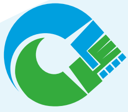

Center for Sharing Public Health Services

Rethinking Boundaries for Better Health

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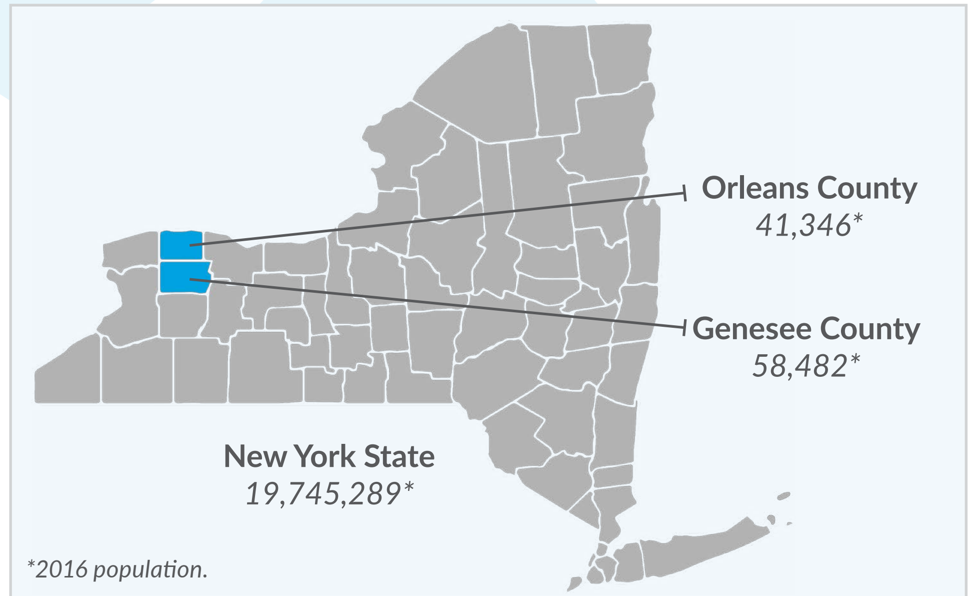
CJS Case Report

Genesee and Orleans Counties in New York

Background

Genesee and Orleans Counties are located in western New York, a very rural part of the state. The counties successfully worked together for a number of years, sharing services between various local government agencies. The county managers in both counties—long-standing colleagues—realized in 2011 that their respective public health department operations were no longer sustainable as structured. The managers both needed a way to achieve cost efficiencies and to maintain, if not enhance, their respective public health capacities. Newly passed legislation at that time permitted health departments to share a public health director, and the county managers, together with the public health director, conceived of the idea to pursue both a shared director and deputy director.

After the public health director led about a year of assessment activities and consensus building, their respective boards of health agreed to pilot test a shared public health director and deputy health director for two years. The letter of agreement, signed in 2012, was written in a flexible manner intended to permit future integration for both management and staff positions, as both boards agreed to consider additional sharing as opportunities arose.



The partnership has resulted in increased public health efficiency and effectiveness.

- Personnel costs for both counties are reduced because they share a management team and other staff.
- The quality of services is enhanced as staff expertise from both counties is applied to updated, standardized policies and procedures for all programs.

The health departments received a grant from the Center for Sharing Public Health Services in 2013 to support the pilot test and any other CJS-related activities that emerged during the grant period. When the grant began, the health departments had implemented the agreement with a shared director and deputy director. Over the next year, the shared leadership team model had expanded to also include a single patient services director and an emergency preparedness coordinator. Grant activities focused on establishing policies and procedures to assure efficient and effective operations under the new model.

Efforts During the Grant Period

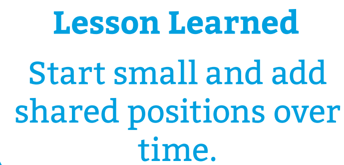
Major Activities and Accomplishments:

One of the first actions requested by the newly shared health director was to undertake a comprehensive review and revision of policies and procedures for both departments. The leadership team members unanimously supported this effort; they viewed this activity as an improvement that would serve both departments well, whether or not the shared leadership team model expanded and/or continued. The public health director also procured joint contracts for medical consultation, environmental engineering consultation, and preschool program transportation. For the first time, a common community health assessment survey was launched, providing a platform for joint community health improvement activities.

Over the course of the project period, union negotiations and policy changes enabled the sharing of existing staff across the counties, and several new, shared staff (at the management level) were hired. On the communications front, the public health director made a concerted effort to communicate with staff, board of health members, and county legislators to keep them apprised of the progress being made. In an unplanned and unforeseen development, the governance structure for each county health department began to evolve. New York state law requires each county to have its own board of health, but does not prevent the boards from meeting simultaneously. The counties pursued a structure in which each county has its own board, and because each board comprises the same individuals, the counties essentially created a common board.

