

Massachusetts Public Health Regionalization Project
Status Report
September 1, 2009

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Abbreviations

LBOH - Local Board (or Boards) of Health

Working Group – The MA Public Health Regionalization Working Group

CLPH – Coalition for Local Public Health

PBRN – Practice-Based Research Network

The Institute –Local Public Health Institute of MA

MDPH – MA Department of Public Health

MDEP – MA Department of Environmental Protection

Executive Summary

This Status Report highlights the work of the Massachusetts Public Health Regionalization Project. The Regionalization Project's goal is to strengthen the Massachusetts public health system by creating a state-funded regional structure for equitable delivery of local public health services across the Commonwealth. The Regionalization Project's Working Group - comprised of representatives from state government, local public health officials from cities and towns with varying populations and governing structures, legislators, and public health experts from the academic community – has made significant progress toward realization of this goal since the release of our previous report in February 2008.

This paper begins with an analysis of why public health regionalization needs to occur in Massachusetts. We paint a picture of a state where resources for local health departments have diminished at the same time that responsibilities of local health practitioners have increased significantly, not least of which in the area of emergency preparedness. These inverse trends have yielded a local public health workforce not always able to provide the basic, essential public health services to their residents, as well as significant inequities across the Commonwealth in residents' ability to access these services.

Informed by feedback from hundreds of the Commonwealth's local public health professionals and catalyzed by the enactment by Governor Deval Patrick of Chapter 529 of the Acts of 2008, An Act Relevant to Public Health Regionalization, the Working Group formed subcommittees with the aim to conduct in-depth research in several areas central to the development of a comprehensive regional structure of local public health service provision. The Working Group subcommittee reports are summarized in this paper, and include:

- A proposed regionalization incentive payment formula which begins with a basic per capita payment, then adjusts that payment based on the degree of regionalization, poverty and population density.
- Recommendations for the minimum size of a regional health district, such as a population of 50,000 or land area of 155 square miles.
- Recommendations for minimum educational background and professional credentials for staff positions, based on a draft report by the Local Public Health Institute of Massachusetts' Advisory Council, though modified to reflect the creation of regional health districts.
- A template for regional health district bylaws, designed to provide a model governance agreement for communities working together to create a regional health district.
- A legal review of matching requirements, examining such entities as the Massachusetts Library Statute, Massachusetts Community Preservation Act, as well as Connecticut's and Ohio's regional health district structures, to describe measures used to prevent decreases in local spending when state government provides funding to supplement it.
- Further research into the need for public health regionalization in Massachusetts.

This status report also highlights both longstanding examples of successful public health districts in Massachusetts, such as the Tri-Town Public Health Department (Lee, Lenox and Stockbridge), as well as recent regionalization efforts by local municipalities, like Melrose and Wakefield. We end with a description of efforts to build upon the recent momentum toward a regional health structure here, including Working Group recommendations to the MA Department of Public Health regarding its role in supporting a regional public health structure, recommendations to municipalities considering transitioning to a regional approach, and plans for moving this agenda forward over the next 18 months. These plans include working with 3 clusters of cities or towns interested in piloting a district model, and formally evaluating their transition process.

After thousands of combined hours of research and meetings with key informants throughout the Commonwealth and other states, it is the firm belief of the Massachusetts Public Health Regionalization Project that the time is right for a regional public health structure. Regional public health districts will enable local public health practitioners to be able to more efficiently and effectively meet the increasing demands on their time. The creation of regional health districts which enable local boards of health to retain home rule will yield a much more robust public health system with the capacity to significantly reduce inequities in local public health provision and keep all of Massachusetts' residents more healthy and safe.

