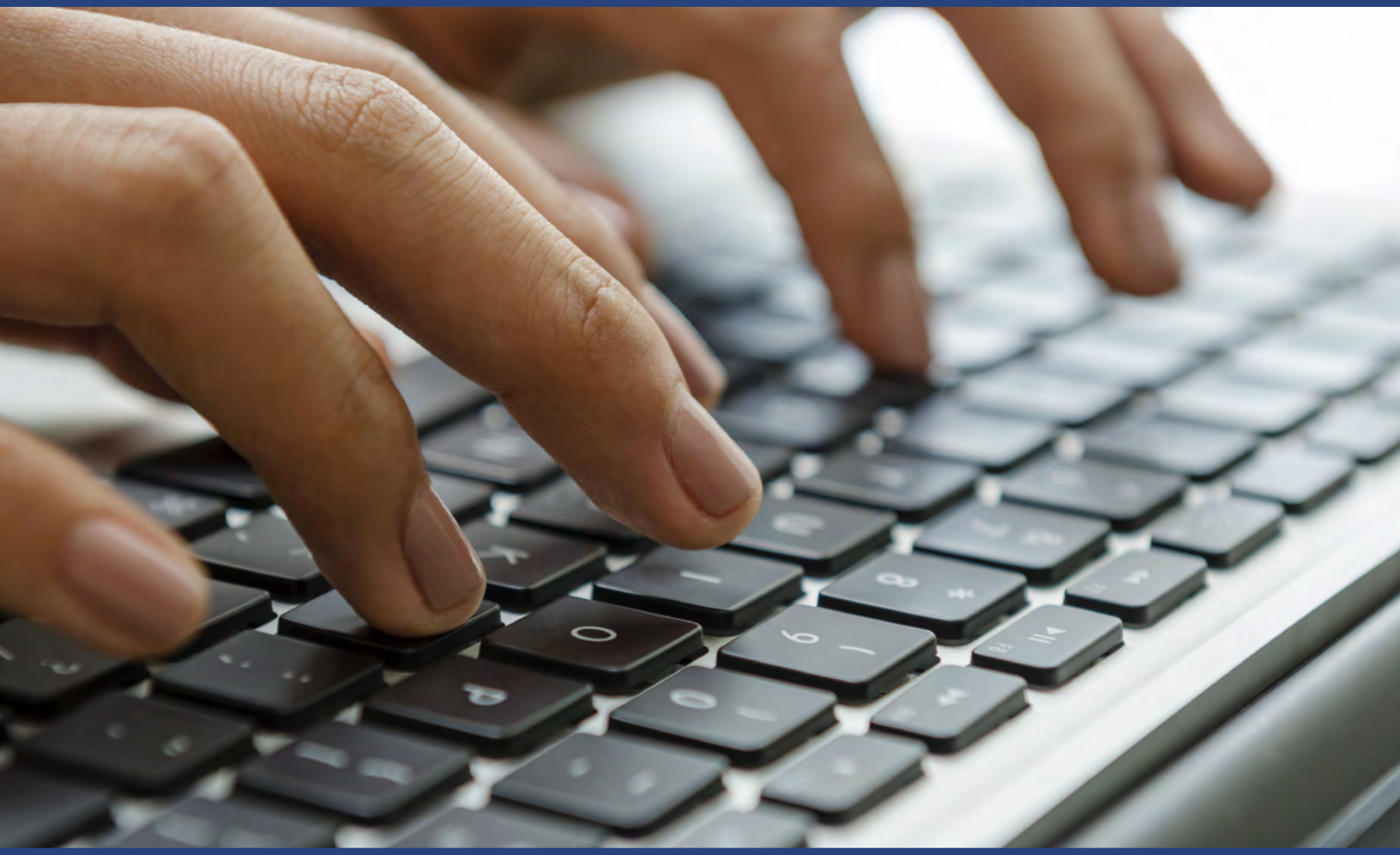
Sharing Administrative Services across Jurisdictions

For more ***efficient*** and ***effective*** public health systems



ICMA | Center for Sharing Public Health Services

Rethinking Boundaries for Better Health

In spring 2014, the International City/County Management Association (ICMA), in collaboration with the Center for Sharing Public Health Services (CSPHS) at the Kansas Health Institute (KHI), conducted a national survey of local governments to study the use of shared administrative service agreements across local health department jurisdictions. This report describes the results of that survey, which were then used to guide the selection of three sites for further examination.

In July and August of 2014, ICMA researchers conducted in-depth interviews with a total of 30 people from the case study sites. These individuals—policy makers, local government executives, and public health professionals—represented diverse interests and perspectives. Guided by a defined protocol, the researchers used a conversational interviewing technique to fully explore the participants' experiences and perceptions. Several of these interviews were tape recorded and later reviewed for the compilation of this report. The researchers sought written permission prior to attributing any quotes to an individual or organization.

Acknowledgments

We are especially grateful to Dr. Gianfranco Pezzino and Mr. Patrick Libbey, codirectors of CSPHS, for their oversight, guidance, and direction in the development of this report.

We also want to thank all the participants who contributed their time to meet with us for face-to-face interviews. Their names are included in each of the case studies found in the appendix of this report. Their experiences and insights were invaluable in helping us determine what makes shared administrative service agreements work.

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CHAPTER 1
Introduction

Local public health departments have a critical mission to prevent disease and promote health in their communities. However, many public health issues don't stop at the city limits or the county line. Addressing public health issues often requires collaboration and a regional approach to problem solving. It is this characteristic of such issues that makes local public health departments good candidates for cross-jurisdictional sharing (CJS) initiatives.

CJS can take on many forms. It may be informal, such as two or more local departments joining together to purchase supplies to get a better price, or it may be more formal, with contracts or other written agreements developed to define each party's terms and responsibilities, such as hiring a staff member for a shared position between two organizations. Whatever form it takes, CJS enables governments to work in a cooperative fashion to resolve problems while meeting the public health needs of the general population.

This report is the result of a national study of how local governments are sharing the administrative services, such as billing, information technology, purchasing, and finance and accounting, required to run their public health departments. With support from the Center for Sharing Public Health Services (CSPHS) at the Kansas Health Institute, the International City/County Management Association (ICMA) conducted the first National Survey of Public Health Shared Administrative Services to learn more about this relatively new practice among public health departments. ICMA also conducted three case studies to examine in greater depth how such collaborations have worked in select jurisdictions, and to identify what specific elements make such agreements successful and can be replicated elsewhere.

The findings from this study have clear implications for local public health departments and how they do business. But CJS is not limited to the field of public health. The opportunity to implement CJS initiatives exists across a wide range of local government services. In an era of continued fiscal constraints under which so many local governments are operating, these lessons point to possible long-term solutions for more efficient and effective local government systems.

CHAPTER 2

Previous Research Findings

In response to rising costs, diminishing resources, and a desire to expand services to meet current national public health needs as well as federal and state mandates, many local governments have experimented with shared services as one strategy for maintaining or expanding service levels while lowering operational costs. The concept of shared services holds that not every jurisdiction needs to administer every program or service in-house. By pooling resources, jurisdictions can often save costs and increase efficiency in delivering services to citizens.

While the decision to share services may seem like a natural solution, complex political relationships between and among jurisdictions can make the decision complicated. Governance, organizational structure, service levels, and budgets are just a few of the many areas that may need to be negotiated before an agreement can be reached.

Within the field of public health, cross-jurisdictional sharing (CJS) among local health departments (LHDs) has gained a foothold. Researchers have sought to better understand the universe of CJS practices and identify what practices can and cannot be replicated in order to achieve the desired ends. In this chapter, we highlight some of the key research findings that practitioners should be aware of when considering CJS for administrative services.

The Universe of Public Health CJS Practices

The field of public health care is highly complex. Federal and state mandates have resulted in a wide range of organizational structures for service delivery across the United States, with each structure adapted to the laws and regulations governing its operations. Glen Mays and colleagues identify seven distinct configurations for public health delivery systems, elements of which are variable and often migrate among configurations over time:[1]

1. Concentrated comprehensive systems
2. Distributed comprehensive systems
3. Independent comprehensive systems
4. Concentrated conventional systems
5. Distributed conventional systems
6. Concentrated limited systems
7. Distributed limited systems.

The shifting taxonomy among these systems complicates the study of CJS because the environmental conditions that would encourage the use of CJS in one region of the country may not exist in another region. Capturing the lessons learned and the conditions needed to encourage and support public health CJS appears to be a critical concern for the field.

Despite this complexity and the corresponding structures that makes comparative study difficult, Joshua Vest and Gulzar Shah found in 2010 that about half of all LHDs engage in some form of resource sharing.[2] The extent of sharing is lower for those departments serving larger populations or larger geographic areas. Sharing is more extensive for state-governed LHDs, those covering multiple jurisdictions, those in states with centralized governance, and in those regions with financial constraints.

What Works

The research community has begun to examine what common elements encourage public health CJS. In 2008, Timothy Burns and Kathryn Yeaton studied the factors needed for successful implementation of shared services in government.[3] Their report defines five key factors:

1. Strong project management skills
2. Senior-level support
3. Effective communication
4. Strong change management
5. A phased approach to implementation.

In 2011, Bruce Miyahara and Patrick Libbey conducted an environmental scan of jurisdictions that had adopted CJS for public health and found the following barriers to establishing CJS:[4]

1. The gap between elected officials and public health leaders in understanding population health
2. Differences in understanding and operationalizing cross-jurisdictional partnerships within the public health community

3. Lack of a common language
4. The many different ways in which CJS and regionalization are being implemented
5. Perception that regionalization itself does not necessarily result in improved public health capacity or performance.

The authors also identified the following conditions needed for successful CJS:

1. Clarity of purpose
2. Incentives
3. Willingness of public health leaders and elected policy makers
4. Attention to environment, culture, and history
5. Stakeholders to have an actual role in governance.

Justeen Hyde provides an overview of the range of shared service agreements, from informal and customary arrangements to full-scale regionalization. She also addresses governance plans, change management plans and strategies, the change cycle, and expected challenges.[5]

By examining how institutional, financial, and community characteristics of local public health delivery systems have influenced the performance of essential services, Mays and other colleagues found that performance varies significantly with the size, financial resources, and organizational structure of local public health systems, with some public health services appearing more sensitive to these characteristics than others.[6] Staffing levels and community characteristics also appear to be related to the performance of selected services. The authors note that reconfiguring the organization and financing of public health systems in some communities—such as through consolidation and enhanced intergovernmental coordination—may hold promise for improving the performance of essential services.

Case Studies

Several case studies on the practice of sharing services provide considerable qualitative detail on site-specific CJS arrangements.

In 2008, Michael Stoto and Lindsey Morse sought to understand how regional structures for preparedness in the Washington, D.C., metropolitan area have been organized, implemented, and governed, as well as to assess the likely impact of such structures on public health preparedness and public health systems more generally.[7] Their study found that no single formal regional structure for the public health system existed in the area and that the vast majority of preparedness, planning, and response activities were the result of voluntary self-organization through governmental and nongovernmental organizations. Some interviewees felt that this is an optimal arrangement in that personal relationships prove crucial in responding to a public health emergency and an informal response is often more timely than a formal response.

In Ohio, the prospect of sustaining 125 LHDs led the Association of Ohio Health Commissioners (AOHC) to establish the Public Health Futures Project in 2011 to explore new ways to structure and fund local public health. The project has guided AOHC members through a critical look at the current status of local public health and a careful examination of cross-jurisdictional shared services and consolidation as potential strategies for improving efficiency and quality. Among the project findings on the current structure and governance of LHDs in Ohio are the following:

- Public health is governed and administered at the local level. The system is decentralized, resulting in significant variability across LHDs in terms of population size served, per-capita expenditures, and capacity.
- Ohio law allows for three different types of health districts: city, general, and combined. Currently, about three-quarters of Ohio LHDs (71%) are "general" or "combined" districts that encompass all or part of a county. The remaining 29% each serve a single city. Ohio does not currently have any LHDs that encompass two or more counties.
- Three-quarters of Ohio counties have only one LHD, while the remaining quarter have up to five LHDs operating within their borders.
- Ohio is home to many LHDs that serve small populations. More than half of its LHDs serve fewer than 50,000 residents.[8]

In 2012, John Hoornbeek and colleagues examined the strategic, operational, cultural, and communications challenges associated with a merger of three health departments in Ohio. While not examining a shared services agreement among the independent jurisdictions, their study does reflect a change management scenario in which different cultures must learn how to operate under a new set of operational principles. It also takes a preliminary look at impacts of the merger on service delivery.[9]

Summary of Findings

Given the fiscal constraints under which local governments operate, coupled with the increasing pressure to provide new services or enhance existing ones, there is a need to explore new ways of operating more efficiently and effectively. While CJS appears to be a growing trend in the field of public health, little literature exists on the value of such sharing for administrative services among LHDs. The literature that does exist reveals the need for a greater understanding of the roles that governance, organizational structure, and operational capacity play in supporting successful CJS arrangements for public health administrative services. And to ensure that such ventures can be sustained over time, further research is needed to determine what factors can be replicated in LHDs across the country.

