# Case Studies in Staff Sharing in Local Public Health

**April 2019**


Center for State & Local Government Excellence

Center for Sharing Public Health Services
*Rethinking Boundaries for Better Health*

**Acknowledgements**

This report was developed by Rivka Liss-Levinson, PhD, and Gerald Young, Center for State and Local Government Excellence. The authors would like to thank Joshua Franzel, PhD, Center for State and Local Government Excellence, and Pat Libbey and Gianfranco Pezzino, MD, MPH, Center for Sharing Public Health Services, for their guidance and support of this project. We are grateful to Anne Phelan for copyediting this report and Rob Maguire Designs.

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## Introduction

Over the past decade following the Great Recession, local public health departments have been asked to do more with less—to provide high-quality public health services, programs, and activities to the people they serve, but with a substantially limited budget. Facing this challenge, local health departments have come up with a variety of innovative approaches to continue their level of services and programs while reducing costs. One such approach is cross-jurisdictional sharing, or the sharing of resources across geographic boundaries—whether sharing of equipment, information, or staff—among one or more local health departments.

In 2017, the Center for State and Local Government Excellence (SLGE) partnered with the Center for Sharing Public Health Services to examine case studies of three cross-jurisdictional staff-sharing arrangements in local public health organizations as a means to expand organizational capacity, better manage expenditures, and contain or address existing or emerging issues. The following year, SLGE worked with the Center for Sharing Public Health Services to develop a checklist enabling public health officials at local health departments to successfully walk general local government elected and appointed officials through the process of establishing and managing staff-sharing arrangements.

Building on the information learned from SLGE's 2017 report "Staff Sharing Arrangements for Local Public Health," and 2018 report "Staff Sharing in Public Health: A Checklist for Communicating with Elected and Appointed Officials," this report presents two case studies of staff-sharing arrangements in local public health. The jurisdictions selected for case studies were two of the five jurisdictions interviewed for the 2018 case studies, chosen for their diversity in geographic region, size of jurisdiction, and type of positions shared. In addition, the report highlights two areas of focus that are critical for jurisdictions considering staff sharing to address: building the business case for cross-jurisdictional sharing, and evaluating the success of the arrangement.

# Case Study: Gloucester County and Salem County, New Jersey

## Introduction

Two New Jersey counties, Gloucester County (population 292,000), and Salem County (population 63,000), have shared a number of staff positions within the public health field, including a health officer, mental health administrator, and medical examiner.[1]

Within New Jersey, health officers are the operational staff responsible for evaluating health problems and the application of state health codes; planning organizational response to those challenges; and directing nursing, environmental health, and other staff accordingly. They carry out these duties in coordination with the health director (the department head who provides policy and budgetary direction) and the medical director (an MD who coordinates standing orders and handles required medical decisions).

State law requires that each county have a full-time licensed health officer, but allows the flexibility for that health officer to be shared, which is what Gloucester and Salem counties have done since 2014.

## Initial Challenges and Concerns

There are a number of issues to consider when determining whether to share local public health staff. More efficient use of staff time is one consideration. While adjacent counties may have their own health officers, in practice many of the administrative or state-related tasks carried out by health officers can be handled more efficiently by a single individual; for instance, one individual, rather than two health officers, attends a state policy briefing. By combining the health officer role, Gloucester and Salem counties were able to save what would otherwise have been duplicative time and instead focus that effort on direct service provision.

Still, in any situation where an outside staff person will be assigned to provide services over an extended territory, there are questions as to both how the individual and the two organizational cultures will mesh. In this case, the person who was selected to take on the health officer role was a Gloucester County employee who had previously worked in Salem County, and she thus had a level of familiarity with both the organization and the community she would be serving.

## Project Implementation

In 2010, Gloucester, Salem, and Cumberland (population 152,000) counties engaged in a temporary staff-sharing arrangement for a health officer. This arrangement lasted just over a year, and when the incumbent left to take a job elsewhere, the counties each hired their own separate staff.