I. Why Regionalization? Why Now?

It is widely understood that many of Massachusetts' dedicated local public health practitioners are struggling to ensure the health and safety of the residents of their communities in light of budget cuts, insufficient staffing and increasing demands on their time. It is the firm belief of the many diverse professionals who comprise the Massachusetts Public Health Regionalization Project that efforts aimed at regionalizing local public health will offer the most cost-effective means of providing equitable, high-quality public health protection to the people of the Commonwealth. While not a solution to the challenges wrought by the current economic climate, local public health regionalization offers an opportunity for local communities to work together in a more comprehensive, meaningful way. This paper highlights the current challenges facing local public health practitioners; relevant research including examples of established, successful regionalization practices; current efforts and progress toward public health regionalization throughout the Commonwealth, including an update of the work of the Massachusetts Public Health Regionalization Project; and planned next steps for this group, the MA Department of Public Health and other key stakeholders. It is the aim of the Regionalization Project Working Group that this status report serves as a vehicle to accelerate both conversation and discrete action by local communities toward a regionalized model of public health delivery in Massachusetts.

Current Local Public Health Challenges

Even prior to this latest economic downturn, there was a trend toward significant state cuts to the public health infrastructure, with dire impact. In the Massachusetts Health Policy Forum study, *Funding Cuts to Public Health in Massachusetts: Losses over Gains*, authors Judith Kurland and Deborah Klein Walker, EdD, reported MA Department of Public Health programs were cut 30% between 2001 and 2004, or roughly \$158 million. "These cuts are disproportionately larger than those of any other agency within the Executive Office of Health and Human Services and are further exacerbated by cuts in Local Aid to cities and towns, which in turn have had to reduce their own support for public health programs." They concluded these budget cuts would yield widening disparities in access, appropriateness and cost of health care based on race, ethnicity and social class.¹ Further, according to the MA Public Health Association, adjusted for inflation, MDPH funding decreased 15% from Fiscal Years 2001 to 2007.

The Commonwealth of Massachusetts has 351 separate cities and towns, each with its own board of health responsible for providing (or assuring access to) a comprehensive set of services defined by state law and regulation. Although it ranks 13th in the nation for population size and 44th in land area, Massachusetts has more local health departments than any other state in the U.S. There is no regional or county public health system established by the state and no direct state funding for local health departments and boards of health; they are supported primarily by local property taxes. Faced with funding and workforce challenges; increasing demands including water and air quality, housing safety, and emergency preparedness; and regional disparities, most municipalities are currently unable to meet many of their responsibilities, providing only those services deemed most essential – in short, performing public health triage. Other workforce challenges include a lack of standardized training requirements, no uniform

¹ Kurland J, Klein Walker D, Hagar C. (2004). Funding Cuts to Public Health in Massachusetts: Losses over Gains." Issue Brief prepared for The Boston Foundation. Massachusetts Health Policy Forum. <http://www.tbf.org/uploadedFiles/Funding.Cuts.to.Public.Health.June2004.pdf>.

minimum qualifications (education, work experience, and credentials), and an aging local public health workforce.

Select examples of the public health challenges facing Massachusetts include the following:

- Of Massachusetts towns with less than 5,000 residents (there are 105), 78% have no full time public health staff, 58% have no health inspector and 90% have no public health nurse. The staffing of the 71 towns between 5,000 and 10,000 residents is not much better.²
- Over 70% of local health officials report they do not have enough staff to consistently fulfill their responsibilities to the public.³ Further, according to a 2004 MDPH statewide needs assessment of local health boards and departments, nearly all responding communities reported they found it challenging to prevent chronic and infectious disease and injuries (98%), ensure a competent public health care workforce (97%) and apply basic environmental public health regulations (89%).
- That same assessment found major regional disparities in public health system capacity--22% of western MA communities had no public health director/agent, compared to 3% for metro Boston; 17% of western MA communities did not keep records of reportable diseases, compared to 1.6% for metro Boston.
- According to the Trust for America's Health, Massachusetts scored 6 out of 10 on various measures of Emergency Preparedness in 2008, which ranks the Commonwealth 37th in the nation.
- That same study ranks the Bay State 9th worst with regard to 2010 public health nursing shortage estimates.⁴

With regard to federal public health funding, according to the Trust for America's Health, the Bay State ranks 19th in monies from the U.S. Center for Disease Control and Prevention, and 31st in allocations from the Office of the Assistant Secretary for Preparedness and Response for the Hospital Preparedness Program.⁵ As this report is being prepared, Massachusetts' cities and towns are reeling from nearly \$130 million in cuts in state local aid funding over the past year. Local public health services in many communities are bearing disproportionate shares of reductions as municipal officials struggle to balance local budgets. In addition, the MDPH budget was cut by \$70 million, or 12 percent, for the year beginning July, 2009, compared to the previous year. These cuts are yielding staffing and program reductions in a wide array of areas, including the department's immunization program, school-based health services, substance abuse services, tobacco control programs, public health hospitals, family health services,