CHAPTER 3

National Survey on Public Health Shared Administrative Services

As noted previously, ICMA received funding from the Center for Sharing Public Health Services to conduct a survey on the use of shared administrative services by public health departments. For the purposes of the survey, "administrative services" refers to back-office operations, such as billing, information technology, purchasing, and finance and accounting, required to run an organization. Program-related work and services for residents were not explored in this survey.

Survey Methodology

The survey was mailed to 4,716 city-type and county governments in states where the researchers knew or suspected that local governments had some responsibility for public health services. The list was prepared first using *State Public Health Agency Classification: Understanding the Relationship between State and Local Public Health,* the 2012 report of the Association of State and Territorial Health Officials and NORC (formerly, the National Opinion Research Center) at the University of Chicago.[10] The report identifies those states where the local public health agencies are either all or mostly locally governed and accountable entities. The initial list was then refined to describe the predominant jurisdictional basis (county, city/town, multijurisdictional, mixed) for local public health in those states. This refinement was informed by Pat Libbey's professional knowledge developed over six years of experience as executive director of the National Association of County and City Health Officials. The survey was addressed to the city or county administrator, who was asked to forward the survey to a more knowledgeable person within his or her jurisdiction, if necessary.

The response rate is 24%, with 1,119 local governments responding. Response rates are lowest in local governments with populations over 1 million (3%) and in the East South-Central geographic division (9%). No findings by population group or geographic region are shown in the tables and figures that follow.

Please note that the terms *department* and *agency* were used interchangeably throughout this survey.

Does your local government have any responsibility for providing public health services? (N = 1,119)

- Yes = 48% (n = 535)
- No = 52% (n = 584)

The majority of local governments under 10,000 in population, as well as a majority of local governments in both the North Central and South geographic regions, reported that they do not have responsibility for providing public health services. On the other hand, 70% of local governments in the Northeast and 83% in the West reported that they do have responsibility for providing public health services.

If "yes," please identify how public health services are provided to your residents. *(Check all applicable.)* (N = 535)

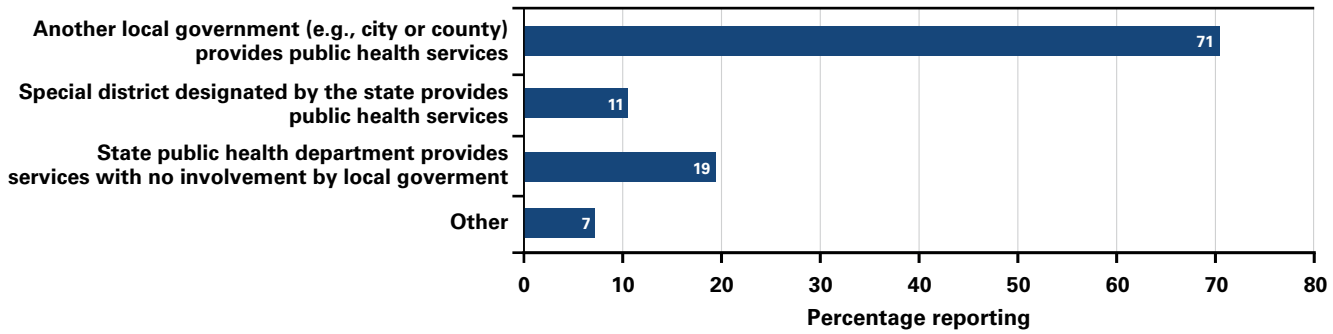
All 14 local governments with a population of 500,000 and above that responded to the survey and have responsibility for providing public health services reported that their public health departments provide the services. Several of them reported contracting with another entity as well, and one reported that the state public health department operates locally with involvement of local government staff. Forty-one percent (7) of local governments under 2,500 in population reported contracting with another local government or nongovernmental entity to provide public health services.

Regional public health services are reported by higher percentages of smaller local governments, especially in the Northeast.

If "no," your local government does not have responsibility for providing public health services, please identify how they are provided to your residents. *(Check all applicable.)* (N = 568)

The South and West geographic regions show the highest percentages reporting that the state public health department provides services with no involvement by local government. The Northeast and North Central regions show the highest percentages reporting that another local government provides the service.

Figure 1. How public health services are provided by those that do not have responsibility for providing public health services



Local governments that do not have responsibility for providing public health services did not need to complete the rest of the survey. The number of local governments that have some responsibility is 535.

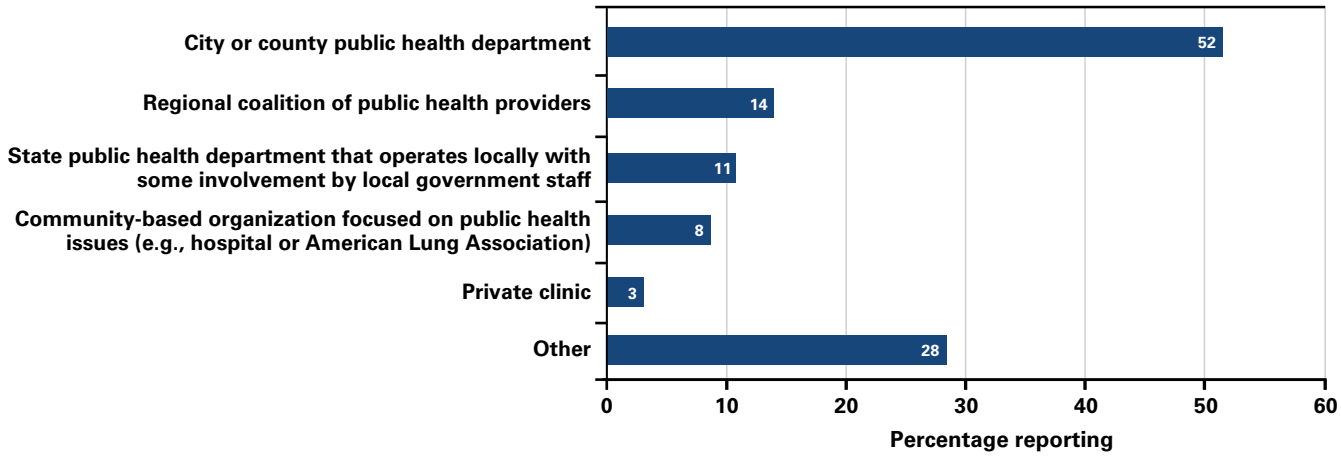
Does your local government public health agency share administrative functions (e.g., back office) with another governmental or nongovernmental entity? (N = 501)

- Yes = 36% (n = 182)
- No = 64% (n = 319)

The highest percentages reporting shared back-office functions are for jurisdictions below 25,000 in population and those in the Northeast region.

If "yes," please identify with which type of organization you share administrative services. *(Check all applicable.)* (N = 160)

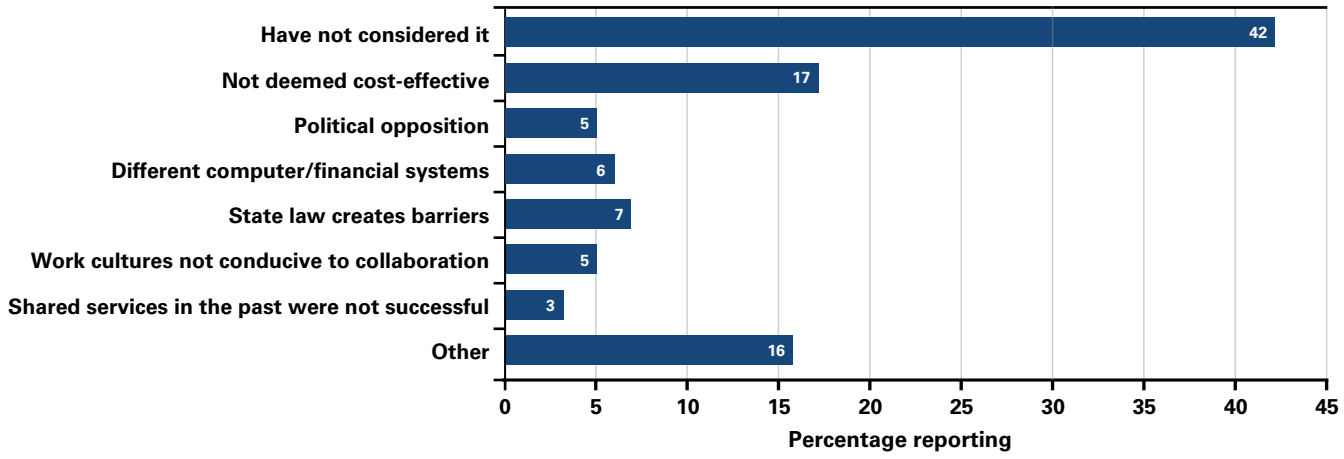
Figure 2. Type of organization with which local government shares administrative service



Under "other," some local governments wrote in other departments in their local government, such as human services and transportation.

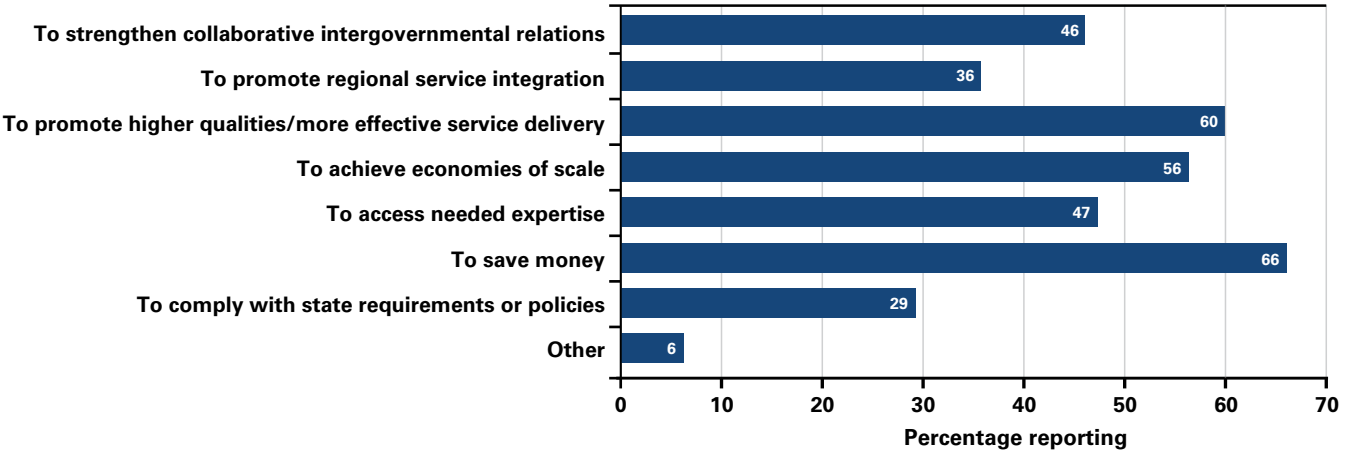
If "no," your local government does not share administrative services, which reason below best describes the reason? *(Select only one.)* (N = 295)

Figure 3. Reason for not sharing administrative services



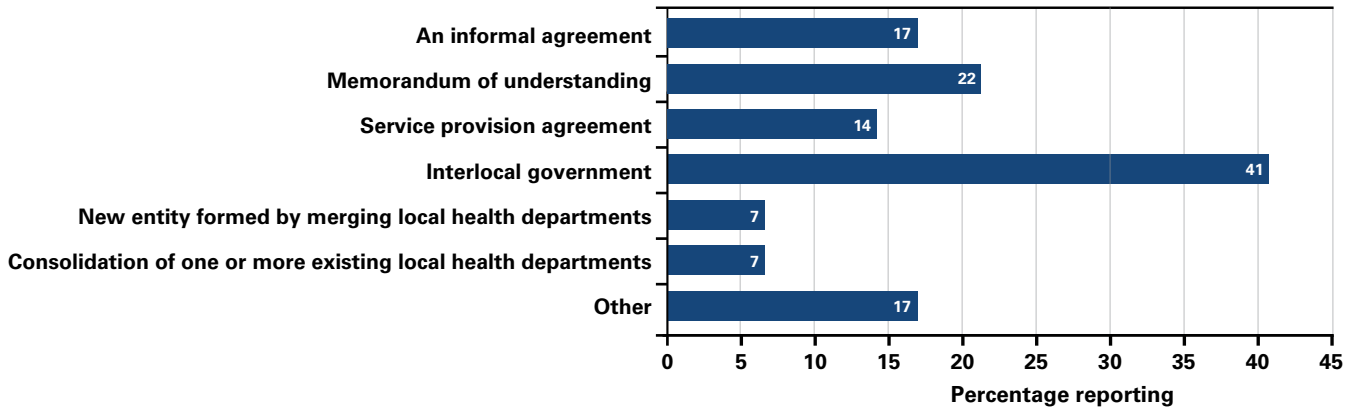
If your local government shares administrative services with another local government or nongovernmental entity, please identify the motivation for doing so. (N = 154)

Figure 4. Motivation for sharing administrative services



What is your organizational arrangement for sharing public health administrative services? *(Check all applicable.)* (N = 170)

Figure 5. Organizational arrangement



In what year did your local government begin sharing public health administrative services? (N = 111)

The responses range from 1950 to 2014. The median year is 2000; the mode—the year reported most often—is 2012.