Then, in 2014, budgetary considerations prompted Salem County to explore re-establishing the staff-sharing arrangement. In executing a shared services agreement,[2] the health officer in Gloucester took on the additional duties of a then-vacant health officer position in Salem County. This shared role was further expanded in 2015, with service to Atlantic City (population 38,000) as well. Each of these arrangements was formalized in a shared-staffing agreement, with no need for any further authorizing legislation or policy changes.

The heath officer—a full-time position within Gloucester County—was designated via contract to serve approximately two days per week in Salem County and one day per week in Atlantic City, with reimbursements based on each year's approved staffing budget. Schedules were typically worked out in advance, so that there was clarity around when the health officer would next be working in a particular territory.

As initially implemented, the agreement did not spell out a formal provision for backup coverage, although on a practical level, whenever an issue had arisen, the health officer responded, whether in person or by phone or e-mail. This was not perceived to be an undue burden. More urgent medical matters were typically handled by the public health nursing directors, with oversight of the medical director or with the guidance of the state epidemiologist. Contract work was subject to quarterly reimbursement, plus appropriate pass-throughs of liability insurance cost increases.

Administrations from the various jurisdictions were champions of the agreement, along with elected officials and the freehold director (chief elected official). Each

**Table 1.** Jurisdiction Background

| | Gloucester County | Salem County | Cumberland County | Atlantic City |
|---|---|---|---|---|
| **Population** | 292,206 | 62,792 | 152,538 | 38,429 |
| **Square Miles** | 322.01 | 331.90 | 483.70 | 10.75 |
| **Population Density** | 895.3 | 199.1 | 324.4 | 3,680.8 |
| **Poverty Rate** | 6.7% | 13.3% | 18.4% | 40.6% |
| **Number of FTEs, shared** | 1 Health Officer<br>1 Mental Health Administrator<br>1 Medical Examiner | Positions and shares vary; see discussion. | | |

Source for population, square miles, population density, and poverty rate: U.S. Census Bureau Quick Facts, as of July 1, 2017.

department went before its respective freeholder board for approval.

The health officer's responsibilities include managing public health programs, data analysis, working with partner agencies, implementing community health improvement plans, and conducting disease investigations. Much of the fieldwork is provided by other staff (e.g., inspectors for swimming pools and food establishments, Women, Infants, and Children (WIC) nutrition program staff, nursing clinical services and disease investigations), with the health officers playing more of a coordinating role. From an administrative standpoint, however, all budgeting, staffing, discipline, and policy decisions remain the province of the health director, allowing the health officer to focus on the direct departmental operations.

On a monthly basis, the health officer would provide each health director with a report on her activities, meetings attended, and issues worked on with staff, and this would also serve as an opportunity for performance evaluation. "Everything was very measurable and clear," said Rita Shade, director, Salem County Health & Human Services. "Accountability was not an issue." Beyond one-on-one discussions of those monthly reports, there was no need for routine interjurisdictional meetings involving the health officer and the department heads in the three local governments. Had there been any performance issues, these would have been handled via the monthly meetings, or if the issues had been more significant, then via the cancellation or renegotiation of the contract.

While direct supervision of other staff was not part of the shared-staffing arrangement, the health officer would work with crews of personal health, preparedness, health education, and environmental staff around program operations. If she saw any competency issues, they would be a further topic of discussion with the directors, rather than something she would act upon independently.

The initial term of the contract was through December 31, 2018, and it was subsequently renewed through March 31, 2019. The Atlantic City contract also extended through March 31, 2019. Gloucester County declined to renew the contracts further based on an interest in taking on a new direction within its organization, not from any dissatisfaction with the functioning of the staff-sharing arrangement. As a result, Salem County reconsidered its options to hire a new full-time health officer or to enter into a shared-staffing arrangement with another jurisdiction.

