial constraints, without the arrangement.

For More Information:

- City of Melrose Health Department.
<http://www.cityofmelrose.org/departments/health-department/>
- Town of Wakefield Health Department.
<http://www.wakefield.ma.us/health-department>
- “Report of the Health Department” section of the 2016 Wakefield Annual Report offers information about the shared staffing arrangement with Melrose.
http://www.wakefield.ma.us/sites/wakefieldma/files/u111/wakefield_fy_2016_annual_report_onlinepdf.pdf

Case Study: Webster County, Iowa, and Neighboring Jurisdictions¹⁵

Webster County, Iowa, (population 37,769), is the largest of a group of rural counties northwest of Des Moines. These counties are working together to apply for grants and share staff in the delivery of public health services that might not be economical if each county were to attempt to provide those services on their own.

Among the jurisdictions sharing staff on at least some services are Buena Vista, Calhoun, Clay, Dickinson, Emmet, Greene, Hamilton, Hardin, Humboldt, O'Brien, Palo Alto, Pocahontas, Sac, and Wright counties. All are in the range of approximately 7,000 to 20,000 in population, with low population densities and service territories of roughly 600 square miles each.

Public health staffing in these jurisdictions ranges from thirty-three full-time equivalents (FTEs) in Webster County to just four or five in smaller jurisdictions (inclusive of health department directors and clerical staff). While the staff sharing approach involves a web of interlocal agreements for mutual support, there are also four administrative FTEs in Webster County who directly support the program or provide financial management and billing services.

Initial Challenges and Concerns

Grant applications requiring minimum service populations provided an impetus for local public health departments to discuss strategies for working together across county lines to provide the necessary services. Additionally, being in a very rural area, the jurisdictions were not always able to have the appropriate credentialed or degreed personnel to provide the services. Considering that some counties in the area do not have any obstetricians, the provision of public health nurses and other skilled staff can be a central part of maintaining area residents' health.

Given these challenges, a solution started to take shape in 1996. There was a Title V block grant application for Women, Infants, and Children (WIC) services and Maternal & Child Health (MCH) programs.

Webster County was large enough to apply, and groups of counties could do so together, but many were too small to qualify on their own. That started the thinking process about how several neighboring counties could arrange for services jointly. First taking the form of an informal agreement, this partnership was formalized about ten years later. The current Webster County health director then oversaw a further expansion of the program around 2009. As the program has continued, additional jurisdictions have joined. Depending on expertise and staffing availability, various counties have played a lead role administering grants or assigning service providers.

Among the other programs that have been provided via shared staffing are oral health screenings and fluoride treatments, Healthy and Well Kids in Iowa (hawk-i) children's health services, breast and cervical cancer screenings, tobacco cessation, family planning, lead poisoning screening/prevention, emergency preparedness, family foundations (through Calhoun County), and environmental health (through Calhoun and Buena Vista counties).

Process and Implementation

Under the terms of the grants, Webster County became the responsible agency for all grant-funded service provision throughout the combined territories of the participating counties. Where the services were more highly specialized and the service territory was compact, Webster County staff provided these services directly. As Hamilton County Public Health Administrator Shelby Kroona noted, rural counties would otherwise face a significant hurdle in meeting such needs on their own. "For [dietitians at] WIC clinics only two days per month—we'd never be able to hire someone for that." Those smaller counties were also more successful in obtaining grants when pooling the populations served, such as in obtaining Ryan White HIV/AIDS program funds.

However, when the other counties had existing staff who were able to provide the services themselves (e.g.,

nurses, social workers), Webster County entered into interagency contracts with them to serve their own territory. The umbrella responsibility and the direct grant-funded support remained with Webster County, but the local providers would deliver the services and receive reimbursement.

With so many of these rural health departments being small operations, the staff sharing approach also provides flexibility for coverage when a staff person happens to be sick or on vacation. In the original conception, that would mean that Webster County staff would step in to provide those services directly during that time period. But as the service territory grew, the group also started writing multicounty partnerships into each contract. For instance, while Webster County might be the responsible party to arrange for services in O'Brien County, providing back-up nursing services might entail a two-hour drive each way for Webster County staff. Instead, since Clay and O'Brien counties are adjacent to each other, contract terms provide for those two or any other participating counties to serve as the backup, depending on availability. Hamilton County, for example, sends staff to other counties approximately once per month.