As requested, the health department director filed quarterly updates with the state health department during the grant period in order to keep them informed of how the implementation of the new shared leadership team model was progressing. Although New York state law currently prohibits the creation of a two-county health district, the state health department is very interested in learning how the shared leadership team model works and further evolves, particularly as the boards of health pursue integration to the degree that it is permitted and is mutually acceptable to the counties.

Toward the end of the grant period, the team quantified the benefits of moving to a model with shared management and staff, estimating upwards of $428,000 in "enhanced benefits" during the first year. They use the term "enhanced benefits" instead of cost savings, as not all benefits involve spending less money. A summary of the enhanced benefits follows:



Lesson Learned

Start small and add shared positions over time.

- Both counties now pay less for a health director (and his travel costs) as well as the director of patient services.
- Genesee County now pays only half as much for its environmental health director (Orleans County did not previously have an environmental health director).
- Orleans County now pays less for medical and environmental engineering consultants, in addition to transportation, due to joining Genesee County's contract for these services.
- A free intern from the Centers for Disease Control and Prevention provided a year's worth of research and analysis activities to both health departments. Previous efforts to secure an intern were unsuccessful, and it's believed that the combined, larger population served made Genesee and Orleans Counties more attractive as a practice site.

Additional cost savings have been realized as well, but have not been quantified, e.g., reduced staff time when one staff represents both health departments at local, regional or state meetings; reduced administrative costs associated with contract staff (vs. hired employees); and savings achieved through process and policy improvements (e.g., reducing the number of

sewage inspections completed each year, based on a more thorough understanding of state requirements).

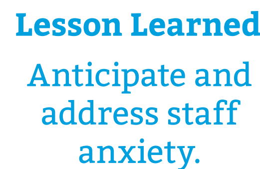
The staffing pattern has been enhanced as a result of this arrangement. Both health departments now have executive level leadership in all major program areas, in addition to an emergency preparedness coordinator. Sharing staff as needed has enabled each health department to fill in gaps due to staff absences and also positions staff to provide surge capacity if needed. In addition, shared environmental health staff has resulted in sharing competencies and special expertise along county lines. This sharing has helped expand the breadth of knowledge without needing to invest in training and keeping certifications.

The common community health assessment that was conducted will provide a foundation for joint community health improvement efforts. This will be particularly helpful when collaborating with partners in the community that serve both counties. In addition, the health departments now work as a single unit with all health care providers in the area, including the two health systems.

The two-year pilot test concluded at the end of the grant period. At that point, an agreement was signed to continue this arrangement—and its expansion, as opportunities arise—for the next five years (though 2020).

Challenges

For a long time, the main challenge in this effort was the anxiety expressed by existing staff members. Staff were concerned that a position in one department would be eliminated in order to create a shared position for both departments. As envisioned, and to date, positions shared by the health departments have been created only when an opportunity presents itself (e.g., through retirement, resignation and new funding opportunities) and when it is mutually beneficial to have a shared position. Staff concerns have lessened over time as they have seen how the approach and the new model have worked. The public health director continues to reinforce that the plan for pursuing further integration of staff will be the same moving forward.



Genesee and Orleans Counties—Two Years Later

Context

Since the grant period ended, the state's governor instituted a two percent cap on local government tax increases, and also provided incentives for local governments to generate more efficiencies and effectiveness in all services. While these actions did not affect the Genesee and Orleans Counties' CJS arrangement, they changed the landscape for local government in general.

Regarding governance, six new legislators have been elected during this time, and all are fully supportive of the CJS arrangement. In addition, a common board of health that serves both counties was formally established. The members are appointed by the county legislators of each county, and the size of the membership went from seven members from each county to seven members total. The transition was fairly smooth, as several of the board members volunteered to give up their seats. Board meetings are now held bi-monthly (previously both boards met monthly), with robust agendas and nearly 100 percent attendance at all meetings. This level of attendance marks an accomplishment in itself, as in the past it was often difficult in both counties to have quorums.