How many formal agreements do you have for shared public health administrative services? (N = 122)

The responses range from 1 to 20, with an average of 2.

For the FIRST agreement for shared administrative services that your local government undertook, approximately what length of time did it take to move from the idea of sharing administrative services to actual implementation of shared services? *(Select only one.)* (N = 125)

Length of time	Percentage reporting
Fewer than 3 months	28
4–6 months	12
6–12 months	38
More than 12 months	22

What processes were used to negotiate the terms of the arrangement for shared administrative services? *(Check all applicable.)* (N = 143)

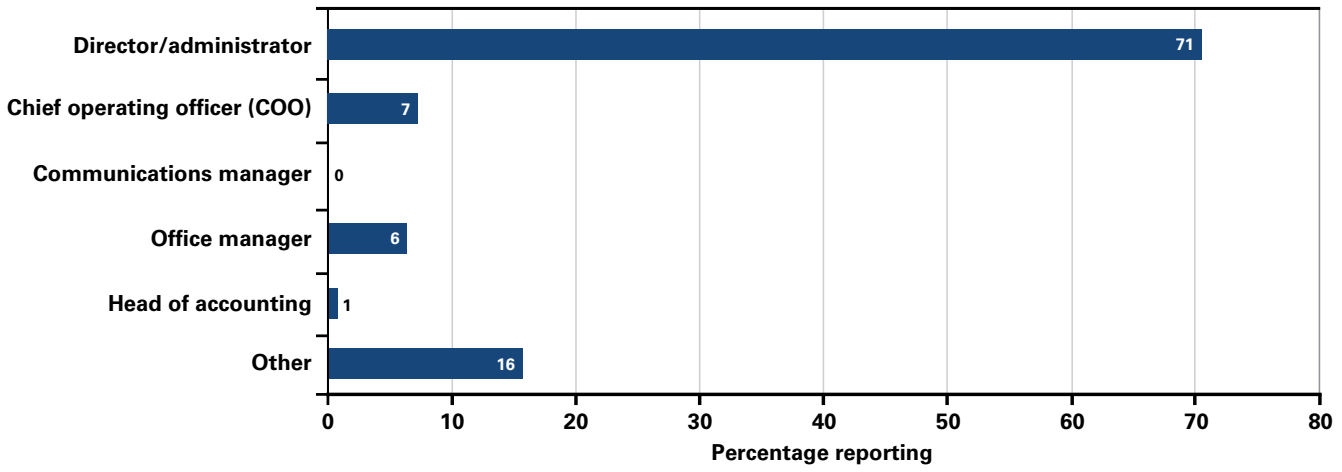
Processes	Percentage reporting
Meetings among local government staff	55
Meetings among elected officials and other policy makers	46
Secured through a request for information/proposals	6
Contract negotiations for fee-for-service or other service arrangement	19
State-mandated framework	15
Other	8

Which of the following administrative services do you share with another entity? *(Check all applicable.)* (N = 150)

Services	Percentage reporting
Executive leadership	46
Fund raising and grant writing	29
Finance and accounting	44
Information technology support	33
Human resources	35
Office and facility maintenance	35
Purchasing	37
Communications and outreach	43
Billing	25
Other	22

Which position within your local government public health organization has responsibility for oversight of the shared administrative services? *(Select only one.)* (N = 163)

Figure 6. Who has oversight of shared administrative services?



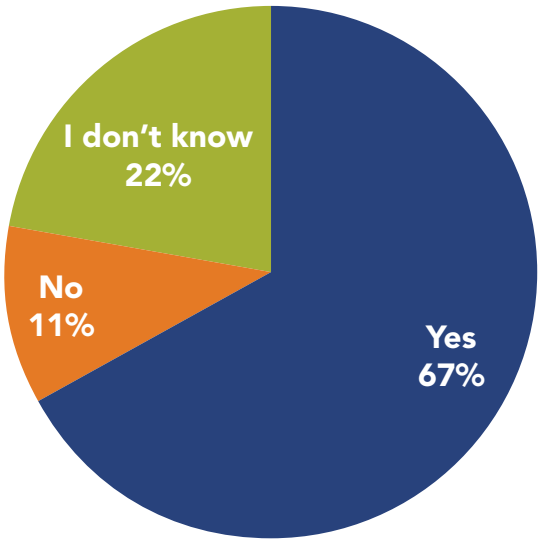
What obstacles, if any, has your local government encountered to sharing administrative services for public health? *(Check all applicable.)* (N = 155)

The majority of responding local governments with a population under 50,000 reported no obstacles. Among obstacles reported, restrictive labor contracts were cited by a higher percentage of local governments in the Northeast (14%) than in other regions, while legal restraints were cited by a higher percentage in the West (10%). The West also showed the highest percentages reporting institutional rigidities (15%), lack of precedent (15%), and incompatible organizational cultures (15%). The West and Northeast regions show the highest percentages (35% and 33%, respectively) reporting concerns about decision authority/control.

Obstacle	Percentage reporting
None	57
Concerns about decision authority/control	2
Concerns about potential costs	18
Opposition from elected officials or other policy makers	8
Opposition from local health director	5
Opposition from the public	2
Organizational cultures incompatible	10
Restrictive labor contracts/agreements	7
Legal constraints	6
Lack of precedent	8
Institutional rigidities	8
Other	7

Has your public health service been able to realize new efficiencies as a result of the shared administrative services arrangements? (N = 161)

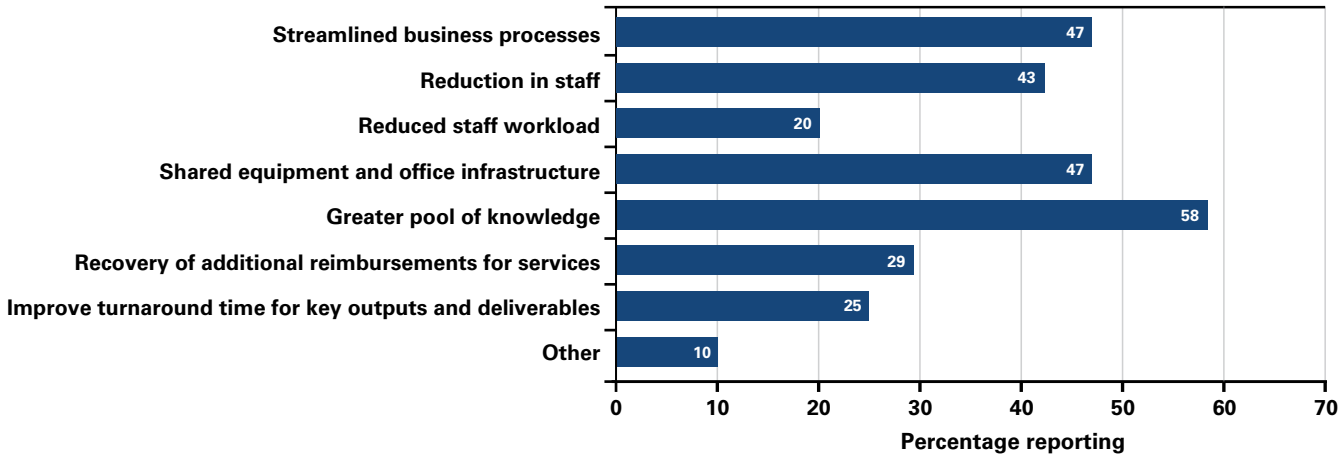
Figure 7. Efficiencies realized as a result of shared administrative services



If "yes," which efficiencies were realized? *(Check all applicable.)* (N = 108)

Overall, more than 40% reported that the efficiencies realized were a greater pool of knowledge, shared office equipment and office infrastructure, a reduction in staff, and streamlined business processes (see Figure 8).

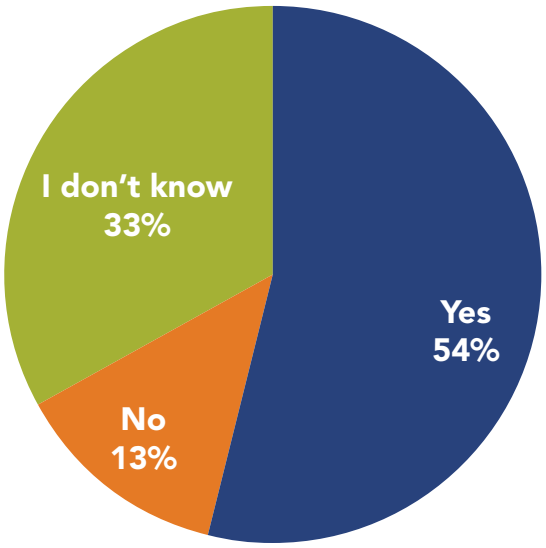
Figure 8. Efficiencies realized



There are no discernible patterns among population groups in this regard, but the North Central and South regions show the highest percentages reporting streamlined business processes. Approximately 65% of those in the South and West reported shared equipment and office infrastructure. Although the North Central region respondents show the smallest percentage reporting reduced workload (8%), those localities also show the highest percentage reporting a reduction in staff (47%).

Has your public health agency realized any cost savings as a result of the shared administrative services arrangement? (N = 160)

Figure 9. Cost savings realized?

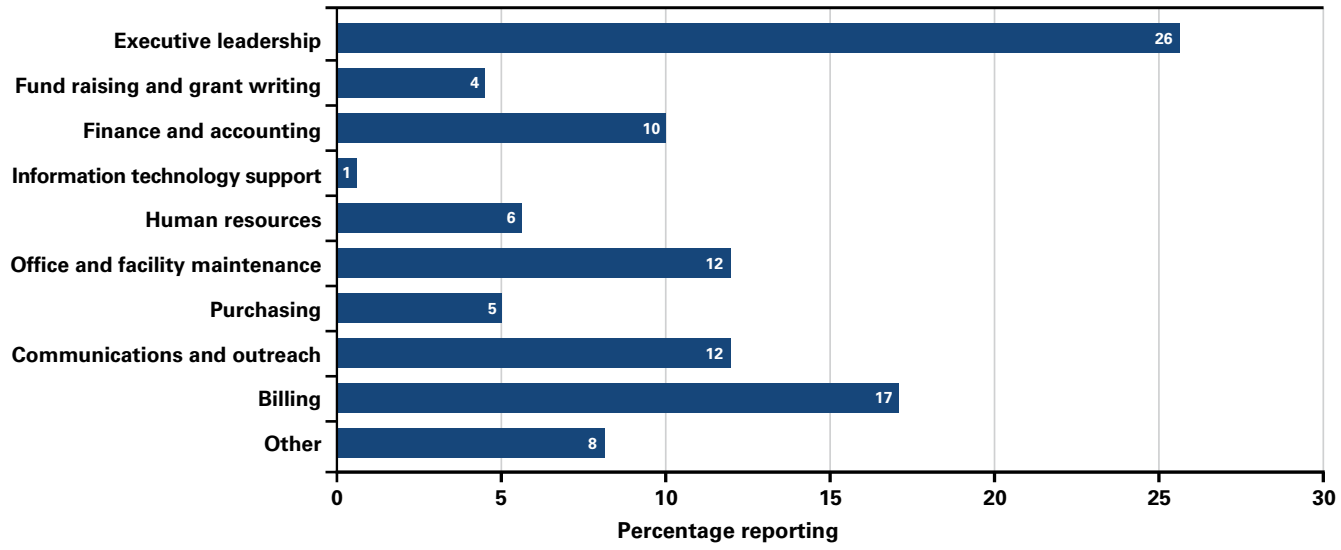


If "yes," which area listed below provided the greatest costs savings? *(Select only one.)* (N = 84)

Although there is variation in the responses, smaller local governments showed generally higher percentages reporting the greatest cost savings in billing. The two local governments with a population of 250,000–499,999 reported fund raising and grant writing (50%) and purchasing (50%).