Of the other shared-services positions, the medical examiner contract has been in place with Salem and Gloucester counties since 2003, and Camden County (population 510,000) was added in 2006. The mental health administrator position has been shared since 2012. Those contracts have varying terms through 2024, but they may also be terminated after 120 days' notice to the other participating jurisdictions. From a staff-support perspective, these positions work closely with staff in the respective jurisdictions, but do not directly supervise them.

## External Stakeholders

Beyond working with the directly contracting organizations, the health officer must also fill a liaison role with each of the 39 incorporated municipalities within Salem and Gloucester counties.[3] Each of these municipalities has its own board of health, but relies on the county

health department to provide services. The health officer meets with each of these boards, giving ideas of ordinances that may need to be reviewed or updated; sharing updates from the county; facilitating reporting to the state; and working with their respective administrators, clerks, and code enforcement staff on environmental/inspection or other public health-related issues.

## Financial Considerations

Expenses for the shared staff are billed and reimbursed quarterly. Both the health officer and the mental health administrator were established as positions to be budgeted two days per week in Salem County, although actual hours have varied. In 2018, the health officer was serving in Salem County one day per week.

There were no particular start-up costs for the shared-staffing approach in that the positions were not new to the organizations, just the entity providing the staff. A desk and a computer were already on-site in each office.

Beyond simply the salary and benefits expenses for the position, there are a number of other costs to be considered. Travel time was considerable, with roughly a 45-minute travel time between counties. The health officer would obtain a pool car for official use when available, but often drove her own car, despite not having mileage reimbursement included in the contract. Nevertheless, it was rare to travel back and forth between the two jurisdictions in the course of the same day. If questions would arise from Salem County, for instance, on a day she was assigned in Gloucester County, she would either handle such issues electronically or table them until her arrival on the next scheduled Salem County day.

E-mail and phone were the primary means of connectivity. Generally, this entailed working on two separate computers (one for each county); however a Surface tablet was provided with virtual private network (VPN) access for Gloucester County only.

Table 2 indicates total FY 2018 shared-services reimbursements.

The total shared-services revenue of $1,416,995 compares to an overall Gloucester County 2018 budget for the Health and Human Services Department of $26.2 million.

**Table 2.** Financial Summary

| | Gloucester County Budget (Salary only) | Reimbursement |
|---|---|---|
| **Health Officer** | $99,382 | |
| Salem County | | $72,529 |
| Atlantic City (10-month contract) | | $26,212 |
| **Mental Health Administrator** | $80,600 | |
| Salem County | | $32,473 |
| **Medical Examiner's Office** | $238,902 | |
| Camden County | | $1,107,281 |
| Salem County | | $178,500 |

*NOTE:* Salary figures do not reflect benefits or other expenses (e.g., for support staff and operations in Medical Examiner's Office).

## Outcomes

Rather than budgeting for a full-time health officer position, splitting the expense among three jurisdictions made it more economical for all.

Other than the positions directly subject to the agreements, there were no new regional programs implemented or any cooperative grants received.[4] Computer systems in the participating jurisdictions remained separate, although a VPN was provided for use on the health officer's tablet computer.

Downsides included the long commutes required of the health officer to reach each of the three work locations. For Salem, there was also a more intangible downside, in that if there were an emergency situation, such as a severe weather event, the health officer might be more likely to be needed in Gloucester County as the most populous of the jurisdictions.

As it becomes more difficult to attract professionals to certain positions that need licenses or specialized certifications (e.g., medical directors, nurses, environmental health specialists, health educators), and especially as the private sector can offer more

competitive compensation, Gloucester and Salem counties could potentially consider sharing more positions.

Annmarie Ruiz, the shared health officer, noted that communication has been a key factor in the success of her shared assignment. Gloucester County staff report to and work closely with their freeholder liaison. There are also formal written reports filed annually, but more informally, the director of health services and the health officer also hold weekly meetings, and monthly reports are provided to each jurisdiction. She noted that the close working relationship between herself and the health directors, along with their ties with county leadership, has helped tremendously. Their team approach has been particularly helpful: they have set out clearly in a signed agreement who is responsible for what (e.g., operations vs. administration), so that implementation and chain of command are clear.