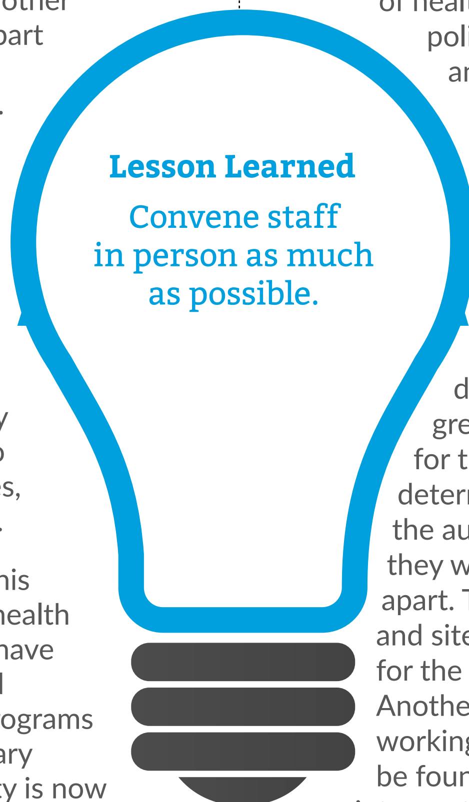
Activities and Accomplishments

A strategic planning process was undertaken in 2015 to develop an integrated, shared strategic plan. The motivation was partly due to an interest in pursuing health department accreditation. The health departments hope to jointly achieve accreditation by 2019, and work is well underway to this end. In addition to a quality improvement council and workforce development efforts, a joint community health improvement planning process with the two local hospitals also has begun.

The strategic plan also served to promote staff collaboration by

establishing a joint vision, mission and values to help align the health departments' culture and philosophies. The health director convenes a monthly staff meeting in each health department, and an annual in-person meeting with all employees from both health departments once a year. In addition, each division has its own routine meetings with staff across the two counties. The leadership team also created peer teams to encourage collaboration across health departments. The teams comprise staff working on similar job functions and are intended to facilitate calls for assistance, guidance and support. The peer management teams organically developed and strengthened, each with its own group personality and varying degrees of cohesiveness. The second annual, in-person staff meeting in 2017 was remarkable, as this was the first time that staff sat in groups of peer teams, and not in groups by health department as had been the case to date.

In 2015, the health director hired the first non-management employee shared between the two health departments—a service coordinator for the early intervention program. The shared position made great sense as each county only needed a half-time coordinator. The health director continues to develop more shared positions only as opportunities arise. The philosophy is to first consider an integrated position when a vacancy occurs or a new funding opportunity emerges, and to proceed accordingly only if a shared position makes sense. When it does make sense, the shared employee is hired by the county where the vacancy occurred, with the other county paying for part of the employee's time via a contract. Both counties also have established intermunicipal funds to be used as needed to reimburse for staff who work across county lines to temporarily fill positions due to absences, vacancies, surge capacity, etc.



After working on this for five years, the health departments now have shared policies and processes for all programs and the local sanitary code in each county is now identical. Also, internships are shared across counties. This approach offers interns a more robust experience and provides support for both individual-county and cross-county approaches. Interns typically are placed in one location as their "host" site—primarily for supervisory reasons—and if possible, the host site is the location that gives the intern the best commute.

The health departments also developed a branding strategy and a new logo for use in some of the joint efforts. They also coordinate their public health education efforts and community messaging.

The health director no longer provides quarterly updates to the state, but they work closely together as the need arises. For example, the director worked with the state to consolidate the state review process. The state conducts routine, onsite audits of health department policies, procedures and other items. Because the health departments share all of the items that are audited, two audit processes and site visits would be unnecessarily duplicative. The greatest challenge for the state was determining how to align the audit schedules, as they were 18 months apart. The first joint audit and site visit is scheduled for the Spring of 2018. Another example of working with the state can be found with the early intervention program. The program staff felt that the Genesee and Orleans Counties' staffing arrangement was not in keeping with the state regulations, so the director worked with his contacts at the state health department to intervene and the situation was resolved.

On the fiscal front, a report covering the period when the shared directorship began (October 1, 2012) through December 31, 2015 analyzed the return on investment, benefits/savings and qualitative impacts of the sharing initiative. Approximately $1.2 million in enhanced benefits/savings was realized during this time.

Looking ahead, both counties' administrators and legislators continue to share a mindset that they can do more and better together to improve their

jurisdiction's health. The health departments are more competitive candidates for grant funding now that they jointly serve a larger jurisdiction and it is anticipated that more grants will be awarded as a result. The director and staff continue to work towards PHAB accreditation, something made more possible as a result of the partially integrated model. Finally, additional shared positions will be considered as new opportunities arise.