Localities in the South reported the highest percentages indicating that executive leadership (43%) and office and facility maintenance (21%) provided the greatest cost savings.

Figure 10. Greatest cost savings



Would you recommend a shared service agreement for back-office services similar to what you have to other local health departments? (N = 150)

		Yes		No	
Classification	No. reporting	No.	% of (A)	No.	% of (A)
	150	**132**	**88.0**	**18**	**12.0**
Population group					
Over 1,000,000	0	0	0.0	0	0.0
500,000–1,000,000	4	4	100.0	0	0.0
250,000–499,999	6	5	83.3	1	16.7
100,000–249,999	12	12	100.0	0	0.0
50,000–99,999	13	11	84.6	2	15.4
25,000–49,999	24	19	79.2	5	20.8
10,000–24,999	47	41	87.2	6	12.8
5,000–9,999	27	24	88.9	3	11.1
2,500–4,999	11	11	100.0	0	0.0
Under 2,500	6	5	83.3	1	16.7
Geographic region					
Northeast	53	49	92.5	4	7.5
North Central	56	45	80.4	11	19.6
South	24	23	95.8	1	4.2
West	17	15	88.2	2	11.8

Summary

The fact that a strong majority of local governments that currently share services would recommend doing so to other local governments makes a case for shared administrative services in public health departments. Those local governments that reported shared services also reported benefits such as cost savings and efficiencies. Among respondents who do not share back-office public health services, the reason reported by the highest percentage is that they have not thought of it. Given the benefits identified by survey respondents, exploring shared administrative services for public health departments may be worthwhile.

For anyone interested in learning more about shared services in local government or wanting to contribute examples of shared administrative services from their own experiences in public health, please see the ICMA Knowledge Network at www.icma.org/knowledgenetwork and type "Shared Services" into the search bar.

CHAPTER 4

Case Study Summaries

To better understand what factors went into planning and implementing shared administrative service agreements and how those agreements work in daily operation, ICMA conducted three in-depth case studies as part of the overall study. The case studies looked at local governments that had successfully planned and implemented these types of agreements. (The full case studies have been included in the appendices to this report.) The selected sites illustrate the use of three distinct models of shared administrative service agreements:

- Prowers County Public Health and Environment and Kiowa County Public Health, Colorado: An interjurisdictional contract between two counties, wherein one county provides administrative services for both.
- Eastern Highlands Health District, Connecticut: A regional public health district formed by 10 towns, the largest of which provides many administrative services through a long-term agreement.
- Pennyrile District Health Department, Kentucky: A five-county district that provides all administration and program services.

Prowers County Public Health and Environment and Kiowa County Public Health, Colorado

The Prowers County Public Health and Environment Office had a history of working collaboratively and providing services for several public health programs over the years. When Colorado public health laws introduced various new professional standards for the field in 2008, including a requirement to hire a director to oversee programs, the Kiowa County commissioners faced a challenge of securing a qualified candidate. When a qualified candidate could not be attracted for the salary being offered, the two counties were encouraged to establish a shared administrative services agreement to help Kiowa County achieve compliance.

QUICK PROFILE

Total population served (2013 Census): 13,822 (Prowers, 12,410; Kiowa, 1,412)

Total land area served (in sq. mi.): 3,430 (Prowers, 1,644; Kiowa, 1,786)

Median household income (2013 BLS annual average): Prowers, $33,671; Kiowa, $41,739

No. partnering jurisdictions: Two counties

No. employees: 24 full-time equivalents (FTEs) for both counties

Websites: www.prowerscounty.net; www.kiowacounty-colorado.com

Decision Points for Sharing Administrative Services

- Ability to comply with state mandates, including the hiring of a qualified director. Kiowa County alone could not offer a high enough salary to attract and retain a qualified director to fill the vacancy and achieve compliance with state mandate.
- Increased efficiency through more streamlined administrative systems and increased administrative knowledge and expertise, thereby reducing time taken for such activities as inventorying and contract management.
- Aligned goals with and similar type of service provision as another county public health department, compared with the alternative of working with a local hospital district (which provides more individual health care than public health care).
- Cost savings in administrative services for Kiowa County and revenue earned by Prowers County on fees from Kiowa County.

Forming the Agreement

After exhausting several options for hiring a qualified director to meet the state requirement, the Kiowa County commissioners asked the director of Prowers County

Public Health and Environment to develop a contract for needed services. Development of the contract took two to three months. Following reviews by each county's commissioners and attorneys, the counties signed an intergovernmental agreement (IGA). Donald Oswald, Kiowa County commissioner, noted the benefit of the IGA contract structure. "It's open-ended and very easy to dissolve," he explained. "We sign it on a yearly basis, but either party can opt out of it at any time. I think that helps reassure the public that we do have the power to change it if we need to."

The Shared Services Model

The contract covers several core public health services required by Colorado state law. In addition to the programmatic work undertaken by Prowers County, the IGA covers two broad categories: (1) assessment, planning, and communication services and (2) administration and governance. The director of public health is in charge and represents the interests of both counties when attending state, regional, and local meetings. The business operations manager of Prowers County Public Health and Environment has developed a close working relationship with the Kiowa County office, especially in organizing that office and establishing needed business systems for it.

Prowers County Public Health and Environment and Kiowa County Public Health are still two distinct organizations, with Prowers County providing administrative services, among other core public health services, to Kiowa County. According to Lisa Neuhold-McCullough, former accountant for Prowers County Public Health and Environment, the annual fee that Kiowa County pays for these services has been more than offset by the salary savings and new revenues captured through the billing and invoicing services provided by Prowers County.

Kiowa County maintains a public health office in Eads, Colorado, with an office manager who is an employee of the county. That individual's work is overseen by Tammie Clark, director of public health for both counties. Additional staff support for Kiowa County is provided by Prowers County Public Health and Environment in accordance with a prorated budget. For example, if an employee works on contracts held by Kiowa County, he or she will charge the time to the Kiowa County account.

Key Takeaways

- Jackie Brown, former acting director of Prowers County Public Health and Environment, was deeply involved in establishing the agreement, and she noted that one of the most important lessons was the need to be very inclusive and to communicate with all parties involved. "We worked hard to be transparent and open about the arrangement. But it would have been good to bring in an outside facilitator to lead discussions with the public about our plans. Being inclusionary from the beginning would have helped to preempt some of the public complaints that arose." Dick Scott, chair of the Kiowa County Commission during the establishment of the agreement, emphasized this point as well. "Both parties needed to be open with each other and the public," he said.
- The cooperation exhibited between the two counties as part of this arrangement is expected to make future collaborative efforts go more smoothly. As Scott observed, "One of the big pluses is that we've gotten to know and respect our neighbors."

Eastern Highlands Health District, Mansfield, Connecticut

The Eastern Highlands Health District, based in Mansfield, Connecticut, provides public health services to 10 towns. Ranging in population size from 1,710 (Scotland) to 25,648 (Mansfield), these towns contain a little more than 2% of the state population. First formed in June 1997, the district began when the town managers and residents of Bolton, Coventry, and Mansfield realized that pooling resources could increase the scope and quality of public health services by providing a full-time public health staff while reducing expenses. The town of Tolland joined the health district in 2000, followed by the towns of Willington (2001) and Ashford (2004). In June 2005, four other contiguous towns—Andover, Chaplin,

QUICK PROFILE

Total population served (2013 Census): 81,004 (10 towns, range: 1,710–25,648)

Total land area served (in sq. mi.): 287.9

Average per household income (Connecticut Economic Research Center, 2011): $82,376

No. partnering jurisdictions: 10 towns with involvement of the University of Connecticut

No. employees: 10 FTEs

Website: www.ehhd.org

Columbia, and Scotland—became part of the health district. Additionally, the district has entered into a joint cooperative agreement with the University of Connecticut (with a student population of approximately 25,000) in Mansfield.

Decision Points for Sharing Administrative Services

- Funding incentives offered by the state for regional public health districts.
- Increased ability to meet state-imposed public health mandates and standards, which would be expensive to the point of infeasibility for the small towns alone. The town of Coventry estimates overall cost savings of 30%–35% by participating.
- Ability to offer more competitive salaries to high-demand employees, resulting in a more stable and qualified workforce and greater professionalism and quality in service provision. Before the health district was formed, towns in the region were experiencing high staff turnover and some low-quality work in their individual health departments, in large part because of their inability to offer competitive salaries.

Forming the Agreement

The original three member towns—Bolton, Coventry, and Mansfield—formed a formal committee that studied the financial impacts for each community involved. The health district was formed in June 1997 with adopted bylaws and a board of directors that functions as a board of health for the region. The board reviews each new proposed community and conducts a cost-benefit analysis before accepting new members.

The Shared Services Model

Each member town has representation on the governing board of directors based on its population size. All but the two smallest towns maintain an office for the health district to offer a one-stop shop for public health services. The towns also provide limited administrative services, including phone and voicemail, Internet access, and a system for the collection of permit fees. The main district headquarters is based in Mansfield, which has a long-term agreement to provide accounting, bookkeeping, communications, data processing, a full range of human services support, and information technology (IT) support.

Key Takeaways

- The Eastern Highlands Health District has been in existence for 17 years and has a well-established record of achievements. As managers and administrators of the towns observe, shared services and regionalism as a concept were not part of the local government agenda back when the district was formed. It is only in recent years that this concept has become much more acceptable as a way of doing business in local government.
- Given the long tenure of the district, many of the study participants offered insights from their experience. Michael Kurland, director of health services at the partnering University of Connecticut, pointed out the value of sharing expectations from the very beginning to keep everyone involved on the same page. If people know what to expect, it helps to build trust in the group. "The need for trust is paramount," he said.
- John Elsesser, manager of the town of Coventry, noted that personalities count. If you can identify the right people who are willing to invest in the effort, the effort will succeed. "We all work at it," he said.
- Elizabeth Paterson, mayor of the town of Mansfield, noted the importance of having patience. "The level of cooperation we have now didn't happen overnight," she said. "Initially all the member towns were pretty protective, but we've had time to establish a trust factor. We try to recognize the needs of every town. And through that level of trust comes a new strength. We have lots of issues in common, and we can lobby the state for things that matter to us regionally. We do it together, which makes us stronger."

Pennyrile District Health Department, Crittenden County, Kentucky

Around the late 1970s, conversations about creating a district health department began among public health administrators in six of the nine counties in southwestern Kentucky's Pennyrile District. With operations similar in size and similar services provided, the administrators felt they could do more with their budgets by pooling resources. The Pennyrile District Health Department was formed in 1981 through an interlocal agreement between five counties in Pennyrile District: Caldwell, Crittenden, Livingston, Lyon, and Trigg

QUICK PROFILE

Total population served (2013 Census): 54,181 (five counties, range: 8,451–14,293)

Total land area served (in sq. mi.): 1,673.1

Average per household income: $38,655

No. partnering jurisdictions: Five counties

No. employees: 47 FTE, 6 contracted

Website: http://pennyrilehealth.org

Counties. The health district department oversees the operations of clinics in those counties, offering public health services to its 54,181 residents.

Decision Points for Sharing Administrative Services

- Cost savings from shared administrative functions—executive leadership, finance and accounting, human resources, and IT—to mean increased dollars available for public health programs.
- Financial incentives offered by the state to encourage jurisdictions to form a district health department.
- Increased eligibility for state and federally funded programs. Although the state and the federal government funded a few special programs to select jurisdictions, funding primarily went to jurisdictions with larger populations.