As noted above, the two counties also share a mental health administrator, which is budgeted for two days per week in Salem County, and a medical examiner's office, the cost of which is split based on caseload (with approximately 65 percent paid by Camden County, 25 percent by Gloucester County, and 10 percent by Salem County). Both arrangements have fostered stronger partnerships/alliances with community partners, permitted uniformity and consistency in service supports; and delivered invaluable cost savings to the jurisdictions. These positions will continue to be shared going forward.

In describing the outcomes achieved from the various staff-sharing agreements, Gloucester County Health Director Tamarisk Jones cited the benefits as including more uniform and coordinated service delivery, stronger relationships among community partners, and streamlined operational oversight. "The experience has been positive," said Jones, "but we are finding the responsibilities are growing as we meet state objectives as well as local needs."

## Spotlight: Building the Business Case

While the specific details of a staff-sharing arrangement (e.g., what the particular goals are, what positions will be shared, governance structure for local public health) may be unique, all staff-sharing arrangements have an important prerequisite for success: the support of senior leadership. Research consistently finds that leadership support is one of the most important preconditions for effective staff sharing—and that lack of support can create significant obstacles.[7] Buy-in for staff sharing includes support from agency leadership, elected and appointed officials, staff at the affected agencies, constituents of the jurisdictions, and other key stakeholders. But how do agencies garner buy-in for staff sharing in local public health?

National Association of Counties' (NACo) "A County Manager's Guide to Shared Services in Local Government" highlights the integral role of elected and appointed officials in leading the way for staff sharing. As the publication explains, these officials can serve as champions for staff sharing by identifying the areas within local public health agencies that are candidates for staff-sharing arrangements, and by having conversations with their constituents to prepare them for the new arrangements. Elected and appointed officials can also explain the goals of the staff-sharing arrangement to the residents of their jurisdictions, and can correct any myths that may be circulating or misperceptions that constituents may have about what the arrangement entails.[8]

Senior leadership must be able to clearly articulate the purpose of the staff-sharing arrangement and what other options have been considered. They also need to articulate the anticipated outcomes, such as the impacts of the new arrangement on the agency, on the constituents of the involved jurisdictions, on the health of the communities involved, and on the agency's bottom line. At its core, a staff-sharing arrangement is a business decision. As such, it is critical to take the time to build a business case to obtain support for staff sharing. This requires a deep understanding of the underlying anxieties and concerns of multiple stakeholders, identification of program champions, a focus on relationship-building and trust, and transparency in communications. It is through building the business case that senior leadership can build momentum for staff sharing, moving the arrangement from a concept to a reality.

## Lessons Learned

Annmarie Ruiz, the shared health officer, offered the following advice to those considering a staff-sharing arrangement:

- Have open lines of communication with the directors. Since they serve as the links to the elected officials, effective communication and trust building can ensure that all parties remain fully informed.
- Starting with a vacant position, as Gloucester and Salem counties did, facilitates implementation without the related human resources issues that might arise from a reorganization, layoffs, or reassignments.
- From a technology standpoint, if e-mail systems feed into a shared inbox, that might lead to confusion over which jurisdiction is the origin of a given request, particularly if the business or individual involved does not have a clearly identifiable street address in the e-mail signature.
- Discuss the use of designated vehicles, laptop docking ports, VPNs, and other methods of making the rotating work locations less inconvenient.

A fortuitous factor that worked in favor of this particular shared-staffing arrangement was the fact that Ruiz had already worked in Salem County for ten years before she took the position in Gloucester County. A collegial working relationship between the neighboring jurisdictions as well as a positive reputation for effective and fairly administered contractual arrangements served to smooth the way both for starting and maintaining the shared-staffing agreement.