From an employment standpoint, the service provider would then be either (1) an employee of Webster County, (2) an employee of the county in which services are to be provided, or (3) an employee of any other participating county. From a quality assurance standpoint, the contracts prohibit subcontracting to any non-public health department staff.

Grant revenues are received by Webster County, and as staff in other participating counties provide services, those jurisdictions are reimbursed, typically on an hourly basis. To ensure there is enough staff to handle the workload, each contract includes an annual cap on the potential hours of service to be provided. Where the service might lend itself to performance measures, that reimbursement might also be tied to the number of tobacco users counseled, the completion of an emergency preparedness drill, or other milestones.

Contracting has also branched out in other directions, including for office and billing services, and in the case of Dickinson County, a short-term contract for Webster County's public health director to

serve as its director as well. Such a proposal was even considered over a five-county area, but this concept was eventually abandoned.

Interestingly, while Webster County is the largest of the counties in the partnership, it is not always the go-to source for specialized services. Due to frequent turnover of its environmental health personnel, it no longer had staff to inspect swimming pools. Since the state-required training program is only offered once per year and it did not wish to fall behind schedule, Webster County instead contracted with Calhoun County staff to handle those inspections. Even though there's a commute involved, the Calhoun County staff person can often arrange multiple inspections in a single day to make efficient use of time. Fees paid by the pool owners stay with Calhoun County, and if re-inspections are required, mileage reimbursement is paid as well. This arrangement has now been in place for over a year, and like the other contractual agreements, will continue to be reviewed annually.

Like the other contracts, this one takes advantage of expertise and staffing capacity that exists in one community and finds opportunities to apply it elsewhere as well. So instead of just inspecting four pools per year in Calhoun County (among her other duties), that one staff person can now inspect twenty pools over a wider area, and there's no need to hire or train new staff.

Similarly, two staff in Buena Vista County are specializing in food preparation inspections, performing inspections across a five-county area under a contract with the state, and limiting those other counties' need to invest in duplicate training.

Considering the number of staff in motion around a fifteen-county area, it is not surprising that a few human resource issues have arisen. So far, though, none has involved disciplinary actions against one county's staff person related to services provided in another county. Instead, most have related to grant-related deliverables. Where standards have not been met, Webster County staff have worked with the staff person or the employing county to discuss expectations or recommend supplemental training, such as regarding documentation requirements. Where those issues have not been resolved, Webster County staff has passed

along further feedback for employee reviews, but has retained the option to void the contract. In one county, Webster County staff now provides all Maternal & Child Health services themselves. Since this has a financial impact on the county that would otherwise provide service and receive reimbursements, that serves as an effective incentive to maintain adequate performance.

Still, in some cases, the services contracted may not be a good fit for everyone. If, for instance, the administrators in two counties might agree on the conduct of a health education program in the schools, they might find that the only staff person available in that county to be assigned to that task is more comfortable and effective as a clinician than as an instructor. Having learned from experience on just such a circumstance, Webster County has now incorporated a “good fit” review of proposed staffing before entering into new contracts.

On a routine basis, program staff meets quarterly to discuss the contracts’ status and results. Since Webster County is the umbrella agency, its public health director also conducts site visits and meets at least bi-annually with the other health directors. Chart audits and client satisfaction surveys also facilitate program evaluation. With the growth and complexity of the contracting arrangements, the counties have standardized a number of internal policies; standardized their information technology systems; and, as of October 1, 2017, they are sharing a single Webster County IT staff person to support those systems.

External Stakeholders

UnityPoint Health - Fort Dodge is the accountable care organization (ACO) for a rural, eight-county region. In 2011, Webster County became the preferred provider for that ACO and a central point of contact for public health issues. Over time, as the partnerships with surrounding public health agencies have grown, Unity Point now knows it will find the same standards and structures in any of the participating counties and fertile ground for the system improvements and patient outcomes they’re trying to drive.

According to Aaron McHone, ACO executive sponsor at UnityPoint Health - Fort Dodge, the Webster County

model broke down the invisible walls between the various public health departments and the local health systems. Whether through telephonic disease management, joint grant applications, flu clinics hosted at UnityPoint facilities, in-home patient follow-ups, or shared access to medical records, the agencies are working not only on staff sharing arrangements but on a fee-for-value approach to promote better outcomes for patients.