Forming the Agreement

Each local county board of health (BOH) acted to have its county's governing fiscal court pass a resolution to unite with the other counties in the district health department, and sent a copy of this resolution to the State Division for Local Health.[12] A steering committee comprising selected representatives from the participating counties' boards worked with local health department personnel and the state to develop a district plan and budget for approval by each county. During the first regular meeting of the Pennyrile District Health Department board on June 18, 1981, representatives from the five participating counties' BOHs met to elect a chairman and vice-chairman, as well as an executive board comprising a physician, nurse, dentist, fiscal court appointee, and member at-large. On July 1, 1981, the state approved formation of the Pennyrile District Health Department.

The Shared Services Model

District office location and employees were to be determined by the district health department's BOH. The state suggested taxing amounts that each participating county should be required to contribute to ensure fairness, eventually establishing a minimum requirement of 1.8 cents per $100 of valuation. Additional state funds were provided to support the district, and each county could provide further funding, if desired, for building maintenance.

The Pennyrile District Health Department BOH contains at least two members from each county BOH: the county judge and at least one other appointed individual. Each participating county has its own public health building; however, there is only one administrator, and that person is housed in a separate building located central to the five-county district in the city of Eddyville in neighboring Lyon County.

Key Takeaways

- Sharing administrative services is critical in small rural areas.
- Management, staff, and elected officials who understand their roles working for the entire district community are critical in maintaining working relationships to achieve success. Fostering trust between board members is a component of this. Getting people on board can prove to be a challenge in the beginning. "The key is effective go-betweens within the district," said Dr. Steve Crider, Crittenden County BOH member. "You have to trust the district administrator. That's where accountability comes in."
- The primary driver and benefit of shared administrative services is financial. This benefit results from increased economies of scale in allocated funds, personnel, and expertise, as well as from incentives and increased funding opportunities from state and federal sources.
- Shared administrative services significantly enhance the capacity of public health departments to provide a range of programs and services, meet federal and state programmatic requirements, and address specialized challenges, such as legal issues, that independent public health departments could not address on their own.

CHAPTER 5
Study Findings

1. Many models exist for shared administrative service agreements among public health departments. Local governments considering such an agreement should talk with their state departments of public health to determine available options.

In the ICMA National Survey on Public Health Shared Administrative Services, respondents were asked about the organizational model that their local governments used for sharing administrative services (see table on facing page). While inquiring about all possible models would have been impossible, the survey did list six different models as well as an "Other" option.

An interlocal agreement was the model used by more than 40% of those responding, but 16.5% reported using some other model besides the options listed. Among those other options were a joint powers agreement, a dues-paying structure, and state laws and statues.

The sites selected for case studies demonstrate three different types of models available to local governments. In the case of Prowers and Kiowa Counties in Colorado, a simple intergovernmental agreement (IGA) governs services provided to Kiowa County Public Health by Prowers County Public Health and Environment and Kiowa County's payment for those services. Kathleen Matthews, director of the Office of Planning and Partnerships at Colorado Department of Public Health and Environment, proved instrumental in advising Kiowa County commissioners of what options they had available.

In the case of the Eastern Highlands Health District in Connecticut, state statue defines the requirements for the provision of public health services while the district's bylaws govern the town's participation in the organization. The district operates as a full-service public health department for all members, with its primary office located in the town of Mansfield. It also maintains office facilities in all member towns so as to be accessible to residents in the district.

The state of Kentucky's commissioner of health played a critical role in the formation of the Pennyrile District Health Department. The state guided the participating counties through the formation process, provided guidance on establishing a fair tax amount that each participating county should be required to contribute, and made additional funding available to support the district formation. The state imposes specific mandates on district health departments, including the composition of the district board of health (BOH) and the frequency with which it must meet.

2. Support from state and federal government—for example, direct financial incentives and grant eligibility—can provide an incentive for establishing shared service agreements.

Kiowa County has been included in many of the grant proposals submitted by Prowers County. Given Kiowa County's limited administrative resources, the county would have a difficult time preparing competitive grant proposals without the collaborative support of Prowers County.

In Connecticut, health districts are eligible to receive annual state funding of $2.43 per capita. This aid formula provides an incentive for rural towns to work together to form a regional health district.

Financial incentives from the state of Kentucky, as well as eligibility for state and federally funded grants, represented a critical decision point for all counties that came together to form the Pennyrile District Health Department. At the time of formation, the counties were seeing cuts in their programs and were not large enough to be eligible for many state and federal grants. The district health department proved to be a lead agent large enough for grant eligibility on special projects.

3. Community leaders—elected officials and executive management—need to have a set of clear expectations about what they hope to achieve by establishing shared administrative services agreements.

All three of the selected case study sites had multiple reasons for establishing shared administrative service agreements. Having clear expectations about what they hoped to achieve through the agreements served well in securing buy-in and support from the community and stakeholder groups. Eastern Highlands articulated three clear expectations: increased state

Classification	No. reporting	An informal agreement		Memorandum of understanding		Service provision agreement		Interlocal agreement		New entity formed by merging local health departments		Consolidation of one or more existing local health departments		Other	
		No.	% of (A)	No.	% of (A)	No.	% of (A)	No.	% of (A)	No.	% of (A)	No.	% of (A)	No.	% of (A)
	170	**29**	**17.1**	**37**	**21.8**	**23**	**13.5**	**69**	**40.6**	**11**	**6.55**	**12**	**7.1**	**28**	**16.5**
Population group															
Over 1,000,000	0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
500,000–1,000,000	4	1	25.0	1	25.0	1	25.0	3	75.0	0	0.0	1	25.0	0	0.0
250,000–499,999	7	1	14.3	4	57.1	2	28.6	1	14.3	1	14.3	1	14.3	3	42.9
100,000–249,999	16	5	31.3	1	6.3	4	25.0	2	12.5	1	6.3	2	12.5	4	25.0
50,000–99,999	13	4	30.8	6	46.2	2	15.4	3	23.1	0	0.0	0	0.0	2	15.4
25,000–49,999	28	2	7.1	8	28.6	2	7.1	15	53.6	1	3.6	2	7.1	4	14.3
10,000–24,999	54	11	20.4	10	18.5	3	5.6	19	35.2	5	9.3	6	11.1	11	20.4
5,000–9,999	29	3	10.3	5	17.2	6	20.7	16	55.2	0	0.0	0	0.0	4	13.8
2,500–4,999	13	1	7.7	1	7.7	1	7.7	9	69.2	2	15.4	0	0.0	0	0.0
Under 2,500	6	1	16.7	1	16.7	2	33.3	1	16.7	1	16.7	0	0.0	0	0.0
Geographic region															
Northeast	56	5	8.9	7	12.5	8	14.3	34	60.7	4	7.1	4	7.1	6	10.7
North Central	65	18	27.7	15	23.1	8	12.3	16	24.6	5	7.7	6	9.2	11	16.9
South	26	3	11.5	8	30.8	4	15.4	13	50.0	2	7.7	1	3.8	2	7.7
West	23	3	13.0	7	30.4	3	13.0	6	26.1	0	0.0	1	4.3	9	39.1
Metro status															
Metropolitan statistical area	69	10	14.5	16	23.2	13	18.8	33	47.8	2	2.9	6	8.7	7	10.1
Micropolitan statistical area	20	3	15.0	4	20.0	2	10.0	3	15.0	1	5.0	1	5.0	10	50.0
NECTA	23	5	21.7	4	17.4	4	17.4	9	39.1	4	17.4	2	8.7	4	17.4
Undesignated	58	11	19.0	13	22.4	4	6.9	24	41.4	4	6.9	3	5.2	7	12.1
Form of government															
Unavailable	6	1	16.7	1	16.7	0	0.0	4	66.7	0	0.0	0	0.0	0	0.0
Mayor-council	23	1	4.3	3	13.0	1	4.3	15	65.2	1	4.3	2	8.7	0	0.0
Council-manager	29	3	10.3	5	17.2	5	17.2	17	58.6	3	10.3	2	6.9	1	3.4
Commission	2	0	0.0	0	0.0	1	50.0	0	0.0	1	50.0	1	50.0	0	0.0
Town meeting	11	3	27.3	1	9.1	2	18.2	4	36.4	0	0.0	0	0.0	3	27.3
Representative town meeting	2	0	0.0	0	0.0	1	50.0	1	50.0	0	0.0	0	0.0	1	50.0
County commission	43	7	16.3	12	27.9	3	7.0	12	27.9	2	4.7	4	9.3	12	27.9
Council-administrator (manager)	40	10	25.0	9	22.5	6	15.0	13	32.5	2	5.0	2	5.0	9	22.5
Council–elected executive	14	4	28.6	6	42.9	4	28.6	3	21.4	2	14.3	1	7.1	2	14.3

aid, greater professionalism, and a working organizational structure for the provision of public health services. Depending on the audience being addressed, proponents for the district used these three goals to generate support for the new agreement.

4. Relationships and personalities matter when developing agreements for shared administrative services among public health departments. A spirit of openness and inclusivity makes it easier to develop the trust needed make the agreements work.

Prowers County Public Health and Environment had a long history of providing services to other counties in southeastern Colorado. Kiowa County commissioners noted that they found regular quarterly reporting from Prowers County Public Health and Environment useful.

Several of the study participants interviewed from Eastern Highlands noted that formation of the district was largely a function of the ability of town managers in the region to work together. Three town managers in particular are largely credited with providing the leadership needed to start the district. While there were initially some concerns about the smaller towns being "swallowed" up by the larger towns, representatives on the board of directors have developed a level of comfort with each other over time and make it a point to treat all towns in the district equally.

In the Pennyrile District Health Department, trust between the participating counties and centralized administrator, among local county BOHs, and between the system and the community has enabled its success as an operation. "When consolidating, you give up some input," explained Crittenden County BOH member and county magistrate, Donnetta Travis. "If there was a concern, it would be brought to the board. It's about establishing community trust." Added Dr. Crider, another Crittenden County BOH member, "The key is effective go-betweens within the district. You have to trust the district administrator."

5. Establishing transparency and trust with the public in planning and implementing shared administrative services is critical to overcoming challenges.

Several of those interviewed for the Prowers County–Kiowa County study commented that if they were to do it again, they would have held more public meetings to discuss what was being proposed. Community forums would have provided those involved with the opportunity to present the facts of the agreement before it was fully executed rather than leaving them to respond to community speculation and rumors after the agreement went into effect. Providing complete and detailed information to the public through the local media proved useful in quelling community unease that arose as a result of local gossip about the agreement.

6. Shared administrative services can expand the number of public health services offered, especially for smaller, rural communities.

With a population of roughly 1,400, Kiowa County has limited resources for meeting Colorado state public health standards, and its ability to attract qualified professionals to run the county's public health programs was virtually nonexistent. Establishing an IGA to provide public health administrative services from Prowers County Public Health and Environment made sense from a compliance standpoint. Perhaps more importantly, the decision has been beneficial for Kiowa County from a financial standpoint. With Prowers County now managing Kiowa's contracts and invoicing functions, Kiowa County has brought in more revenues that were previously being left on the table. This, in turn, has enabled the county to provide more public health services to its residents.

Likewise, several participants in the Eastern Highlands Health District noted that by sharing administrative services, the district is able to direct more resources toward the provision of public health programs. Greater access to professional staff when needed—for example, the ability to assign several staff people to issue environmental permits in a town experiencing fast growth—enables the district to provide better coverage than each town could accomplish with its own resources.

The advantage of providing more health services for citizens at lower costs was the key in the decision to form the Pennyrile District Health Department. The counties would be able to achieve greater economies of scale in administration, resulting in increased cost-effectiveness. "When I was administrator in Crittenden and Lyon Counties, the total budget was $70,000 for operations and services," said former health administrator Don Robertson. "We continued to expand over the years, and when I retired in 2003, the annual budget was $2.3 million and we had 40 employees. From everyone pulling together to lower administration costs, operations became more efficient. As a result, more money could be directed to serving citizens, which was the main goal."

7. Shared administrative services can result in higher-quality public health services for the public.

While cost savings were the most repeated reason given by case study participants for implementing shared administrative service agreements, the ability to attract and retain qualified professionals was also mentioned frequently. Greater professionalism is likely to translate into higher-quality public health services, and participants in all three case studies reported this to be another by-product of these agreements.

The Kiowa County commissioners commented on the professionalism of the staff from Prowers County Public Health and Environment and on the commitment of that staff to connect with and represent the interests of Kiowa County residents. As a result of the formation of the Eastern Highlands Health District, participating towns have access to a full-service public health department rather than a part-time medical advisor. Several participants noted the benefits of having a full-time professional running the public health services in the district.