Challenges

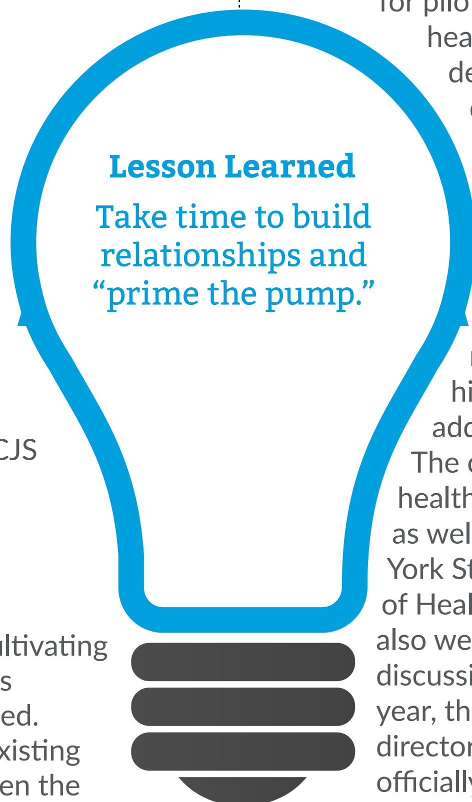
The greatest challenge to date continues to be a lack of synchronized information technology (IT) systems. The two counties' IT departments have different approaches, cultures, trust issues, firewalls and data. "Opening" the systems to make system-level adjustments would create too much risk. Therefore, staff have developed a number of workarounds to address this issue. Even so, shared staff still need to keep two updated calendars, monitor two email accounts and deal with many duplicative emails. Collectively, these difficulties affect only five of approximately 700 employees (both counties combined) so addressing this IT situation in either county is not a priority. Furthermore, the state programs also necessitate additional steps for staff when they sit in the other county's office to do their work. Because this situation only involves two of the state's 58 health departments, resolving state-level IT issues isn't a priority either, and staff have developed many workarounds in response.

Perspectives From the Health Director

Paul Pettit has been the health director since the discussions regarding a CJS model first began. He shared the following insights regarding the Genesee and Orleans Counties CJS experience.

Exploring

The importance of establishing and cultivating strong relationships cannot be overstated. Pettit credits the existing relationship between the county managers—as well as the relationship he developed with each of them when he became the Orleans County Health Director—with providing the foundation that was essential to moving forward.



For about a year, Pettit conducted research and developed a case for pilot testing a shared health director and deputy health director. During this time, Pettit and the county managers frequently discussed the idea, gradually moving from high-level issues to addressing specifics. The counties' boards of health and legislatures, as well as the New York State Department of Health (NYSDOH), also were engaged in discussions. After about a year, the plan for a shared director and deputy was officially brought to the boards of health, county legislature and NYSDOH for approvals. Taking time to lay this groundwork and then progressing into greater levels of detail was another strategy that worked well.

Planning and Preparing

Several aspects of the letter of agreement that permitted the shared staff model were key to the initial successes of this effort. First, the sharing began with a two-year pilot test. Although the fiscal savings and program enhancements looked quite promising, all of the decision-makers acknowledged that it would be important to carefully evaluate whether these improvements were achieved before making a long-term commitment to the model.

In addition, the personnel changes were minimal. The pilot test involved only two existing staff, so if the model did not work it would have been easy to revert to having one director per department.

Finally, the financial aspect of the agreement was very simple. The cost of the two shared positions would be split 50/50, even though the combined population was split at about 60/40. Orleans County, the smaller of the two, anticipated immediate and significant cost savings through this model and decided that the overall benefits outweighed the time and effort it would take to pro-rate all of the expenses according to the percent of the population served. This approach made the sharing model much easier for each county's fiscal office.

Implementation and Monitoring

Generally speaking, the implementation of a shared director and deputy director went quite smoothly. After the two-year pilot project, as more staff members were shared between the two departments and significant structural and operational changes began to occur, implementation became more difficult.

Many staff were anxious during the pilot and beyond about potentially losing their jobs. This occurred despite Pettit's continued assertions that shared positions would be established only as a result of vacancies and not by consolidating currently filled positions. Although ongoing communication and complete transparency regarding staffing changes were central to managing the changes, Pettit noted that it took time for staff anxiety to lessen. Staff relaxed and were more trusting once they had seen that changes occurred only as Pettit had promised.

Finally, bringing staff together in person as much as possible helped a great deal. The more exposure to each other they experienced, the more cross-county teamwork occurred. Pettit recommended slowly nudging cross-county staff teams forward.

Sustainability

According to Pettit, the fiscal and programmatic success of the shared staffing model, coupled with the fiscal pressures faced by both counties, make it "extremely challenging both programmatically and fiscally" to go back to a model where the two counties do not share any staff. Although this could possibly happen if there is a major turnover with decision-makers, a changed political environment, a new county manager or some other change, it's quite unlikely.

Looking into the future, Pettit notes that their model is and will continue to be fluid. All new program opportunities and all new staff vacancies are evaluated through a cross-jurisdictional sharing lens and the staffing structure, therefore, will continue to evolve over time.

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. *Copyright© Center for Sharing Public Health Services, 2017. Materials may be reprinted with written permission.*

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