In Calhoun County, some public health services are offered at the local hospital. And since the patient population extends to non-county residents, the health department provides services to those patients as well.

Financial Considerations

It is difficult to quantify the administrative costs for this partnership, as it started very informally more than twenty years ago. More operationally, each grant received represents a revenue source for new or expanded services. Counties delivering services are reimbursed for their staff’s hours dedicated to those tasks.

Beyond the direct staffing and reimbursement transactions, participating counties also benefit from the fact that Webster County is credentialed under Title XIX and can bill insurance companies for the nursing services provided. Prior to the partnership arrangement, these smaller counties may have delivered some of the same services, but would not have been able to file such insurance claims and thus missed out on additional revenue. Now, Webster County handles the administration and filing of those claims, and when insurance payments are received, remits all but its own administrative costs to the county that provided the service.

Outcomes

In a rural area where trained staff may be difficult to recruit or retain, this partnership has enabled specialized staff, such as registered nurses, dietitians, dental hygienists, and pool inspectors, to provide services to a wider area. It has also enabled jurisdictions that have some existing staffing capacity internally to supplement those staff’s workload with contractual hours, filling in as needed in neighboring jurisdictions.

Just as importantly, counties that would have been too small to be considered for grant awards on their own are

now able to offer services that had previously bypassed their communities.

And while the services are expanded and possibly supplemented with specialists, most of the staff carrying out the work in a county are already part of the county payroll. “They like to have local representation where providers know the community,” said Kari Prescott, Webster County health director. “That’s why it works so well.”

Also, a central database now allows the tracking of social determinants of health, as well as individual diagnoses, vital statistics, interventions, and results across a fifteen-county region.

Lessons Learned

For Webster County, there is one central, key lesson:

- **Relationship building:** A modest start placed Webster County on the path that has allowed adequate time for planning and communication, and eventually a significant expansion of services to a wide and underserved rural area.

Diane Ferguson, home health nurse with Pocahontas County, noted that “We’ve got a good rapport with them. Our small county has been able to expand the services that we can do. It’s a valuable thing.”

- **Pooled resources:** More generally, counties that see themselves as too small to qualify for grant funding on their own, or limited in their ability to recruit for more specialized positions that may only be needed part-time, may find such a shared staffing arrangement to be a workable alternative that allows them to enhance their service to the community.

For More Information:

- Webster County Health Department Strategic Operational Plan, 2015-2020. <https://icma.org/documents/wchd-strategic-operational-plan-sept-2015>
- “Webster County Health Department gets grant,” The Messenger, March 2, 2016. <http://www.messengernews.net/news/local-news/2016/03/webster-county-health-department-gets-grant/>

Case Study: Tri-County Health Officers, Oregon¹⁶

Multnomah County, Washington County, and Clackamas County, Oregon, have shared the staffing of their health officer positions since 2006, with a resulting increase in efficiency and expertise.

Community characteristics vary, from urban to suburban to rural, sometimes all in the same county, as indicated in the following table:

Table 2. Jurisdiction Background¹⁷

County	Multnomah	Washington	Clackamas
Population	799,766	582,779	408,062
Square miles	431	724	1,870
Population density	1,705	731	201
Poverty Rate	15.7%	10.5%	9.4%
Percentage with a bachelor's degree or higher (age 25+ years)	41.3%	40.7%	33.1%
Health department: annual expenditures	\$307 Million	\$17 Million	\$82 Million ¹⁸

Note: Multnomah is the most urban of the three, but all have an urban/suburban/rural mix.

Initial Challenges and Concerns

Oregon law requires each county to have a physician to serve as a health officer. This position provides expert consultation, medical and technical direction, and public health leadership and advocacy, both for the health department and for community health care providers. Areas of focus include preparedness and response for disease outbreaks and natural disasters and coordination of emergency medical services.

In 2006, staff turnover left both Washington County and Clackamas County with health officer vacancies. Since those two counties are located immediately adjacent to Multnomah County (home of Portland), and since communicable diseases do not respect the boundaries of the metro area communities, a regional approach seemed to make sense. On an interim basis, the health officer in Multnomah County took on this responsibility for all three counties, supplemented by a few other public health physicians who assisted on an informal basis. This arrangement was then

formalized in 2008 with a tri-county health officer and three deputies, with one assigned to each county. This structure provides both a regional perspective and a dedicated deputy for each community.