² Better Prepared But Spread Too Thin: The Impact of Emergency Preparedness Funding on Local Public Health. Disaster Management & Response, Volume 4, Issue 4, Pages 106-113 J. Hyde, B. Kim, L. Martinez, M. Clark, K. Hacker

³ Hyde, J., and Tovar, A., Institute for Community Health. Strengthening Public Health in Massachusetts: A Call to Action. Coalition for Local Public Health, June 2006, at http://www.mphaweb.org/resources/strength_lph_6_06.pdf. Survey results were reported for 191 participating communities, which did not include most of the state's larger cities.

⁴ <http://healthyamericans.org/states/?stateid=MA>. Trust for America's Health. State Data 2009.

⁵ <http://healthyamericans.org/states/?stateid=MA>. Trust for America's Health. State Data 2009.

HIV/AIDS programs, and health promotion and disease prevention initiatives.⁶ Cuts to MDPH environmental health and laboratory services have direct impacts on the department's ability to provide technical assistance to local boards of health. From town administrators to community-based healthcare providers, from local foundations to urban hospitals that serve primarily the indigent, the ripple effects of the current economic crisis are being felt widely and deeply.

As the Pioneer Institute, a Massachusetts non-partisan public policy think tank, describes in a recently published white paper entitled *Regionalization: Case Studies of Success and Failure in Massachusetts*, "Cities and towns face ongoing budget challenges as local aid continues to lag (on an inflation-adjusted basis) behind levels from earlier this decade. Employee compensation costs continue their inevitable upward march. And higher levels of disclosure about unfunded liabilities for pensions and retiree healthcare place further pressure on budgets. These constraints exist in the context of a hard cap on property tax revenues. Communities also face increasing pressure on the service side as well. State and federal mandates require more specialized skills and stricter compliance standards. Many communities suffer from a lack of qualified citizens with an interest in participating on boards and committees. Within this framework, regionalization is a more compelling choice than ever."⁷ The many compliance standards which exist for local health departments are critical to ensuring basic public health needs for town and city residents are being met.

An Opportunity: The Benefits of Regionalization

As described in the February 2008 Status Report of the MA Public Health Regionalization Project, our investigation into the practices of other states supports the lessons learned from Massachusetts' limited experience with cooperation among its cities and towns: *public health regions work*.⁸

- Regionalization has been shown in other states to offer economies of scale for communities who band together.
- Increased state funding as incentives to form districts will give cities and towns access to more staffing and other critical resources.
- Local jurisdictions can choose from different models to ensure the best fit for their unique circumstances.
- Larger districts have greater capacity to apply for grants and are more competitive in grant applications, bringing additional resources to their communities.
- More state funds, pooling resources, greater cooperation and communication, and more standardized training will yield a stronger and better prepared local public health workforce.

Due to current and projected budget cuts to localities, more and more Massachusetts towns and cities are coming together to share resources within other realms, such as

⁶ Massachusetts Medical Society, "State Budget Cuts Affect Public Health Programs," *Vital Signs*, December 2008, January 2009, http://www.massmed.org/AM/Template.cfm?Section=vs_current_ph&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=23931.

⁷ "Regionalization: Case Studies of Success and Failure in Massachusetts," *Pioneer Institute* 43 (2008):1.