Finally, for participating counties in the Pennyrile District Health Department, the shared administrative arrangement also ensures greater reliability of services through greater staffing capacity. In case a nurse or other service provider cannot come into work, the district can reallocate staff to fill that service gap and ensure continuity of health services in all counties.

APPENDICES:

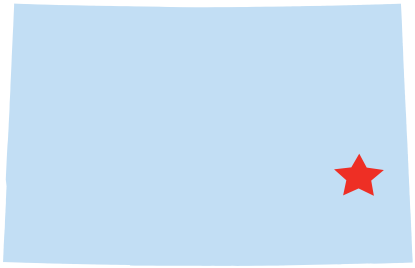
Full Case Studies

Center for Sharing Public Health Services

Rethinking Boundaries for Better Health

CASE STUDY:

Prowers County Public Health and Environment and Kiowa County Public Health, Lamar, Colorado



PROFILE

Total population served (2013 Census): 13,822 (Prowers County, 12,410; Kiowa County, 1,412)

Total land area served (in sq. mi.): 3,430 (Prowers, 1,644; Kiowa, 1,786)

Median household income (2013 BLS annual average): Prowers, $33,671; Kiowa, $41,739

Total revenues (calendar year [CY] 2013): Prowers, $848,255; Kiowa, $196,704

Total expenses (CY 2013): Prowers, $628,468; Kiowa, $176,874

No. partnering jurisdictions: Two counties

No. employees: 24 full-time equivalents (FTEs) for both counties

Websites: www.prowerscounty.net; www.kiowacounty-colorado.com

Background

In 2008 Colorado passed the Colorado Public Health Act of 2008, which Governor Bill Ritter signed into law. The act requires identified boards, agencies, and public officials to collaboratively develop state and local public health plans that set priorities for the public health system in Colorado. Its primary purpose is to ensure that core public health services are available at a consistent standard of quality to everyone in Colorado.

Among its requirements, the act stipulates minimum qualifications for local public health directors and medical officers hired in the role of director. When the public health director of Kiowa County resigned in 2011, County Administrator Peggy Dunlap approached Jackie Brown, then director of Prowers County Public Health and Environment, for help in keeping the Kiowa County office functioning until the Kiowa County commissioners could identify a qualified candidate. For three to four months, Brown and her team in Prowers County oversaw the Kiowa County office, providing day-to-day management services such as contracts, accounting, and invoicing, in what Brown characterized as a "gentlemen's agreement." Brown herself provided human resource support to Kiowa County, reviewing applications and assisting with interviews.

A candidate was identified, but the $35,000 salary offered by the county was not sufficient. The county commissioners—Dick Scott (chair), Bill Kohler, and Donald Oswald, who also serve as the county board of health—considered working with a local hospital district to administer the public health office in Kiowa County. When Kathleen Matthews, director of the Office of Planning and Partnerships at Colorado Department of Public Health and Environment, learned of this option, she advised them that responsibilities associated with overseeing a public health office are very different from those required for running a hospital district. She urged the commissioners to maintain the public health office as a separate program or work with another neighboring county public health agency. With no leads for qualified personnel and no additional funding available to make the position more

attractive, Dunlap and Brown sat down with Kiowa County commissioners to talk about a shared services agreement.

Prowers County Public Health and Environment Office had a history of working with Kiowa County Public Health on several programs over the years, such as sharing an environmental health officer among four counties (1996); implementing a nurse-family partnership program, which began with four counties and has grown to six counties (2000); and instituting an early periodic screening and diagnostic testing program among three counties (2004). With this history in mind, Brown suggested that Prowers County could provide the necessary staffing support and services required by state law to bring Kiowa County into compliance.

After several discussions, the commissioners asked Brown to develop a contract for the needed services. Following reviews by the two counties' commissioners and their attorneys, an intergovernmental agreement (IGA) was signed.

Forming the Agreement

Development of the contract took two to three months and involved multiple discussions with the Kiowa County commissioners, the Prowers County commissioners, and staff at Prowers County Public Health and Environment. The contract for services covers several core public health services required by Colorado state law. In addition to the programmatic work undertaken by Prowers County, the agreement also covers two broad administrative categories: (1) assessment, planning, and communication services and (2) administration and governance. Specifically, Prowers County Public Health and Environment provides

- Executive leadership and staffing support
- Timesheets and project tracking
- Human resource functions
- Billing and invoicing
- Contract management
- Grant development and administration
- Reporting (state and county)
- Communications
- Representation at state, regional, and local meetings.

Tammie Clark serves as director of public health for both Prowers County and Kiowa County and represents the interests of both counties when attending state, regional, and local meetings. Jo Lynn Idler, business operations manager, also has developed a close working relationship with the Kiowa County Public Health office, especially in organizing the office and establishing business systems.

Commissioner Oswald noted the benefit of the IGA contract structure. "It's open-ended and very easy to dissolve," he explained. "We sign it on a yearly basis, but either party can opt out of it at any time. I think that helps reassure the public that we do have the power to change it if we need to."

"I think openness between the two parties was important," said Commissioner Kohler. "You have to go into [contract discussions] knowing that you can work [any problems] out. And if you can't work it out, you probably shouldn't be entering into any kind of agreement."

The Case for Sharing Administrative Services

"For small counties like ours, [sharing resources] is a matter of survival. If we don't share, we're in trouble," said Oswald.

Kiowa County Public Health didn't have many administrative systems in place when the agreement went into effect, and its office required considerable time to organize, including taking inventory and cataloging supplies. Prowers County staff undertook these tasks as part of the agreement.

Lisa Neuhold-McCullough, the former public health accountant for Prowers County Public Health and Environment, observed that contract management—processing invoices, deposits, journal entries, and bill coding—is very labor-intensive and one area in which Kiowa County required considerable help. "We discovered that Kiowa County did not have an approved indirect rate when we began working with them. In the state contracts that we administered, there is a cap of 10% of salary and fringe that is allowable for indirect reimbursement in the absence of a certified indirect rate. Most local departments have an approved indirect rate in the range of 20%–30%, much higher than the state cap. The bottom line is that Kiowa County was losing a huge part of their public health revenues by not having an approved rate. They were leaving a lot of money on the table," said Neuhold-McCullough.

As Joe Marble, outgoing chair of the Prowers County Commission, observed, "We might have been pushed into this arrangement by economics, but it's worked great." His fellow commissioner, Henry Schnabel, echoed that thought, noting that Prowers County

has a long history of providing services to other nearby counties. "Regionalism just makes sense," he said. Jo Lynn Idler also pointed out that Prowers County receives revenue from the arrangements. Marble characterized the relationship as a win-win proposition for all involved.

Shared Services Model

Prowers County Public Health and Environment and Kiowa County Public Health have remained as two distinct organizations, with Prowers County providing administrative and other public health core services to Kiowa County. The annual fee that Kiowa County pays for these services has been more than offset by the salary savings as well as the new revenues captured through the billing and invoicing services provided by Prowers County, according to Neuhold-McCullough.

Kiowa County maintains a public health office in Eads, Colorado, with an office manager who is an employee of the county. That individual's work is overseen by Clark in her role as director of Kiowa County Public Health. Additional staff support for Kiowa County is provided by Prowers County Public Health and Environment based on a prorated budget. For example, if Idler works on contracts held by Kiowa County, she will charge her time to the Kiowa County account.

When asked about the value of shared services, Neuhold-McCullough suggested some caution: "If you have two agencies doing the exact same work, it makes sense to pool resources. Shared services can work if you're comparing apples to apples," she said. "But [the services] need to be compatible." As Kathleen Matthews pointed out, "Administration and contracting can be complex, and it makes sense to share those services and allow more funding for direct public health work. Some services need to be provided onsite, but others can easily be managed from a distance. We have many different models of sharing services in Colorado that have evolved over time. Learning from each of these models can provide counties looking for solutions with a number of options."

Obstacles in Planning and Implementing the Agreement

Commissioners from both counties had concerns going into contract discussions. Prowers County commissioners were hesitant about the possibility of paying for services being provided to Kiowa County. The implementation of strict accounting procedures for recording time spent on work done on each county's projects was critical to securing their support. The use of the Prowers County timekeeping system, which enables staff to prorate their time among projects, ensured that a record of charges to each project would be maintained.

The Kiowa County commissioners were concerned about maintaining local control of the office. Dick Scott, chair of the Kiowa County Commission, noted that a number of local groups objected to having this work being performed outside the county. In particular, a local hospital district had indicated its interest in providing the necessary services, but the Colorado Department of Public Health and Environment recommended that the county not take that course of action because of the two very different natures of the health care services—public health care and individual health care—being provided. But as Commissioner Kohler explained, "We had to roll up our sleeves and do what's best for the county" despite these objections.

"If I had to go back and do things over again," said Brown, "I think the commissioners should have held public forums for the citizens. People didn't understand why there was a need to make a change." Scott also referenced the need to be more transparent with the public: "We have a great grapevine here. It's faster than the Internet. But the public needs to know the facts. If people understand why decisions are being made, they'll be receptive to change."

Another obstacle that arose was staff workloads. Because of reduced funding from 2004 to 2009 due to the economic downturn, the staff in Prowers County had not received salary increases or bonuses in several years. Thus, when the new arrangement was implemented, some employees were concerned about the potential for increased workloads without any compensation. A revised staffing plan that realigned work shifts eliminated this concern.

Benefits

Most of those interviewed commented on the cost savings for Kiowa County as being the primary incentive for instituting the agreement. "This is saving us money. They [Prowers County Public Health and Environment] are working for our county," said Kohler. From its standpoint, Prowers County is receiving new revenues as part of the arrangement, and those interviewed identified other benefits beyond the financial ones.

Scott and Kohler both commented on the level of quality and professionalism now available to the residents of county. "We have access to far more expertise now," said Scott. "We would have been pretty far out in left field without them," added Kohler. "The quality of our programs has never been higher."

Another critical benefit is that Kiowa County Public Health is in compliance with core public health services required by state law. As a result, as Brown pointed out, residents of Kiowa County have improved access to public health programs. Idler observed that the number of people using Kiowa County Public Health has risen since the agreement went into effect.

"It's been a real positive agreement," stated Kohler. "It's improved a lot of our programs. We're in the best shape we've been in in a long time."

Key Takeaways

Brown noted that one of the most important lessons for her was the need to be very inclusive and communicate with all the parties involved. "We worked hard to be transparent and open about the arrangement. But it would have been good to bring in an outside facilitator to lead discussions with the public about our plans. Being inclusionary from the beginning would have helped to preempt some of the public complaints that arose." Scott emphasized this point as well: "Both parties needed to be open with each other and the public."

The cooperation exhibited between the two counties as part of this arrangement is expected to make future collaborative efforts go more smoothly. As Scott observed, "One of the big pluses is that we've gotten to know and respect our neighbors."

"Rural areas need to pool their resources in order to keep services affordable," noted Schnabel.

Study Participants

Jackie Brown, integrated care director, Southeast Health Group, Lamar

Wendy Buxton-Andrade, county commissioner, Prowers County

Tammie Clark, director, Prowers County Public Health and Environment, Lamar

Peggy Dunlap, county administrator, Kiowa County

Jo Lynn Idler, business operations manager, Prowers County Public Health and Environment, Lamar

Bill Kohler, county commissioner, Kiowa County

Joe Marble, county commissioner, Prowers County

Kathleen Matthews, director, Office of Planning and Partnerships, Colorado Department of Public Health and Environment

Lisa Neuhold-McCullough, former public health accountant, Prowers County

Donald Oswald, county commissioner, Kiowa County

Henry Schnabel, county commissioner, Prowers County

Richard Scott, county commissioner, Kiowa County

Center for Sharing Public Health Services
Rethinking Boundaries for Better Health

CASE STUDY:
Eastern Highlands Health District, Mansfield, Connecticut

PROFILE

Total population served (2013 Census): 81,004 (Andover, 3,272; Ashford, 4,284; Bolton, 4,960; Chaplin, 2,286; Columbia, 5,461; Coventry, 12,425; Mansfield, 25,648; Scotland, 1,710; Tolland, 14,964; and Willington, 5,994)

Total land area served (in sq. mi.): 287.9

Average per household income (Connecticut Economic Research Center, 2011): $82,376

Total revenues (fiscal year [FY] 2012–2013): $991,560

Total expenses (FY 2012–2013): $939,741

No. partnering jurisdictions: 10 towns with involvement of the University of Connecticut

No. employees: 10 full-time equivalents (FTEs)

Website: www.ehhd.org

Background

The Eastern Highlands Health District, based in Mansfield, Connecticut, provides public health services to slightly more than 2% of the population of Connecticut. The district was formed in June 1997, when town leaders and residents of Bolton, Coventry, and Mansfield realized that they could increase the scope and quality of public health services while reducing expenses by pooling resources to establish a full-time public health staff. The town of Tolland joined the health district in 2000, followed by the towns of Willington (2001) and Ashford (2004). In June 2005, four other contiguous towns—Andover, Chaplin, Columbia, and Scotland—became part of the health district. Each of these towns has the benefits of full-time public health services and is assured of the essential public health services mandated by state statue. Additionally, the health district has entered into a joint cooperative agreement with the University of Connecticut (with a student population of about 25,000) in Mansfield.