Process and Implementation

The tri-county arrangement houses all four staff as employees of Multnomah County, with the contracting agencies agreeing in their annual budgets to a given level of full-time equivalent (FTE) staffing. Those counties then reimburse Multnomah County for their own assigned deputy, a portion of the tri-county health officer, and the support staff required to provide payroll, IT support, or related services. When the program began, the support component was somewhat larger, to include a program manager.

In their respective counties, the deputy health officers supervise individualized, local public health activities. But where there is an issue of regional concern, such as treatment of tuberculosis patients, the tri-county health officer provides direction for that medical care. Typically, that type of direction comes in the form of standing orders, which set out the policies for immunizations; epidemic response; and interagency coordination with hospitals, school districts, and other community stakeholders.

The drafting of standing orders or other policy statements is in part a function of the expertise each of the health officers brings to the group. Among them, there are two family practitioners, an internist, and a pediatrician with a specialization in infectious diseases. Where any of the four has a particular skill set, that person may take the lead on crafting the proposed procedures, thus eliminating a triplicate level of effort among the three counties and possibly saving time that others might have needed in researching areas where they were less expert.

Interaction among the health officers typically takes the form of a weekly meeting. Those meetings are held at Multnomah County offices or at other events in the region the health officers might all be attending (e.g., at

area hospitals). More recently, health officers have also experimented with holding some of those meetings via conference call and limiting their in-person gatherings to perhaps once per month.

The other significant interaction among them is around backup staffing. Under the prior system, if the health officer for Multnomah, Clackamas, or Washington counties was unavailable for some reason, there was no designated backup. Now, the three jurisdictions share four staff among them, with the practical benefit that each night, weekend, or holiday, they arrange for one of their number to serve as a primary on-call resource and another to be available as a secondary. This facilitates quick and knowledgeable response. As Tri-County Health Officer Dr. Paul Lewis observed, “Nobody waits more than three minutes to get a call back from a senior physician.” By comparison, the state or other large agencies may take much longer to respond or only be able to provide a mid-management resource, not specifically someone with a public health background. The tri-county model is, as Dr. Lewis said, “a staffing approach that doesn’t overwhelm a single staff person.”

Within their assigned counties, the deputy health officers work with the other staff who may be direct employees of that county. This is more of an interagency task force relationship, as the health officers do not have direct lines of supervision over these other staff. If a personnel issue were to arise with any of the line staff, this would be a matter for that county’s health administrator to address.

Personnel matters for the health officers are all handled within the Multnomah County organization. The county conducts annual surveys and 360-degree reviews of all employees. The health department administrators in the contracting counties provide feedback to Multnomah County for use in those performance appraisals, and typically schedule their own monthly meetings with their assigned deputies. To this point, there have been no disciplinary or workplace difficulties with the health officers, but that may be due in part to the fact that the number of people involved and the years since implementation remain low. Since the formal program started in 2008, there has been very little turnover in the health officer positions.

Dawn Emerick, the Clackamas County public health director, notes that the interagency relationship has been very cooperative, and provides the appropriate level of health officer staffing for the county’s size. Speaking in terms of the organizational chart, she noted that the deputy health officer for Clackamas County is “a dotted line to me; she’s a solid line to Dr. Lewis.” That could present challenges when a staff person’s baseline availability is only twenty hours per week, but she feels the communication has been very effective around setting workplans, so the county’s priorities are being met. Plus, she knows that three others are backing up her one half-time deputy. Thus, as vacations roll around, she knows the work will still get handled.

Implementing this partnership required budgetary approval by the Multnomah County Board of Commissioners and approval of inter-local agreements with Clackamas and Washington counties. Those agreements have been renewed each year since, with the option of increasing the level of staffing as deemed necessary.

In Washington County, the original staffing of 0.5 FTE was raised to 0.8 FTE in 2015. Tricia Mortell, Washington County public health division manager, notes that this supplemental staffing had been studied for a few years, and after the counties’ joint work on Ebola, she put together some funding to make the increase a reality. Now, the Washington County deputy health officer is available not only for day-to-day work on infectious diseases, but also on policy changes and program implementation such as around Naloxone distribution, early intervention, harm reduction, health care provider education, and community outreach.