⁸ "MA Public Health Regionalization Project: Status Report," February 2008. http://sph.bu.edu/images/stories/scfiles/practice/regionalization_status_report_2-21-08.pdf.

public safety and education. The Pioneer Institute white paper analyzed eight examples of regionalized efforts throughout the Commonwealth, from Veterans Services to Metrowest 911 Dispatch Services to the Nashoba Associated Boards of Health. Their conclusions include:

- The provision of better service is equally as important as the cost savings reaped from regionalization.
- Most successful regionalization efforts stem from grassroots as opposed to a top down mandate.
- State incentives alone are often necessary but not sufficient to encourage communities to regionalize services.
- Jurisdictional disputes and union challenges are the most common barriers to successful regionalization efforts.⁹

The Time is Right for Regionalization

The recession that began over a year ago has prompted officials in numerous Massachusetts communities to restructure local public health services. In many cases, this has taken the form of staff cuts with resulting program reductions and/or the replacement of municipal employees with private contractors to perform specific, limited services. Several cities and towns have eliminated staff positions, including health directors, and moved health inspectors into building inspection or inspectional service units. Other communities, however, have used the economic crisis as a catalyst to move toward regionalization by negotiating shared service arrangements or combining health departments with neighboring communities.

While important concerns and reservations exist among local communities, there is general consensus of a need to move in the direction of regionalized public health service provision. The following are highlights of a brief real-time survey conducted with attendees of the Massachusetts Public Health Regionalization Project's February 29, 2008 panel discussion (the document "Statewide Meeting Summary for Feb. 2008" can be found at <http://sph.bu.edu/regionalization>). The nearly 250 attendees included health agents/directors (35%), public health nurses (12%), sanitarians /inspectors (12%), Board of Health members (15%), other local public health professionals (10%), and others who do not work for local health departments (16%).

- 80% agreed or strongly agreed that local public health departments are understaffed, under-funded, under-resourced and cannot provide the most essential public health services to their citizens.
- 85% indicated they have working relationships with neighboring health departments / health boards.
- 74% agreed or strongly agreed that home rule authority is critical to maintain in their community.
- 75% agreed or strongly agreed that regionalization of public health services is the right approach to enhance the delivery of public health services to Massachusetts residents.
- 92% indicated that the district workforce should meet minimum standards in education, experience and credentials; 86% felt it should meet minimum performance standards.

⁹ "Regionalization: Case Studies of Success and Failure in Massachusetts," Pioneer Institute 43 (2008):2.

- 70% agreed or strongly agreed that now is the right time to take on a project aimed at regionalizing public health services in Massachusetts.

Regionalization Models and Examples

Most communities in Massachusetts provide public health services for their own residents. This method of service delivery is referred to as “a stand-alone community” by the Regionalization Project Working Group. Based on our research, the Working Group recommends state funding for local health and the adoption of the following two models of regionalization for local health departments. We will describe current and proposed efforts in light of these two models.

- i. **Comprehensive Services District:** All local public health services for two or more municipalities are carried out by one set of employees. Governance and legal policy making authority are retained by the municipal boards of health or may be delegated to a Regional Board of Health.
- ii. **Shared Services District:** Select, but not all, local public health services are carried out under formal agreement between consortiums of municipal boards of health. Examples include sharing staff (e.g. Animal Inspector, Epidemiologist, Health or Environmental Inspector, Public Health Nurse, Sanitarian) and/or providing designated services (e.g. clinic operations, inspections, investigations).

A few established examples of public health districts - Nashoba Associated Boards of Health (1931), Barnstable County Department of Health and Environment (1926), and Quabbin Health District (1980) - are summarized in *Appendix 3*. The following case study of the Tri-Town Health Department illustrates a long-standing, successful “Shared Services District” model.

Overview

Tri-Town Public Health Department provides services to three towns in Berkshire County, MA – Lee, Lenox and Stockbridge. Based on 2000 Census figures, the total population served by the Tri-town public health department is approximately 13,338 people and covers roughly 72 sq. miles. Lee is the largest town in the collaborative with 5,985 people, followed by Lenox with 5,077 people and Stockbridge with 2,276 people. Located within the Berkshire Hills, these three towns are popular tourist destinations for people living in and outside of the Commonwealth.

Lee, Lenox and Stockbridge have been collaborating to protect the public’s health since 1929. The partnership was originally born out of a concern for health problems emerging from dairy farms. At the time, dairy farms were a primary industry in Berkshire County and a major employer for many residents in the area. Prior to 1929 there were few standards or regulations in place to protect the health of employees and consumers of dairy products. Widespread health problems were common as a result of poor hygiene among workers and bacteria in the dairy products. Municipal leaders within several communities decided to pool resources to hire a professional inspector. The inspector worked with local dairy farmers to improve hygienic practices on farms and reduce levels of bacteria and parasites in milk products. The partnership was originally called the Tri-Town Milk Control Lab. One of its major successes was the early adoption of pre-pasteurization of milk as a measure to protect the public’s health.