*Based on interviews with Tamarisk Jones, Division of Health Services Director, Gloucester County, and Annmarie Ruiz, Health Officer, Gloucester/Salem County, July 27, 2018; with Annmarie Ruiz on February 22, 2019; and with Rita Shade, Director, Salem County Health & Human Services, on March 11, 2019.*

## Spotlight: Evaluating Success

While most people tend to think about evaluation as something that occurs at the end of a program, the most successful programs are those in which evaluation is considered well before the program begins. Building in an evaluation component, whether formal or informal, enables measurement of the success of the program. When establishing a plan for evaluation, it is important to identify the goals of the evaluation, and to define what constitutes success of the evaluation. Clear goals allow for a better understanding of how much time and what kind of resources (whether staff, monetary, or other) are needed.

Having defined goals makes it possible to select metrics for measuring success. Metrics for success will vary on a case-by-case basis, but can be focused on indicators such as financial measures (e.g., cost savings), efficiency (e.g., decrease in wait time for service), outputs (e.g., number of establishments inspected), outcomes (e.g., increase in patient/client satisfaction), and/or management goals (e.g., enhanced collaboration between local health departments and state health agency). The frequency with which the staff-sharing arrangement is evaluated will depend on the metrics that are utilized. Before implementation, it is important to know whether the defined metrics can be described or established using a common baseline among participating jurisdictions, and followed accordingly. To first begin work on reconciling/aligning different approaches to data collection after implementation is challenging.

One clear benefit to developing an evaluation plan is the opportunity for continuous quality improvement. The more information jurisdictions have about what is going right—and wrong—about the staff-sharing arrangement, the better able they are to make lasting improvements. Evaluation is also cyclical in another sense, as evaluation results can be used as evidence of the business case for the arrangement, and thus help garner continued support from a variety of stakeholders for the staff-sharing arrangement.

# Case Study: Brown County, Nicollet County, Cottonwood County, and Watonwan County, Minnesota

## Introduction

The rural counties of Brown, Nicollet, Cottonwood, and Watonwan, in south central Minnesota,[5] have been sharing the services of the Brown-Nicollet Environmental Health (BNEH) staff since the mid-1990s. At present, BNEH is staffed by three full-time employees: an environmental health director, an environmental health specialist, and an administrative support specialist. In the state of Minnesota, all jurisdictions provide public health services through the oversight of a community health board, or CHB. More than two-thirds of counties are part of a multicounty CHB, while about one-third are served by a single city/county CHB.[6]

In 1990, Brown County and Nicollet County entered into a Joint Powers of Agreement (JPA) to establish a joint community health board. The agreement, signed by Brown and Nicollet counties and the Minnesota Department of Health, gives the CHB the authority to perform public environmental health services at the local level. While Cottonwood County is part of a different joint CHB (Cottonwood-Jackson), Watonwan has its own community health board. Services in Brown, Nicollet, and Cottonwood (Cottonwood-Jackson) are provided through stand-alone public health departments, while Watonwan is part of a combined health and human services agency. Table 3 displays key jurisdiction characteristics for each of the four counties.

## Initial Challenges and Concerns

As described below, the origins of the staff-sharing arrangement were fairly unique, arising out of other collaborative efforts between the counties. As such, some of the challenges that are traditionally associated with the implementation of a public health staff-sharing arrangements (e.g., potential for layoffs, concerns about trust, and communication between the counties) were not of concern. The staff-sharing arrangement builds capacity for licensing, education, and regulation to be done locally, rather than at the state level—licensed establishments and residents of the four counties know who to call, and can get a local response quickly. This arrangement allows the Brown-Nicollet CHB to hire staff and maintain the important environmental health services and programs and staff that other counties may not be able to afford.

One element of the staff-sharing arrangement that can be a challenge is the amount of time spent traveling. While BNEH staff do their best to group together visits for licensing, education, and inspections by geographic location, that is not always possible; travel between counties can take up to one-and-a-half hours, leading to a large chunk of work time being spent in transit.