As any changes are made, Multnomah County then increases the hours of the designated deputy health officer and increases that county’s reimbursement amount. Presumably, if the hours requested exceeded the availability of any of the deputies, Multnomah County might then be in a position where it would need to hire an additional employee to cover the requested hours. Just as with any annual renewal of the interagency agreements, the reimbursement formulas would be subject to negotiation with the contracting jurisdictions.

There were no other ordinances, operating

agreements, or personnel rules that needed to be changed, and no special permissions required from the state. Although Oregon has not had any specific incentives in place supporting such partnerships, it has been supportive in principle, as an extension of the broad home rule authority granted to local governments to address such issues in their own ways. In fact, another tri-county partnership exists in a more rural corner of the state—the North Central Public Health District serves Wasco, Sherman, and Gilliam counties (<http://ncphd.org/>).

External Stakeholders

The health department staff in these counties does not act in a vacuum, as they are in close partnership with other public, private, or nonprofit organizations throughout the region. For the most part, those entities have a cooperative attitude that has facilitated population-based public health efforts.

For a typical public health issue, such as vaccinations, the health officers may write standing orders that involve hospitals, school districts, private practice physicians, fire/emergency medical departments, parks and recreation programs, community groups, or other stakeholders. The implementation of those orders and protocols depends on a close working relationship with all parties concerned. Where that cooperation is fostered ahead of time, emergency or epidemic response can unfold as planned.

Among the key partnerships already facilitated by the shared staffing arrangement are programs to plan for or respond to outbreaks of measles, flu, and Ebola. Those same structures have also helped the three counties work together effectively on response to a series of strong winter storms in 2016 to 2017.

All those disease and weather phenomena easily cross borders, but one of the more recent challenges they have faced is one that had typically been considered an urban problem in the past—opioid addiction. Unfortunately, with the rising incidence of addiction in suburban and rural areas as well, that has become a universal issue and one on which the three counties can partner effectively without turf battles over agencies paying to fight “someone else’s” problem.

Program Expansion

For that opioid epidemic response, Multnomah County had received an umbrella grant, and Washington County a much smaller portion (\$13,000) earmarked for provider education and public outreach. While the health officer team can provide some high-level coordination, Ms. Mortell noted that a more robust campaign within Washington County would require a dedicated staff person, a position that at this point, they don’t have the resources to hire. Ms. Emerick echoed that while the shared health officers have done excellent work on policy formulation, the staff time available for implementation remains limited.

One approach that has not been considered so far in Multnomah, Clackamas, and Washington counties has been the expansion of their shared staffing arrangement to other levels of staff within their organization. In part, this has been by design. As Dr. Lewis noted, they are trying to take a leaner approach to “public health 3.0,” with more of the direct service being provided by the health care sector rather than the public health sector. In some specialized areas, such as communicable diseases or sexually transmitted infections, they may consider further shared staffing down the road, but they have not reached that point yet.

One area where expanded staff sharing was considered, but later abandoned, was in emergency preparedness. The proposal met with some resistance, in part out of concern that the incumbents providing those services would be phased out as the function became regionalized. Since the health officer positions in Washington and Clackamas counties were vacant when the staff sharing arrangement started, this type of transitional concern never materialized.

Looking ahead, Oregon has passed public health modernization legislation (HB 3100) and has approved \$5 million in funding to facilitate that, with a focus on regional cooperation. With the state’s first priority area being infectious diseases, Ms. Emerick sees potential for building on the staff sharing approach. Because the three counties’ existing capacity in that field is very limited, she said, staff would not feel displaced so much as supplemented by additional resources.

Another area where shared staffing is already

in place is the Tri-County 911 (TC911) Service Coordination Program. Operated within the Multnomah County Health Officer Division, this team of four social workers (all officially employees of Multnomah County), provides services to residents of Multnomah, Clackamas, and Washington counties who are frequent users of 911 services. They help to determine whether some alternate interventions might reduce demand for emergency services. Although this staff sharing arrangement is similar to that with the health officers, the costs of this program are entirely borne by the Medicaid managed care plans' coordinated care organizations, not by reimbursements from the participating counties.