Before the health district was formed, towns in the region were experiencing high staff turnover in their individual health departments and seemed to hire employees back and forth, in large part because of their inability to offer competitive salaries. In some cases, the quality of the work being performed was dubious. Joyce Stille, administrative officer for the town of Bolton, explained that in her town, an employee who had been brought on with the necessary professional skills to perform one job ended up with responsibilities that he hadn't been hired to do and lacked the educational background to perform. Additionally, the small towns in the region simply did not have enough funds individually to do all the tasks that the state was requiring.

Forming the Agreement

Planning for the health district started in the mid- to late-1990s as informal discussions among several of the town managers. Robert Miller, current director of health for the district, was brought into the discussions in part because he had worked for three of the

towns and was familiar with issues in the region. The informal talks continued for at least a year before a formal study committee was formed. All three original member towns—Bolton, Coventry, and Mansfield—appointed representatives to the study committee, which met monthly to study the financial impacts for each community involved.

"The town managers were the driving force in the formation of the health district," explained Miller. "They understood that consolidation of their resources would enable the towns to provide the same level of service at a much lower cost." A subsidy from the state of Connecticut for regional public health districts was also an incentive to form a regional collaboration.

In forming the health district in June 1997, the group developed and adopted a set of bylaws and established a board of directors to provide governance for the new district. The board functions as a board of health for the region. As the health district expanded over the years, the board carefully reviewed each new proposed community and considered a cost-benefit analysis prepared by Miller. As Elizabeth Paterson, mayor of Mansfield and chair of the board of directors, pointed out, "It's important to get the balance right." John Elsesser, Coventry town manager, noted, "There's no reason to add another member at this time. Small towns can have high demands as start-ups. We need to ensure that there is a compatibility of interests among members of the health district."

The Case for Sharing Administrative Services

"We didn't want to create a new bureaucracy," Elsesser said. "We want to provide a service for all citizens in the region."

The per capita aid formula set by the Connecticut Department of Public Health definitely provided an incentive for forming a regional health district. In Connecticut, health districts are eligible to receive annual state per capita funding of $2.43 per capita.

The state has imposed several public health mandates and standards for service. Meeting these requirements would have been extremely expensive and simply not feasible for most small towns. The centralized model developed by the Eastern Highlands Health District makes "life easier," said Elsesser. He estimated that the town of Coventry has saved between 30% and 35% in costs by helping to form and participating in the health district.

State aid and cost savings, however, were not the sole reasons the towns opted to join forces. By pooling their resources, the towns were able to provide competitive salaries to skilled employees, an ability that has brought a greater level of professionalism to the provision of public health services for all the towns.

Finally, the new health district established a structure that allowed the towns to provide full coverage of public health services throughout the region. Individually the towns would not have had sufficient funds to hire the necessary staff to implement all the public health services required by state law.

A stable and qualified workforce was yet one more argument for sharing administrative services. Steve Webner, town manager of Tolland, shared that Tolland has experienced an explosion of growth recently, with nearly 150 houses built in a year. These houses must undergo inspections before occupancy permits can be granted—a workload that would have been impossible to accomplish without shared staff. But as Elsesser and Stille pointed out, the massive staff turnovers that the towns used to contend with are largely a thing of the past now that the district can afford to pay fair salaries. Elsesser noted that it would cost his town roughly $100,000, including salary, benefits, and office expenses, to hire one professional employee. By sharing employees, he estimated that his town saves approximately 50%.

Shared Services Model

As noted above, Mayor Paterson chairs the health district's board of directors. Each member town has representation on the board based on its population size. State statute requires for towns with a "population of 10,000 or part thereof" to have one representative on the board. In the district this means that most towns have one representative. A few towns with populations over 10,000 have two representatives, and Mansfield, with a population of over 20,000, has three.

All but the two smallest towns maintain an office for the health district in order to offer a one-stop shop for the delivery of public health services. In addition to office space, a town provides limited administrative services, such as a phone and voicemail, Internet access, and a system to collect permit fees for environmental inspections on houses and other buildings. Permit fees are uniform throughout the district. Because they are often collected while staff are out in the field

and there is a need to secure the funds as quickly as possible after they are received, the district opted to go with a decentralized model for collection.

The main district headquarters is in Mansfield, which has had a 25-year agreement since the district's inception to provide

- Accounting
- Bookkeeping
- Communications
- Data processing
- Human resources
- Information technology support, including hardware and software.

Given the level of commitment agreed to by the participating town to the health district, a long-term agreement seemed appropriate.

The town of Mansfield provides financial support to a number of organizations, including Mansfield Board of Education, the Discovery Depot Daycare Center, and, by contract, the Region 19 School District. Bringing the health district into the town's system required establishing a designated fund for tracking purpose. "We have a robust accounting system," said Cherie Trahan, Mansfield's director of finance. "Incorporating a new fund into the town's system was not difficult."

In addition to accounting and disbursement services, the town assists the district with budget development, including estimating staff salaries, and handles the district's auditing and grant management, including submitting quarterly reports and drawing down funds as required.

Maria Capriola, assistant town manager of Mansfield, oversees human resource support to the district. She noted that in addition to staff recruitment, which includes job descriptions, applicant screening, and background checks, Mansfield provides the health district with a full range of support for other human resource issues, including

- Health and life insurance
- Payroll, pension, and benefits
- Personnel management, including counseling on performance appraisal and disciplinary measures when needed.

"Most small-town health departments couldn't provide this level of support on their own," Capriola said. "Working as a regional health district enables us to achieve a certain economy of scale."

Obstacles in Planning and Implementing the Agreement

Elsesser and Stille both agreed that, by and large, the formation of the health district went quite smoothly. The Connecticut Department of Health led some workshops to help with the transition. "It helps that the ownership of public health services is not generally an issue that residents tend to become protective of," observed Elsesser.

Still there were some obstacles. For example, smaller towns in the region initially had concerns about being swallowed up by larger towns when the district first formed. However, Connecticut state law dictates how transitions are to take place, which provided a measure of comfort to representatives of the smaller towns. Members of the health district have also made a commitment to treat all members equally. "We've had some growing pains over the years," said Elsesser, "but at this stage, the work of the district is almost seamless."

Formation of the health district enabled towns in the region to come into compliance with state statues, which proved disquieting to many private sector stakeholders—mostly restaurant owners and developers. Local business people were not used to the increased frequency of visits from the health district employees. There was also some pushback from farmer's markets and churches that hold dinners, which had to be licensed to come into compliance. "We definitely had some transition issues. It was a cultural shock for many, having to do sampling and testing, set up handwashing stations, and the rest," said Elsesser.

One frustration that Mayor Paterson expressed was the lack of active involvement on the part of a few smaller towns. "We've tried different ways to keep all the towns involved, but it depends so much on the representative," she said. While state statute requires a spot on the board of directors to be allocated to a member of each town, towns have not always appointed a representative to the board. Mike Kurland, a representative for the town of Mansfield as well as the director of health services for the University of Connecticut, observed that many nights the board cannot achieve the required quorum needed to make decisions because the representatives from some of the smaller towns do not show up for the meetings. "While I don't see the district ever downsizing, we may have to ask some of the smaller towns to step up to the plate or drop out of the arrangement," said Kurland.

Benefits

"We focus on tight relationships rather than tight controls," Elsesser explained.

Several participants commented that one of the most important by-products of their shared services agreement is that members of the board of directors get to know each other and learn about the priorities of the participating communities. "The health district has been able to leverage a number of grants and contracts that the individual towns wouldn't have been able to do on their own. These have offset substantial personnel costs," said Miller.

"We haven't systematically measured the benefits of this arrangement," said Kurland, "but from a strictly observational standpoint, we have enhanced collaboration and cooperation among the towns in the district. And more importantly, we have highly improved communications. It's a much more efficient way of doing business."

Miller noted that there is always something that needs to be done. "We're always looking to provide the next level of service," he said. "But with a regional health district, we have more flexibility, and it's easier to innovate because we don't have local politics to contend with the way urban health departments do."

"Administrative services take a considerable amount of work, and that steals time away from practicing public health," he added. By sharing administrative services, we can reduce the amount of time devoted to administrative services and stay focused on our mission."

Key Takeaways

The Eastern Highlands Health District has been in existence for 17 years and has a well-established record of achievements. As Elsesser, Stille, and Webner observed, shared services and regionalism as a concept were not part of the local government agenda back when the district formed. It is only in recent years that this concept has become much more acceptable as a way of doing business in local government.

Given the long tenure of the district, many of the study participants had insights they offered from their experience. Kurland pointed out the value of sharing expectations from the very beginning to keep everyone involved on the same page. If people know what to expect, it helps to build trust in the group. "The need for trust is paramount," he said.

Elsesser observed that personalities count. If you can identify the right people who are willing to invest in the effort, it will succeed. "We all work at it," he said.

Mayor Paterson noted that it's important to have patience. "The level of cooperation we have now didn't happen overnight," she explained. "Initially all the member towns were pretty protective, but we've had time to establish a trust factor. We try to recognize the needs of every town. And through that level of trust comes a new strength. We have lots of issues in common, and we can lobby the state for things that matter to us regionally. We do it together, which makes us stronger."

Study Participants

Maria E. Capriola, assistant town manager, Mansfield

John A. Elsesser, town manager, Coventry

Michael Kurland, director of health services, University of Connecticut, Mansfield

Robert Miller, director of health, Eastern Highlands Health District, Mansfield

Elizabeth Paterson, mayor, Mansfield

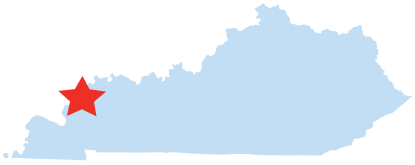
Joyce Stille, administrative officer, Bolton

Cherie Trahan, director of finance, Mansfield

Steve Webner, town manager, Tolland

Center for Sharing Public Health Services
Rethinking Boundaries for Better Health

CASE STUDY:
Pennyrile District Health Department
Crittenden County, Kentucky



PROFILE

Total population served (2013 Census Estimate): 54,181 (Caldwell, 12,823; Crittenden, 9,255; Livingston, 9,359; Lyon, 8,451; and Trigg, 14,293)

Total land area served (in sq. mi): 1,673.1

Average per household income: $38,655

Total revenues (fiscal year [FY] 2013–2014 est., Crittenden County alone):* $743,825

Total expenses (FY 2013–2014 est., Crittenden County alone): $975,071

No. partnering jurisdictions: Five counties

No. employees: 47 full-time equivalents (FTEs) and 6 contracted

Website: http://pennyrilehealth.org

*Revenue estimates are based on the population eligible for federal benefits within the county and on tax revenue contributed; expense estimates are based on Medicaid match and administrative costs for Crittenden divided among the five counties in the district.

Background

Crittenden County, a rural community in southwestern Kentucky, is part of the nine-county Pennyrile Area Development District designated by the State of Kentucky.[13] It is governed by a board of magistrates and a judge executive elected to a four-year term.[14] Historically, Crittenden County has often partnered with neighboring Lyon County and other counties within its state-designated area development district in matters of public health and economic development.[15]

Before the Pennyrile District Health Department was officially established in 1981, each of the nine counties in the Pennyrile Area Development District, including Crittenden County, ran its own independent health department. The state required that each county establish its own board of health (BOH) with a specific composition of practitioners, including a physician, dentist, pharmacist, fiscal county appointee, nurse, engineer, optometrist, veterinarian, and layperson.[16] Local BOHs met annually. Each county was required to fund local public health at 1.8 mills (or 1.8 cents per $100 dollars of property valued annually) in order to receive its share of public health funding from the state. Funds for the Crittenden County Health Department were appropriated by the county's fiscal courts, and some cities contributed funding. The state funded a few special programs to select jurisdictions, but funding primarily went to larger ones.

