



Cross-Jurisdictional Sharing

Description

Cross-jurisdictional sharing (CJS) is the deliberate collaboration across jurisdictional boundaries to deliver essential public health services (Center for Sharing Public Health Services, 2013). It's typically used when health departments are either strained for staff, funding, or both, and used to ensure residents are able to access high-quality services at the lowest possible cost for the health departments. Cross-jurisdictional sharing ranges from informal arrangements to more formal changes in structure at both the local and state levels. Typically, when applying cross-jurisdictional sharing to public health services, this sharing occurs between health departments or agencies serving two or more jurisdictions (CDC).

Benefits

- Allows health departments to reach greater populations and/or provide additional services with the same or fewer resources
- Health departments are able to split costs and provide services for a lower cost
- Allows for a continuity of services, can add more people to certain services, depending on need
- Can help to establish relationships between officials at different health departments
- Can decrease individual workloads of health department officials

Challenges

- A more time-consuming planning process, as there are more stakeholders involved
- Can be difficult to communicate with all partners involved
- Politics and competition can dissuade LHDs from engaging in this strategy
- Geographic closeness may not equate to similar demographics among populations and similar populations may be too far to involve in programming
- Can be difficult to change the mindset of municipal government to function more as a commission, as opposed to looking out for just the specific needs of one municipality

Considerations and Recommendations

- Requires frequent and open communication with all parties involved to ensure everyone has same goals/priorities
- Collect data on programs so that if there is political/financial pushback, you have quantitative data to support this strategy
 - Also necessary in ensuring programs are efficient and reaching all populations encompassed by sharing module
- Important to consider before implementing how each town will participate, what services they will provide, and how they will be represented
- Need to price programs at a point that is both sustainable for the organization and competitive with other LHDs

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#2

INNOVATION SNAPSHOTS



FIELD EXAMPLE #1



Provincetown, Massachusetts

Provincetown, Massachusetts sits at the very tip of Cape Cod, only bordered by one town and the Atlantic. In a place known for its beaches and summer tourism, the local health department uses a shared services model to help alleviate seasonal depression in the winter.

Sharing areas of expertise.

Provincetown primarily shares services with Wellfleet, Massachusetts, which is two towns over from Provincetown. Currently, Provincetown Health Department implements public health interventions for both towns and Wellfleet provides both with sanitation reviews. The informal agreement works well because Provincetown was the first town on the outer Cape to begin implementing public health services through its local health department, and Wellfleet does not have a sewer system like Provincetown, so their health director focuses primarily on on-site septic reviews as well as drinking well reviews. Since beginning this arrangement five years ago, Wellfleet has been able to help fund public health programs through the Provincetown Department of Health to ensure that they are free for the participants.

Building on pre-established relationships.

This arrangement began at an annual professional organization where both directors of health happened to be in the same session about cross-jurisdictional sharing.



After hearing about other towns in Massachusetts that were implementing this structure with their health departments, and realizing that if tasks were divided differently the towns could help lessen the workload of each while reaching more people, the towns agreed to test out this model.

The model works well for the towns; their departments were severely understaffed, but now they can split positions between them and provide more for their residents. The two towns began by mapping out their regular duties, identifying crossover or similarities, and then selecting areas for sharing. Currently, they are working to model their regulations as similarly as possible to ensure ease of shared services between them. Aside from services, the two towns are able to share ideas, and compare processes, software, and budgets with ease due to their pre-established relationship.

Challenges and facilitators.

In terms of challenges, the process has proved time consuming due to a larger amount of stakeholders. Additionally, despite geographic closeness, surrounding towns may have very different demographics and thus it may not be worthwhile to partner on certain programs and it can prove to be difficult to partner and even find communities with similar population demographics. This is specifically the case for Provincetown, Massachusetts where the majority of the population is LGBTQ and male.

To quell the challenges, the two health departments have gone all in, in terms of time, energy and commitment to the shared services model. They also are starting with smaller, less expensive programs in order to avoid political pushback and ensure there are participants for the programs they're implementing.

Ability to provide free services.

One of the cross-jurisdictional sharing success stories has been adult education classes, which are free and aim to ameliorate all the barriers of participation. The towns involved pay for the instructors and participant transportation to ensure people can attend, get connected, and engage in educational activities during the winter.