The early success of the Tri-Town Milk Control Lab led to the development of a public health entity that tackled a number of issues, including protection of local water supply, septic tank and other waste disposal inspections, food safety, and others. Essential public health services for the three towns are provided by public health officials in the

town of Lee, where the central office is located. Their organization may best be described as a “shared services” model, with the towns of Lenox and Stockbridge purchasing public health services from the town of Lee. However, Tri-town’s success goes beyond these borders. Today the Tri-town health department works with 12 neighboring communities to provide wellness programs, such as tobacco control and healthy weight promotion.

Staffing

The public health department in the town of Lee has three full-time employees, three part-time employees, and a range of individuals and agencies with whom they contract for services. One of the full-time employees is the director of the department. In addition to the administration of the public health department for the three towns, his primary responsibilities include oversight of inspectional services. He directly supervises the assistant director and one full-time and one part-time health inspector. The assistant director, also a full-time employee, oversees all of the prevention programs for the three towns and beyond. The person in this position develops and secures funding for prevention and wellness programs, collaborates with neighboring communities to implement these services, and oversees contracted services, such as those provided by the Visiting Nurses Association. The department also employs a part-time animal control officer and a part-time administrator. Contractors are hired on an as-needed basis, depending on the health needs and goals of the Tri-Town communities.

Legal Authority and Governance

Tri-Town operates as a district under the provisions of a state law (MGL Chapter 40, Section 4a) that allows communities to negotiate shared services. Each town within the Tri-Town collaborative assumes responsibility for providing their residents with public health services. Lee, Lenox and Stockbridge each have their own Boards of Health, which meet regularly to discuss and respond to local health issues and concerns. The three Boards of Health meet together on a quarterly basis to discuss local and cross-jurisdictional health concerns, service needs and provision, and budgetary issues. Together, they set health priorities for their communities, review successes and challenges in meeting these priorities, and identify appropriate resources for funding of needed services. The public health director in the town of Lee is responsible for reporting to the three Boards of Health and providing them with information to make informed decisions about services and budgets.

Financing of Regional Services

Public health services in the towns of Lenox and Stockbridge are purchased from the town of Lee. On a quarterly basis, these towns pay Lee for salaries and expenses associated with public health services. The amount that each town contributes to public health services is based on a formula, with population size being a primary factor in the equation. The contribution of each town covers approximately 50% of the overall budget for public health services in the three towns. The remaining 50% is covered through a combination of grants and fee-for-service programs. Grant dollars typically focus on wellness programs and services. Fee-for-service dollars are generated primarily through permits, environmental testing and other inspectional services.

Like other towns within the Commonwealth of Massachusetts, municipal contributions to local public health services must go through a relatively lengthy approval process each year. The Board of Health in each town works with the public health director in Lee to develop and approve a budget for public health services provided to their respective towns. These budgets then go to each town’s finance committee for review and

approval. Finally, the allocations for public health services are approved annually by each town through the town meeting process.

Decision-making about public health financing and service provision is an on-going process in these three communities. Some services, such as prevention and wellness programs, are more difficult to sell than others. The public health staff in the town of Lee is proactive in their approach to securing funds for these services. They collect data to highlight the success of their efforts and disseminate information to the citizens in each town as often as possible. Their belief is that if the public sees worth in a program, they will support it financially. The budget approval process motivates the public health staff to continuously assess what services each town needs and reflect upon and improve the services they provide. This motivation has allowed the public health department to survive the ebb and flow of municipal resources over the years.

Please see Appendix 4 for additional scenarios designed to illustrate how regionalization could yield a more robust public health delivery model for local communities.

