CASE EXAMPLE

Sharing a Nurse to Improve Health in New Jersey

THE CHALLENGE

Like most municipalities across the state of New Jersey, Montgomery Township, a suburban community in the southern corner of Somerset County, could no longer afford to hire a public health nurse to meet needs after the recession hit in 2008. Instead, discrete and routine nursing services were provided through contracts with nursing agencies, totaling about one-tenth of a full-time equivalent position. During the H1N1 outbreak in 2009, "We recruited every nurse we could from schools, the Medical Reserve Corps, and anyone with a license who was willing to volunteer," said Stephanie Carey, Health Officer of the Montgomery Township Health Department (MTHD). Not only did the piecemeal approach fall short of the needed capacity, it illuminated the township's vulnerability in the event of a major communicable disease outbreak.

MAKING THE CASE

MTHD has provided "full services" to three adjacent municipalities, and various other services to some non-contiguous townships, for years. A strong home rule state, New Jersey statute requires every municipality to have a local board of health that ensures the provision of mandated services, either directly or through contracts. This long-standing culture of shared services has paved the way for thinking creatively about how to meet public health needs.

As Carey devised a new model for a shared public health nurse, she considered the full potential of the position. With time available after fulfilling statutory requirements, a full-time nurse could build partnerships with faith communities and other community-based organizations, opening the door to more collaborations around public health issues. Health education classes could be offered on a regional basis, with the potential to draw in more attendees and improve chronic disease management with at-risk populations. The nurse could develop relationships with school nurses and establish the health department as their go-to resource. And above all, a full-time position would mean that a public health nurse always was available to respond to a communicable disease outbreak in any participating municipality.

> *"It was very clear that we would be 'critically exposed' if there was any kind of communicable disease outbreak. This is what kept me up at night."*
>
> **– STEPHANIE CAREY**
>
> Health Officer of the
> Montgomery Township Health Department

Carey's next step was to develop a return on investment for the full-time position. This involved gathering quantitative data, such as the average time needed per person to conduct a communicable disease investigation. Carey then was equipped to calculate the costs for the four municipalities she serves as health officer.

Most of the funding for the position came from existing funds. Moreover, the health insurance fund management group for Montgomery Township provided a small grant so 10 percent of the nursing position could be used to expand the town's wellness program. Carey also structured the position so that a proportion of the nurse's time could be purchased by other municipalities, based on their unique needs.

Carey then shared the concept with her four boards of health and with health officers in nearby towns to gauge interest in the shared public health nurse model. While many people expressed interest, only her four boards of health and another in nearby Branchburg made enough of a commitment to the idea for her to proceed.

Armed with the business case, as well as qualitative data (e.g., Branchburg school nurses expressed excitement at the prospect of having access to a public health nurse colleague), Carey met with each board of health to present a formal proposal for the new, shared position. In addition to sharing the data, Carey also presented sobering scenarios highlighting what could happen if they did not have a nurse in an emergency — scenarios that have become even more dire over the years due to a shortage of nurses throughout the region. Each of the five boards of health readily were convinced of the value of sharing a full-time public health nurse, and the proposal was uniformly accepted.

THE RESULTS

In addition to guaranteed nursing coverage in the event of a communicable disease outbreak, new relationships are being developed with school nurses and other partners in the five communities. Moreover, additional towns are making serious inquiries about participating in the shared position. There is enough interest that a regional model for providing nursing and health education (with rotating program locations) is under consideration, with great potential for improvements in community wellness.

One year after $17,000 was invested in an expanded employee wellness program, health insurance claims dropped by $200,000. Carey notes, "We can't prove cause and effect, but these figures generated support among the commissioners for continuing the program expansion."

KEYS TO SUCCESS

Carey has worked with her boards of health and health officers throughout the county for a number of years. She cites these strong relationships as the number one key to success, noting the importance of deliberately building relationships whenever a new member joins the governing entity.

A close second is trust, and Carey is quick to point out the importance of investing time in relationship-building as a means to build trust.

Both quantitative data and story-telling are needed to describe the value of a cross-jurisdictional sharing arrangement. It's important for governing entities to understand what they are buying for their dollar and the numbers only tell part of the story. Concepts such as having what is needed to respond to an emergency can be quite compelling.

Carey also credits the Center for Sharing Public Health Services for facilitating their efforts. The Center's *Roadmap* and *Success Factors* were useful resources for educating and engaging their stakeholders, elected officials and partners, and the technical assistance provided a sounding board for ideas as well as gentle guidance on how to make their process work even better. Carey notes, "The fact that the Center thought this concept was worth funding, and that our small agencies could become a national model, carried a lot of weight with our elected officials."

October 2019 – PHSharing/19-13-V1

Center for Sharing Public Health Services
Rethinking Boundaries for Better Health

ADDRESS 212 SW Eighth Avenue, Suite 300 | Topeka, Kansas 66603-3936
TELEPHONE (855) 476-3671
EMAIL phsharing@khi.org **WEB** phsharing.org

The Center for Sharing Public Health Services provides access to tools, techniques, expertise and resources that support better collaboration and sharing across boundaries. We help public health departments across the country work together to protect and promote the health of the people they serve.