For Provincetown and Wellfleet, combining services allowed the two smaller, outer Cape towns to share expertise and build on their proximity and already established relationship while providing an increased amount of free services to their populations.



FIELD EXAMPLE #2



Monmouth County, New Jersey

Monmouth County, New Jersey began doing cross-jurisdictional sharing in 1936; this model is now called shared services in the state of New Jersey. The original model utilized a grant from the Social Security Administration. The initial aim was to try and have more coverage in regard to the provision of public health services in various states and locales. Currently, the region, which encompasses the northern most parts of the Jersey Shore, implements a cross-jurisdictional sharing model that covers 18 different municipalities. Each town is charged based on a combination of population and workload and the yearly cost is determined by a three-year model, which is collected by the Regional Health Commission. The Regional Health Commission, as it's referred to, works to ensure that the fees are lower than the competing local health departments and aims to retain the 18 towns that are currently included in the model. To do this, they conduct a yearly assessment where average workload (food inspections, complaints,

etc.) and town population are compiled into a weighted average. This model is unlike other health departments that base their fees on property assessments.

The importance of processes and agreements.

The commission works through a governing board where every town that is represented by the commission has a seat at the table, so that they get a chance to contribute to discussions surrounding health policy and budgets. When a town agrees to become a member town, they sign a two-year agreement committing them to be part of the shared service/cross-jurisdictional sharing arrangement for that time period. At the end of the two-year time period, a town can choose to extend until modified or terminate. These agreements work as a facilitator by allowing the governing body to be ongoing, as they meet on a monthly basis to work through successes, grant funding or finding grants, and budgeting and human resources in regards to either scaling up or scaling down the operation, and which is based on New Jersey's practice standards for local boards of health. Other facilitators include the original grant from the Social Security Administration.

With more partners can come more challenges.

As with any method, there have been challenges in implementing cross-jurisdictional sharing in Monmouth County. Namely, when implementing an agreement across 18 different towns, it can sometimes be difficult to communicate with all partners represented on the governing board. Additionally, a long-term challenge has been changing the mindset of municipal governments to function more as a commission, as opposed to looking out for the specific needs of one municipality. Funding also plays a huge role as the shared model ends up being in direct competition with other local health departments that may be at a lower price point or provide a higher salary for their workforce.

Financial successes.

Cross-jurisdictional sharing began in New Jersey as a way to organize public health jurisdictions, similarly to county and municipal governments. But, using a cross-jurisdictional model has allowed Monmouth County to deliver the same services as other departments, but for a lower cost. Today, it is estimated that starting up a

brand-new health department in New Jersey would cost a minimum of \$300,000–\$350,000 to meet all the practice standards for the state, but for towns included in the shared services model, the fee scale doesn't go higher than \$265,000. Further, using this model has allowed the county to experience a continuity of operation. As a result, there are several inspectors who can serve as backup to one town or individual towns in case there's a need to surge up for a particular public health situation, an outbreak, or similar event.

Similarly, the county utilizes a cross jurisdictional sharing model called the Monmouth Public Health Consortium which provides services for communicable disease investigations. Which is perhaps the most noteworthy success. The consortium started out with a part time initiative eight years ago, and has expanded into a whole division, where it can provide public health investigation services, and contact tracing for all 18 towns and four other additional towns outside the shared services model. This initiative began at a time when New Jersey was seeing that there were problems with communicable disease outbreaks in long term care facilities, and there was a decent share of long-term care facilities amongst the 18 towns included in the shared services model. The shared arrangement was very helpful in enabling relationship building with long term care communities. Because this began before COVID came, once the pandemic hit there was already a team in place who was ready and well-equipped to pivot to COVID. Each year, the group does 1-2,000 non-COVID communicable disease investigations. Additionally, this consortium can add more people to help out during an outbreak, which increases efficiency.

Monmouth County relies on cross jurisdictional sharing to cut costs but the model has also proved to be an extremely efficient way to ensure all residents can access services, especially during disease outbreaks like COVID-19.



FIELD EXAMPLE #3



Genesee and Orleans County Health Departments, New York

Genesee and Orleans County in western New York have been implementing a cross-jurisdictional sharing model for their health departments for the past nine years. The health departments initially had to shift existing policies to ensure this partnership was able to occur, but have since been using the method to save money and restructure and redesign county government to ensure they are efficient and streamlined. Currently, the health director believes that since implementation, they've been able to save well over seven figures of costs.