As with the health officers, TC911 staff have assigned territories—helping build rapport with local EMS, behavioral health staff, and the client base—but they also serve as needed across the whole area. Ms. Mortell noted that Washington County has seen some program challenges, ranging from wait lists for services to the need to better coordinate communication, but she is looking to strengthen this program as a key support network for local residents.

Financial Considerations

When the shared staffing arrangement was formalized in 2008, the total staffing reimbursement was \$366,742. Since the shared staffing model was so new for all three jurisdictions, a program manager was part of the initial budget to facilitate the start-up. Funding decreased somewhat in 2009 and 2010 as that position was phased out, but has increased again over time, particularly as Washington County increased its staffing in 2015.

In Fiscal Year 2018, Clackamas County's contribution to the shared staffing was \$185,000 and Washington County's share was \$278,000, for a total of \$463,000.

These amounts cover the designated level of FTEs for each deputy health officer, a share of the tri-county health officer, the related Multnomah County support staff, and related office or personnel expenditures (e.g., for professional development training).

Expenditures for the Tri-County 911 Service Coordination Program total about \$1 million per year. While the staff are housed in Multnomah County and shared with Clackamas and Washington counties, the

expenses are paid through Medicaid community care organization funds as part of an effort to decrease unnecessary use of 911 services. According to a recent study, the savings from reduced emergency room visits and hospitalizations exceeded program costs by approximately 13 percent.

Outcomes

The goal of the tri-county partnership is a uniform and consistent, high-quality program for public health, and as such, the health officer sharing program has been very successful, as the indicated by the following examples:

- During a 2009 influenza epidemic, the counties were able to address a vaccine shortage in tandem, putting in effect a uniform policy for allocating the scarce supplies.
- In 2014, with several Ebola cases confirmed within the United States, the tri-county staff coordinated a regional response plan with all area hospitals for triage and evaluation.
- Measles, whooping cough, and rabies have been areas for further partnership, also extending to non-contractual work with their counterparts in adjacent Clark County, Washington. Their coordinated approach won the counties recognition as a model of practice from the National Association of County and City Health Officials.
- Economies of scale have never been a primary goal, according to Dr. Lewis, but by assigning the drafting of standing orders to the individual with the most relevant expertise, then adopting that policy regionally, he estimates that each county is getting much more value for their money than they would if they each had a stand-alone part-time health officer.

From a political standpoint, the details of health department staffing structures have not been of high-profile concern. But of course, if there had not been an effective working relationship, that could easily have resulted in very negative outcomes. Instead, the tri-county staff have had very positive feedback on their work to coordinate flu and Ebola protocols and to partner on the 2016 to 2017 winter weather response, in which they prioritized EMS transport and hospital resources and at a time when the road conditions

made some facilities in the region inaccessible or travel difficult.

Regardless of the regional scope of policy or protocols, each county retains its own authority to set its own priorities, and implementation approaches may differ. To immunize health care workers, for example, one county may work through local hospitals, while another might set up a special pop-up clinic for health care workers.

Those approaches vary in part with the urban, rural, and suburban nature of the communities being served, but these are not cookie-cutter differences that align with the county boundaries. Taking immunizations as an example, there are certain religious, ethnic, or socio-economic groups within the region that have higher or lower rates of immunization, and these groups may cluster around individual neighborhoods, churches, or private schools. The assigned deputies who work within Multnomah, Clackamas, and Washington counties understand those community characteristics and can tailor their implementation and outreach strategies accordingly—knowing what will work in a city of 100,000 within their territory and what alternate approaches might not be necessary in a town of 1,000 on the opposite side of the county.

From a nonfinancial standpoint, the program has achieved significant return on investment. “We all respect the value of Paul’s mentorship and expertise,” said Ms. Mortell of Dr. Lewis. “Having central leadership helps things move a little more quickly,” compared to the results they might achieve through a more informal means of networking. That relationship is also facilitated by Dr. Lewis’ experience working in both Clackamas and Washington counties prior to joining Multnomah County staff.

The fruits of that collaboration are seen not just in the speed of activity, but in the quality of the results. Together, the team of four health officers has written protocols that have become the model for statewide policy, such as in tuberculosis standing orders, measles and pertussis investigation protocols, and Ebola response.