## Project Implementation

According to Karen Swenson, retired director of Brown-Nicollet Environmental Health, the impetus for the partnership can be traced back to the late 1980s/early 1990s, when Brown County and Nicollet County joined with Cottonwood County to form a Joint Water Quality Board. The Environmental Health staff were contacted by a homeowner in Nicollet County whose infant died. This home had a private well, and it was suspected that the death may have been due to the high level of nitrates in the private well. A township-by-township well-water testing program began to offer free well-water tests for all

**Table 3.** Jurisdiction Background

| | Brown | Nicollet | Cottonwood | Watonwan |
|---|---|---|---|---|
| **Population** | 25,194 | 33,966 | 11,295 | 10,840 |
| **Square Miles** | 611.09 | 448.49 | 638.61 | 434.95 |
| **Population Density** | 42.4 | 73 | 18.3 | 25.8 |
| **Poverty Rate** | 8.0% | 8.8% | 11.3% | 11.2% |
| **Number of FTEs, shared** | 3 | | | |

Source for population, square miles, population density, and poverty rate: U.S. Census Bureau Quick Facts, as of July 1, 2017.

Nicollet County residents, and this effort soon spread to Brown County private well owners.

Finding high levels of nitrates in Nicollet private wells—and concerned that the water safety issues were not limited to Nicollet County—Nicollet and Brown counties worked together to pay for free testing in all townships in both counties annually. Additional studies not only revealed high levels of nitrates in Brown County, but also suggested that some of the problematic drinking water likely came from nearby Cottonwood, leading to collaboration among all three counties to develop a wellhead protection program.

Pleased with the partnership in place for addressing water quality, the Cottonwood County commissioners approached the Brown-Nicollet Community Health Board in 1993 to see if there were other areas for potential collaboration, leading to the sharing of environmental public health services. One year later, as news spread to other counties of the success of the partnership, the Watonwan County Board approached the Brown-Nicollet CHB to set up a similar arrangement for environmental public health services. While the Brown-Nicollet-Cottonwood Joint Water Board dissolved around 2009, the staff-sharing arrangement for environmental public health services has continued, in place for more than 25 years.

Through the Brown-Nicollet Community Health Board's contracts with the Cottonwood and Watonwan County Boards, Brown-Nicollet Environmental Public Health staff perform the following environmental public health services for Cottonwood and Watonwan counties: regulation, licensing, education, and inspection of all food and beverage establishments; lodging establishments, boarding establishments, hotels/motels and resorts; public swimming pools; manufactured home parks, recreational camping areas and youth camps; consultation on other environmental public health issues; and public education regarding environmental public health issues. These services are also provided by BNEH staff for Brown County and Nicollet County as well as additional mitigation of public health nuisances, including the proper cleanup of clandestine drug lab sites.

BNEH is governed by the Brown-Nicollet Community Health Board (CHB), consisting of five county commissioners from Brown County and five county commissioners from Nicollet County. The Brown-Nicollet CHB oversees the activities and services performed by Brown-Nicollet Environmental Public Health staff, and has in place a purchase of services agreement with Nicollet County. This agreement allows BNEH staff to follow all of Nicollet's policies and procedures as well as the Nicollet County pay scale (e.g., the paychecks that the employees receive come from Nicollet, their e-mail addresses are from Nicollet). The BNEH office space utilized is in Nicollet County (with rent for the space paid to Nicollet County), and the staff work with Nicollet County's Office of Technologies to address any issues related to computer software or technology.

Each contract with Cottonwood County and Watonwan County is renewed annually. If either party does not want to renew the contract, they are required to give 60 days' notice. The contracts between Brown-Nicollet and Cottonwood and Watonwan have undergone very few substantive changes since they were first enacted.

## External Stakeholders

In addition to working closely with the Cottonwood and Watonwan county boards, the Brown-Nicollet Environmental Public Health staff work closely with the Minnesota Department of Health. In Minnesota, local environmental public health programs and services are delegated by the state of Minnesota to the local jurisdictions (the state reviews and approves the locals' authority to conduct the program). BNEH follows the requirements of the state. Data and information on outcomes are submitted annually to the Minnesota Department of Health. The state of Minnesota evaluates locally delegated programs every five years. The state environmental health office and local public health agencies work together to measure outcomes and make improvements in the performance of programs and services.