Around the late 1970s, conversations began among public health administrators in six of the nine counties in the development district. As they were running operations similar in size and services provided, these counties were interested in pooling resources to do more with their budgets. At a Crittenden County BOH meeting on December 28, 1979, Health Administrator Don Robertson reported that efforts were under way to organize a district health department, which organizers believed would produce cost-savings that would dramatically diminish this up-front investment over the next 30 years.

At the time, the state was offering financial incentives to encourage jurisdictions to come together to form district health

departments, and the state's commissioner of health engaged in conversations with the counties to begin setting it up. In April 1981, participating localities approved program plans and budgets.

Forming the Agreement

Crittenden County followed the same directed steps as the other partnering jurisdictions in the formation of the district health department:

1. The Crittenden County BOH acted to have the county's governing fiscal court pass a resolution to unite with the other counties in the district health department, and it sent a copy of this resolution to the State Division for Local Health.[17]
2. The Crittenden County BOH (as well as the BOHs of other participating counties) selected representatives for a "steering committee" for district formation. This committee worked with local health department personnel and the State Department of Human Resources to develop a district plan and budget, which were passed by Crittenden County on April 13, 1981, and sent to the State Department of Human Resources.
3. During the first regular meeting of the Pennyrile District Health Board on June 18, 1981, representatives from the five participating counties' BOHs met to elect a chairman and vice-chairman, as well as an executive board comprising a physician, nurse, dentist, fiscal court appointee, and member at-large.
4. On July 1, 1981, the state approved the formation of the Pennyrile District Health Department.

The location of the district office and employees was to be determined by the district BOH. The state suggested the taxing amounts that each participating county should be required to contribute to ensure fairness, eventually establishing a minimum requirement of 1.8 cents per $100 of valuation. Additional state funds were provided to support the district, and each county could provide further funding for building maintenance.

The Case for Sharing Administrative Services

Although motivations for the decisions made over 30 years ago require some conjecture today, financial benefit was most strongly cited as the initial and primary driver for establishing the district health department, followed closely by an increased ability to offer more health services to county residents. Before the district health department was created, the Crittenden County BOH had concerns about the disadvantages presented by greater bureaucratic control from the state level; however, the advantage of providing more health services to citizens at lower costs was the key decision point.

The counties would be able to achieve greater economies of scale in administration, which would mean increased cost-effectiveness. "The ability to hire one administrator to oversee the office for five counties meant that each county paid only one-fifth of the cost for an executive administrator," noted Robertson. "Dollars saved from decreased administration costs could be allocated more heavily towards programs."

Additionally, because the counties are not large enough to be eligible for many state and federal grants, they realized that being part of a district would help bring in federal grant-funded programs. At the time, counties were seeing cuts in their programs; on February 6, 1981, the Crittenden County health administrator announced budget cuts in the Early Periodic Screening, Diagnosis, and Treatment program, with further cuts expected. For the counties to take advantage of several state and federal grants, a district health department could be a lead agent large enough for grant eligibility on special projects.

The Districtwide Shared Services Model: Establishing a Public Health Taxing District by Resolution

Today, the Pennyrile District Health Department in rural southwestern Kentucky oversees the operations of clinics in Caldwell, Crittenden, Livingston, Lyon, and Trigg counties, offering public health services to their 54,000 residents.

In accordance with Kentucky State Statue KRS 212.855, the Pennyrile District BOH comprises at least two members from each county BOH within the district; those members must be the county judge and at least one other appointed individual. Selection of those other members is guided by a state mandate, applicable to both county- and district-level BOHs, that requires representation by at least one physician, nurse, dentist, and fiscal county appointee. The district BOH meets quarterly.[18] In practice, it carries out the interests of the county BOHs, whose members are nominated by

anyone in the community and then approved by the Department for Public Health in Frankfort. The county BOH is a liaison between the community and the health department, explained Dr. Steve Crider, member of the Crittenden County BOH. "We are there to ensure that the public interest is being carried in the community. Since we have a chiropractor, a veterinarian, and other health practitioners represented, we can get a good feeling of what is going on in the county."

Each of the five participating counties has its own building, including Crittenden, whose new facility opened in 2010. Each county building does not have its own administrator but does have supervisors present, and an explicit chain of command is established between supervisors and senior management. All staff members are district employees. Since 2010, management, including the director and human resources and finance staff of the Pennyrile District Health Department, has been housed in a separate district building located central to the five-county district served by the city of Eddyville in neighboring Lyon County. Previously, the administrator had been housed in the Lyon County clinic.

The district health department receives state funding through a block grant, and it allocates funding according to need. It bills the state to receive its federal Medicaid allocation. Each county BOH has authority to collect its local health tax and contributes the amount collected from the mandated district health tax rate to department. Crittenden County's local public health tax was 3 mills (or 3 cents per $100 in taxable property value) in 2014. Of that amount, the revenue from 2.3 cents per $100 in valuation is contributed to the department, and the rest goes toward maintenance of county buildings.

Program focuses are decided by the state, and implementation is coordinated at the district level. For example, the state establishes requirements for programs such as WIC (Women, Infants and Children), health education, and disaster preparedness. The state provides some funds for compliance with state mandates, but not for all programs. With declining funding, state-mandated programs are prioritized, and decisions are made from there for additional programming.

Obstacles in Planning and Implementing the Agreement

The establishment of the district has resulted in increasingly effective and efficient administration over the past 30 years, with challenges in implementation most prevalent in earlier years. The original five jurisdictions that came together to form the Pennyrile District Health Department were not the same as those that participate currently. One of the original participants was incentivized by the opportunity to receive additional state funding; however, it later decided to separate from the effort and took its funds with it. But despite the unexpected loss of anticipated funds, the counties still succeeded in forming the department. Caldwell County, another neighboring jurisdiction that had initially hesitated to participate, decided to join one year after the department was established.

The loss of autonomy was an anticipated obstacle to the formation of the district health department that recurred at times during implementation. Gaining the necessary local support of the county fiscal courts, BOHs, and public health department staff proved challenging. The fiscal courts were reluctant to sign resolutions that reduced the amount of funding they controlled. More recently, a district-initiated tax raise presented a conflict between the district and the local BOHs. As has been noted, prior to 2010, each participating county's tax contribution was at 1.8 cents per $100 of valuation. When the district health department administrator prompted the district BOH to raise the mandated public health tax rate for each county to 2.3 cents per $100, it was troubling to those counties that would need to increase rates to residents.

Perceived favoritism by district administrators over the years also posed potential obstacles to implementation of the agreement. This has been evident in situations related to the placement of the district offices, as well as in perceived inequity in the level of services provided in some counties versus others.

Despite these challenges, the trust established between the counties and the centralized administrator, among BOHs, and between the system and the community has enabled success. "When consolidating, you give up some input," explained Crittenden County BOH member and county magistrate Donnetta Travis. "If there was a concern, it would be brought to the board. It's about establishing community trust. Knowing that somebody local is looking at the dollars coming in and decides on what taxes will be paid and how they will be used is an important aspect."

Advantages

"When I was administrator in Crittenden and Lyon Counties," Robertson reported, "the total budget was $70,000 for operations and services. We continued to expand over the years, and when I retired in 2003, the annual budget was $2.3 million and we

had 40 employees. From everyone pulling together to lower administration costs, operations became more efficient. As a result, more money could be directed to serving citizens, which was the main goal."

The anticipated financial advantage resulting from this arrangement was achieved and has resulted in more cost-effective service delivery. The shared services arrangement increases economies of scale in allocating funds, personnel, and other resources. Four environmentalists can work among the five counties, reducing the cost of providing that service. Multijurisdictional contracting for specialized services, such as legal services, is more cost-effective when centralized and shared.

"When we had to eliminate services for a program, we didn't know what the legalities were of transferring funds," explained Dr. Crider. "Through a lawyer we were able to hire through the district, we found out that we could not eliminate those services."

Estimated costs for Crittenden County alone in FY 2013–2014 were $975,071; however, the county's estimated revenue contributed from taxes and Medicaid allocation was only $743,825 (suggesting that the county might have to provide its current level of services with $231,246 less in revenue). Reduced cost has been especially advantageous in an environment of increasingly diminished revenues to minimize negative impact. In the past four years, the state has moved to managed care with Medicaid, so the reimbursement rate at the district health department has been dropping. Additional savings have resulted from cheaper procurement. The department pays less for supplies and equipment by buying in bulk for five counties rather than one.

In allocating staff, the shared administrative agreement also ensures greater reliability of services through greater staffing capacity. In case a nurse or other service provider cannot come into work, the district can reallocate staff to fill that service gap and ensure continuity of health services in all counties.

Additionally, the district health department provides a logical placement for staff and programs designated by the state to serve multiple counties. For example, the state funds an epidemiologist who provides services to the nine counties in the state-designated Pennyrile Area Development District. The district health department can house this epidemiologist and cover associated expenses, and the epidemiologist will conduct investigations for all counties in the district, including those five that receive services from the Pennyrile District Health Department and the other four in the state-designated area. This is the case for other federally and state-mandated and funded programs, such as a preparedness program and grants from the Centers for Disease Control and Prevention.

One final advantage identified is the network enabled by the district health agreement. Interacting with and learning from other counties and their experiences has been valuable for community building and maximizing knowledge to guide decision making. "There is a big benefit in a larger pool of experience and knowledge," said Crittenden County BOH member Carol Harrison. "Many of the districts face challenges. [Through this arrangement], counties can help each other in solving problems that they have."

Key Takeaways

- Sharing administrative services is critical in small rural areas.
- Management, staff, and elected officials who understand their roles working for the entire district community are critical in maintaining working relationships to achieve success. Fostering trust between board members is a component of this. Getting people on board can prove to be a challenge in the beginning. "The key is effective go-betweens within the district," said Dr. Crider. "You have to trust the district administrator. That's where accountability comes in."
- The primary driver and benefit of shared administrative services is financial. This benefit results from increased economies of scale in allocated funds, personnel, and expertise, as well as from incentives and increased funding opportunities from state and federal sources.
- Shared administrative services significantly enhance the capacity of public health departments to provide a range of programs and services, meet federal and state programmatic requirements, and address specialized challenges, such as legal issues, that independent public health departments could not address on their own.

Study Participants:

Allison Beshear, public health director, Pennyrile District Health Department

Stuart Collins, member, Crittenden County BOH

Steve Crider, member, Crittenden County BOH

Raymond Giannini, former administrator, Pennyrile District Health Department and Caldwell County Health Department

Carol Harrison, member, Crittenden County Board of Health

Perry Newcom, judge executive, Crittenden County; member, Crittenden County BOH; Member, Pennyrile Area Development, District board of directors

Gaye Porter, member, Crittenden County BOH and Pennyrile District BOH

Don Robertson, former administrator, Pennyrile District Health Department and Crittenden/Lyon County Health Department

Roberta Shewmaker, member, Crittenden County BOH

Donnetta Travis, member, Crittenden County BOH, and magistrate, Crittenden County

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10 Association of State and Territorial Health Officials (ASTHO), *State Public Health Agency Classification: Understanding the Relationship between State and Local Public Health* (Arlington, Va.: ASTHO, 2012), http://www.norc.org/PDFs/Projects/Classification%20of%20State%20Health%20Agencies/ASTHO%20NORC%20Governance%20Classification%20Report.pdf.

11 One of the original six communities initially involved in conversations about setting up the district health department eventually decided not to participate.

12 Under the Kentucky Constitution, the fiscal court is the county legislature and governing body of a county.

13 Although nine counties are part of the state-designated Pennyrile Area Development District, only five of them participate in the Pennyrile District Health Department.

14 The county judge/executive is the chief executive of the county and has all the powers and performs all the duties of an executive and administrative nature within the municipality. Judge executives and magistrates have no responsibility for judicial proceedings.

15 Fifteen districts throughout the state make up 2 to 10 counties. The regional concept was developed in the 1970s and 1980s to reduce redundancies with the number of counties in the state.

16 See Kentucky State Statute KRS 212.020.

17 Under the Kentucky Constitution, the fiscal court is the legislative and governing body of a county.

18 Noted in the Pennyrile District Health Department Articles of Incorporation.

ICMA

ICMA is the premier local government leadership and management organization. Its mission is to create excellence in local governance by developing and advocating professional management of local government worldwide. ICMA provides member support; publications, data, and information; peer and results-oriented assistance; and training and professional development to over 9,000 city, town, and county experts and other individuals throughout the world.

Center for Sharing Public Health Services

Rethinking Boundaries for Better Health

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

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