Outcomes from the TC911 Service Coordination Program have not yet included a reduction in the number of 911 calls, but they have included reduced

emergency room visits among the target population (4.2 fewer visits per person per year) and a net savings when comparing program costs to reduced hospitalizations—estimated at \$740,000 in costs versus \$836,000 in savings over a recent study period.¹⁹

Lessons Learned

- **Localized justification:** When the staff sharing arrangement was first proposed, there was some hesitation in Multnomah County for staff to take on new roles outside their official territory. It helped, however, that the shared staffing request came from the other counties rather than being a regionalization initiative imposed by the state. There was also a built-in predisposition in public health to work together on prevention before nascent issues become larger problems. In the end, that cooperative future orientation and the ability to provide 24/7 availability of a senior physician helped justify the shared approach. The productivity gains in eliminating duplicative efforts and taking advantage of each health officer’s expertise have brought benefits to each participating agency.
- **Communication:** Communication is essential, both around the core services being provided and some of the political sensitivities that may be encountered. For example, Multnomah County has decided to sue pharmaceutical companies in response to the opioid epidemic, and that was a decision taken at the county board level and subsequently reported in a tri-county newsletter. But since some might assume this meant all three counties were plaintiffs in the lawsuit, the messaging had to be fine-tuned to ensure that it was clear what actions were being taken unilaterally rather than on behalf of or in cooperation with the other counties.
- **Equity and geography:** While Multnomah County sits somewhat between Washington and Clackamas counties and there may be a natural tendency to meet in the largest jurisdiction, the health officers work together to ensure that all three counties are fully included and rotate as event hosts.

If Multnomah, Clackamas, and Washington counties were starting the program today, one suggestion Dr. Lewis offered is that they might allow the option for

health officers in Washington and Clackamas to directly supervise staff, if appropriate. To this point, all staff supervision has been provided by each county's own health administrator. Considering that each of the contracts for shared staffing is renewed annually, that's a proposal that could be considered by Washington and Clackamas counties during the next renewal cycle.

For her part, Ms. Emerick notes that counties should not be fearful of trying such regional approaches. Considering perennial budget challenges, she finds that a shared staffing arrangement has helped provide expertise and reduce the risk of staff burnout. In addition, since Clackamas County's deputy health officer is housed within the county, the decentralized structure contributes toward local connections and understanding.

For More Information:

- TC911 Service Coordination Program. http://oregon.providence.org/~ /media/Files/Providence%20OR%20PDF/core_tc911_report.pdf
- Multnomah County, "Public Health wins national award for measles plan," July 29, 2017. <https://multco.us/multnomah-county/news/public-health-wins-national-award-measles-plan>
- Health Share of Oregon, "Outreach Intervention— Helping Patients Overcome Barriers to Health." <http://www.healthshareoregon.org/transforming-health-together/care-innovations/primary-care/outreach-intervention.html>

