



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 statute. 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 statutes, 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 hand-washing 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



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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.