Brown-Nicollet Environmental Health staff pride themselves on their relationship with licensed

establishment owners and staff located in each of the four counties. They put out a quarterly food safety newsletter (TIPS), and go above and beyond in their communications with licensed establishments. For example, through their "Inspection Connection," BNEH provides free trainings for food establishments after inspections on topics such as cross-contamination and employee illness, proper handwashing techniques, or other topics, as requested. These trainings allow BNEH to provide licensed establishments with additional resources, to provide additional education, and to take time building and maintaining important relationships and trust.

## Financial Considerations

Finances are tracked by Leah Cameron, the BNEH administrative support specialist, with separate financial records kept for Cottonwood and Watonwan counties. All budgets from Brown-Nicollet are subdivided into travel, conference, lodging, meals, and staff time. While costs for items that are prepared for all four counties are shared equally (e.g., newsletters, general information sheets), items such as supplies, postage, and printing are prorated for each county. Mileage and certification costs are charged to each county. The four counties are provided with quarterly financial reports that detail what they spent over the previous three months.

Cottonwood and Watonwan are billed for half of their contract costs in January of each year, and for half in June or July (in 2018, total contract costs for Cottonwood were $15,206 and for Watonwan were $14,835). In addition to the fees from administration of services, the contract costs for Cottonwood and Watonwan include an administrative fee. An audit is conducted once a year. The BNEH budget is reviewed and approved annually; if costs associated with either Cottonwood or Watonwan are over budget, there is a need to increase their respective contract rate. For example, both counties' contracts increased by 5 percent this past year due to the amount of time spent performing activities in each county.

## Outcomes

It is clear that all four counties find value in this collaborative approach. First and foremost, the staff-sharing arrangement allows staff to have a pulse on what is going on at the local level, and to respond quickly to local citizens and licensed establishments as well as maintain environmental public health expertise and capacity at the local level. Watonwan and Cottonwood feel that their establishments are getting good service—they are being assisted and are receiving educational support. Individuals and establishments in all four counties know who to call for help, and know that they have someone who can be a direct communicator with the Minnesota Department of Health. The staff-sharing arrangement also helps with consistency among the four counties in regulations and procedures.

Each year, Jesse Harmon, Brown-Nicollet environmental health director, shares an annual report that tracks the performance of the BNEH with the boards of each of the counties. The report includes sections on environmental health program activities (number of inspections broken down by type and county); environmental health complaint response (number of investigations broken down by establishment type and county); environmental health education and community activities (e.g., TIPS newsletters sent, education to licensed establishments, plan reviews by counties); and staff training and development. Independent evaluation is also conducted through risk factor analysis for single foodborne risk factors such as proper handwashing and employee illness exclusion.

In addition to measuring performance with metrics such as number of inspections and complaints, multiple interviewees noted other benefits (in some cases less easily quantifiable). As Karen Moritz, Brown County public health director, explained, the shared staff and experiences can lead to collaboration among the counties in other areas. It is also incredibly valuable to have environmental public health staff who can be shared and cross-trained, and are not only able to do regulatory work, but who are also knowledgeable about new and emerging trends, such as climate change.

There is a still a long way to go in terms of measuring the value of environmental public health programs overall. As retired Environmental Health Director Karen Swenson notes, it is difficult to measure bad things that do not happen due to your programming. Despite this limitation, the general consensus is that the collaboration has been exceedingly successful, allowing the four counties to do more together than any of them could do alone.