Recruitment challenges lead to a shift in policy.

Shortly after Paul Pettit took over as the public health director for Orleans County in 2012, the same vacancy was posted in nearby Genesee County. Historically, both health departments struggled with financial constraints as well as recruiting and retaining qualified staff at the more senior levels. At the time, due to New York State law, cross-jurisdictional sharing was not possible. While the state encouraged working collaboratively across counties, it said that each county in the state shall have its own public health director and a separate Board of Health, ruling out the possibility of formally sharing staff and services. Paul soon worked with the state legislature and elected officials to get the law changed. And while there are still parameters, the new law allowed for a public health director to be shared for up to three counties, with a total of 150,000 population or less. This was especially beneficial to the smaller rural counties areas that

may especially struggle to hire qualified candidates. Because of this reform, Orleans and Genesee counties, with a cumulative population of 100,000, were able to begin a process of public health cross-jurisdictional sharing.

“This CJS work is really built on relationships. There has to be a high trust factor, a high willingness to look towards the longer-term strategy and the bigger picture than the short term gains and that’s kind of what’s in it for me, so it’s really a mindset that I think you have to get all the partners or at least have a strong majority of the partners on board with it.”— Paul Pettit, Orleans County Health Department

Laying down the groundwork before implementing.

Even before it was implemented, the whole concept took quite a while to get in place, as it utilized two independent county legislators from both counties and two separate boards of health, as well as the State Department of Health. The leadership team had to work with each of the five entities individually to gain buy in and support. Finally, after almost a year of planning and relationship building, the units formally signed agreements to share a public health director and deputy, while operating under two county budgets. Despite this, the two share services and employees, splitting the costs evenly between them. They currently share six to seven full-time employees, mainly the department heads of each division, as well as a shared lead coordinator and several shared physicians. The collaborative model has also allowed the health departments to provide more services to their constituents, as well as enabled them to offer a higher pay scale to attract certain talent and credentials for their staff. Essentially, the model has allowed the two small counties to act as one medium-sized county.

Using relationship building as the springboard for success.

To get the process started, Paul worked with the Center for Shared Services out of the University of Washington to get a grant to pilot cross-jurisdictional sharing in a public health context. Then, Paul worked to create relationships with all the stakeholders involved. On the topic of relationships, Paul states, “This CJS work is really built on relationships. There has to be a high trust factor, a high willingness to look towards the longer term strategy and the bigger picture than the short term gains and that’s kind of what’s in it for me, so it’s really a mindset that I think you have to get all the partners or at least have a strong majority of the partners on board with it.” Paul worked to create trust with both counties’ boards of health, attending monthly board meetings, met staff, and worked collaboratively with those involved to work through processes. Doing so helped to alleviate some of the barriers, namely shifting culture and ensuring that political decisionmakers as well as staff were fully on board.

Shifting culture on both ends.

Framing the process as an integration of two departments and not a merger or takeover helped to alleviate staff concerns regarding job security and uncertainty. The department also utilized a well-developed plan and open, constant communication to ensure staff understood the process. While changing the culture remains an ongoing process, leaders used an intentional model to bring both counties together and ensure everyone knew one another, but allowed them to operate mostly as normal, slowly bringing more staff under the shared model. Currently, the model is closer to 50/50, going back and forth between the two health departments. Concurrently, they worked on a rebranding to have both health departments under a [shared website](#) with the same look.

Increasing area covered can also increase burden on staff.

A current challenge the health departments are facing is the strain on individual staff in covering two independent counties. For certain positions, there is only one person working with both counties and trying to communicate effectively with each, including attending scheduled meetings, and sharing out necessary and pertinent information.

Make cross-jurisdictional sharing align with the long-term vision of your health department.

The most critical piece of advice Paul has for those who may want to implement this is to ensure that cross-jurisdictional sharing is part of the longer-term strategy. Including long-term goals and anticipating needs within this strategy can also help to develop relationships across health departments over time. Allowing this process to grow over time also allows the decisionmakers to create formal agreements and build out processes.

Working collaboratively has not only saved millions of dollars between the two health departments, but it has also allowed for the enhancement of services and benefits and has allowed the counties to get additional grants that a smaller county would struggle to get on its own. Especially during COVID, Genesee and Orleans counties were able to utilize a larger workforce to help with risk communication, working clinics, and contract tracing at a time when staff were stretched to full capacity.

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