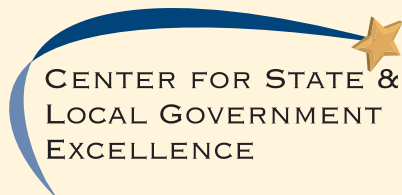
Endnotes

- 1 The authors would like to thank Pat Libbey, Co-Director, and Grace Gorenflo, Senior Project Consultant, of the Center for Sharing Public Health Services for their advice and input on this project and Anne Phelan for copy editing this report.
- 2 “Spectrum of Cross-Jurisdictional Sharing Arrangements,” Center for Sharing Public Health Services, 2017. <http://phsharing.org/wp-content/uploads/2017/05/CJS-Spectrum-V2.pdf>
- 3 See Figures 1.1-1.5 of: J. Darnell, S. Cahn, B. Turnock, C. Becker, J. Franzel, and D. Miller Wagner, “Local Health Department Workforce Recruitment and Retention: Challenges and Opportunities,” Center for State and Local Government Excellence and UIC School of Public Health, November 2013. http://slge.org/wp-content/uploads/2013/12/Local_Health_Dept_Workforce_Challenges_Opportunities_14-305.pdf
- 4 “A Roadmap to Develop Cross-Jurisdictional Sharing Initiatives,” Center for Sharing Public Health Services, 2017. <http://phsharing.org/wp-content/uploads/2017/09/Final-RoadmapRevised2017.pdf>
- 5 Information for this case study comes from publications on City of Melrose and Town of Wakefield websites and interviews with Ruth Clay, Health Director, on July 11, 2017 and July 31, 2017; Ann Santos, former Wakefield Board of Health member and current Wakefield Board of Selectmen member, on August 1, 2017; Stephen Maio, Wakefield Town Administrator, on August 2, 2017; and Robert Dolan, Mayor of Melrose, on August 3, 2017.
- 6 Population data offered throughout the report (unless otherwise noted) from U.S. Census Bureau. <https://www.census.gov/data/tables/2016/demo/popest/total-cities-and-towns.html>, <https://www.census.gov/data/tables/2016/demo/popest/counties-total.html>
- 7 From 2010 through 2015, the town of Reading, Massachusetts (population estimate, 2016: 25,834) was also part of the shared staffing arrangement.
- 8 “Local Public Health in Massachusetts,” Commonwealth of Massachusetts, Executive Office of Health and Human Services. <http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/comm-office/local-public-health-in-massachusetts.html>; U.S. Census Bureau, “2012 Census of Governments: The Many Layers of American Government.” https://www2.census.gov/govs/cog/2012/2012_cog_map.pdf
- 9 City of Melrose, MA, “Keeping the lines of communication open,” October 1, 2012. <https://www.cityofmelrose.org/2012/10/01/keeping-the-lines-of-communication-open/>
- 10 Geoff Wilkinson, “New State Incentive Grant Program to Fund Regional Public Health Districts,” Commonwealth of Massachusetts, Department of Revenue, December 28, 2010. <http://www.mass.gov/dor/local-officials/dls-newsroom/ct/new-state-incentive-grant-program-to-fund.html>
- 11 Metropolitan Area Planning Council. <http://www.mapc.org/>
- 12 Hallmark Health System. <https://www.hallmarkhealth.org/melrose-wakefield.html>
- 13 Massachusetts Association of Health Boards, “Duties of Local Boards of Health in Massachusetts.” <http://www.mahb.org/wp-content/uploads/2015/12/Duties-of-BOH.pdf>
- 14 Virginia Gray and Peter Eisinger, *American States & Cities* (New York: Harper Collins, 1991).
- 15 Information for this case study comes from documents provided by Webster County and from interviews conducted with Kari Prescott, Webster County health director, on July 26, 2017; Shelby Kroona, Hamilton County public health administrator, on August 14, 2017; Diane Ferguson, Pocahontas County home health nurse, on August 22, 2017; Barb Riley, Calhoun County public health administrator on August 22, 2017; Shelly Schossow, Calhoun County environmental health manager, on August 24, 2017; and Aaron McHone, ACO executive sponsor at UnityPoint Health - Fort Dodge, on September 8, 2017.
- 16 Information for this case study comes from websites and documents provided by Multnomah County, along with interviews conducted with Dr. Paul Lewis, tri-county health officer, on July 31, 2017; Tricia Mortell, Washington County public health division manager, on August 8, 2017; and Dawn Emerick, Clackamas County public health director, on August 9.
- 17 Source: Population, education and poverty figures from U.S. Census Bureau Quick Facts, effective July 1, 2016. Land area and population density figures from 2010.
- 18 Organization and components of health departments vary. For Washington County, the total reflects the health-related portions of its Housing, Health & Human Services Department (Public Health, Emergency Medical Services, Oregon Health Plan, Health Share of Oregon, Tri-County Risk Reserve, Mental Health HB2145, and Mental Health Crisis Services). Multnomah County’s includes the Health Department Director’s office, Health Officer, Public Health, Integrated Clinical Services, Business Operations and Human Resources, Corrections Health, and Mental Health and Addiction Services. Clackamas County’s includes the Behavioral Health, Health Center, and Public Health divisions of the Health, Housing and Human Services Department.
- 19 TC911 Service Coordination Program, Analysis of Program Impacts and Sustainability, The Center for Outcomes Research & Education, Providence Health & Services, October 13, 2014.

Staff Sharing Arrangements for Local Public Health

About the Center for State and Local Government Excellence

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The Center for Sharing Public Health Services helps communities learn how to work across jurisdictional boundaries to deliver 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.