## Lessons Learned

When it comes to key takeaways, there are several critical lessons learned from this staff-sharing arrangement:

- Staff-sharing arrangements may arise out of other collaborations between counties, as was the case for Brown, Nicollet, and Cottonwood, who initially partnered to address water quality and then moved to partner on other environmental public health services. Public health agencies may not be able to anticipate what partnerships may form, but a general openness to collaboration can enable new ways of working together.
- Use the resources available to you. There is no need to reinvent the wheel or to start from scratch when it comes to developing the staff-sharing arrangement. Brown-Nicollet Environmental Health staff are in touch with other agencies throughout the state of Minnesota to share recommendations, and help is available at the state level as well. Peers at other local agencies and at the state health agency can be a great resource.
- Interpersonal relationships are as critical as expertise and knowledge to successful staff-sharing arrangements. Having strong levels of trust and a good relationship between the parties involved in the staff-sharing arrangement can have a big impact. In this instance, Brown-Nicollet having such a good relationship with all four county boards has been a tremendous help.
- When it comes to the nuts and bolts of the staff-sharing arrangement, make sure everything is clearly spelled out. This includes roles and responsibilities, expectations for each partner in the agreement, and how communications will take place.
- Being a good steward of the money that you receive goes a long way toward continued support for the agreement, as does hearing from constituents that the programs and services were helpful.

### For More Information

- See "Brown-Nicollet Environmental Health," at https://www.co.nicollet.mn.us/174/Brown-Nicollet-Environmental-Health

*Based on interviews with Jesse Harmon, Brown-Nicollet Environmental Health Director, on February 11, 2019; Leah Cameron, Administrative Support Specialist, Brown-Nicollet Community/Environmental Health, on February 15, 2019; Karen Moritz, Brown County Public Health Director, on February 15, 2019, and Karen Swenson, retired Brown-Nicollet Environmental Health Director, on February 21, 2019.*

# Endnotes

1 The medical examiner position/office is also shared with Camden County. This shared service is overseen by the director of the Gloucester County Department of Health and Human Services.

2 The original shared-services agreement is available at: http://www.gloucestercountynj.gov/civica/filebank/blobdload.asp?BlobID=7457

3 There are 24 municipalities served in Gloucester County, plus 15 served in Salem County.

4 Child and adult vaccination programs and STI treatment were already being provided or ensured provision by the individual county.

5 Cottonwood County is in southwest Minnesota

6 Minnesota Public Health Research to Action Network, *Governance and Local Organization of Local Public Health Services in Minnesota* (St. Paul, MN: Minnesota Public Health Research to Action Network, 2011). Available at: https://www.health.state.mn.us/communities/practice/research/pbrn/docs/1103brief.pdf

7 See ICMA and Center for Sharing Administrative Services, *Sharing Administrative Services across Jurisdictions* (Washington, DC: ICMA, 2014), available at: https://icma.org/sites/default/files/Sharing%20Administrative%20Services%20across%20Jurisdictions%20Full%20Report-1.pdf; Timothy J. Burns and Kathryn G. Yeaton, *Success Factors for Implementing Shared Services in Government* (Washington, DC: IBM Center for The Business of Government, 2008), available at: http://www.businessofgovernment.org/sites/default/files/BurnsYeatonReport.pdf; and Eric Zeemering and Daryl Delabbio, *A County Manager's Guide to Shared Services in Local Government* (Washington, DC: IBM Center for the Business of Government, 2013), available at: https://www.naco.org/sites/default/files/event_attachments/Additional%20Service%20Sharing%20Resources.pdf

8 Zeemering and Delabbio, *A County Manager's Guide to Shared Services in Local Government*.

# Case Studies in Staff Sharing in Local Public Health

## About the Center for State and Local Government Excellence

The Center for State and Local Government Excellence (SLGE) helps local and state governments become knowledgeable and competitive employers so they can attract and retain a talented and committed workforce. SLGE identifies leading practices and conducts research on public retirement plans, health and wellness benefits, workforce demographics and skill set needs, and labor force development. SLGE brings state and local leaders together with respected researchers. Access all SLGE publications and sign up for its newsletter at slge.org and follow @4govtexcellence on Twitter.

## About the Center for Sharing Public Health Services

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.

CENTER FOR STATE & LOCAL GOVERNMENT EXCELLENCE

Center for Sharing Public Health Services

*Rethinking Boundaries for Better Health*