II. Current Massachusetts Public Health Regionalization Efforts

On March 3, 2008, the Working Group of the MA Public Health Regionalization Project (described below), along with its legislative partners, introduced a bill based on our research to the MA Legislature, sponsored by Senator Susan C. Fargo and Representative Peter J. Koutoujian, then co-chairs of the Joint Committee on Public Health. The bill was intended by its sponsors to encourage communities to coordinate and share services in order to improve disease and injury prevention, promote wellness and protect populations. The bill passed both the House and Senate on January 8, 2009, and was signed into law by Governor Patrick on January 15, 2009.

The law, Chapter 529 of the Acts of 2008, An Act Relevant to Public Health Regionalization, amended the previous law by removing barriers to cooperation among cities and towns. The amended law paves the legal way for towns and cities throughout the Commonwealth to voluntarily form regional public health districts “which shall consist of a regional board of health, a director of health and staff thereof.” Other elements of Chapter 529 include the following:

- Under the old law, only City Councils or Town Meetings had authority to approve forming health districts. Now, approval requires votes from both the Board of Health and the City Council or Town Meeting for all communities forming a district.
- Under the old rules, communities that formed health districts were required to transfer their "home rule" policy making authorities to those districts. Now, cities and towns have the flexibility to decide whether to transfer or keep their board of health authority.
- New communities may now join existing health districts. They were not allowed to do so before.
- Communities have the flexibility to design governance agreements, financial terms, and service sharing arrangements that work for them.
- Chapter 529 includes a variety of protections for local public health workforces. The old law made no provisions for part time employees. Civil service, retirement, and compensation rights are protected under the new law for municipal employees who are transferred into districts. Rights are also protected for employees of towns that withdraw from districts.
- The new law shortens the minimum time communities must participate in districts from five years to three years.
- Chapter 529 charges the Department of Public Health, in consultation with the Department of Environmental Protection, to develop workforce credentials for district directors and performance standards for districts.
- In turn, the new law provides the legal basis for state funding of start-up and operating costs of districts. ***Please note, however, the new law does not provide funding for districts.*** State support for district operating costs is subject under the law to financial appropriations by the legislature.

The Massachusetts Public Health Regionalization Project

An outgrowth of several years of grassroots activism by local public health professionals, and catalyzed by a 2003 report issued by the Coalition for Local Public Health (comprised of 5 statewide public health associations), a group first convened in 2005 to

examine the ways in which regional structures could be used in Massachusetts to enhance local public health services.¹⁰ Over time, the Massachusetts Public Health Regionalization Project's Working Group, led by the Boston University School of Public Health, has expanded to include representatives from state government, local public health officials from cities and towns with varying populations and governing structures, legislators, and public health experts from the academic community. Since its inception, the Working Group also has benefited from the periodic guidance of a broad-based statewide Advisory Group. *Please see Appendix 2 for a listing of the Working Group members.*

The goal of the Massachusetts Public Health Regionalization Project is to strengthen the Massachusetts public health system by creating a state-funded regional structure for equitable delivery of local public health services across the Commonwealth.

The Working Group has received financial and networking support from the National Association of County and City Health Officials (NACCHO), which brings to the table a particular interest in the creation of national public health accreditation standards, as well as sharing among states best practices in public health regionalization.

The Working Group identified a number of critical steps that needed to be taken in order to set the stage for moving forward with regionalization, such as addressing legal barriers and researching appropriate regional models. To date the Group has:

- Solicited input through meetings with dozens of organizations across the state, including public health coalitions, regional planning agencies and local boards of health.
- Developed Guiding Principles (e.g. The system must respect existing legal authority of local health [home rule]) and Critical Elements (e.g. Provide the ten essential public health services to ALL residents of Massachusetts through an integrated public health system that offers a legal foundation, governance structures, and financial incentives for forming regions). *See Appendix 1 for a listing of the Guiding Principles and Critical Elements.*
- Conducted research on trends and disparities in Massachusetts' local public health system, other states' experiences transitioning to a regionalized system, the economic determinants of public health system performance, and various regionalization models and funding structures.
- Drafted three reports with recommendations for moving forward.
- Identified legal, funding and other concerns that need to be addressed in order to facilitate regionalization – and created subcommittees to address each head on.

¹⁰ Even prior to the 2003 CLPH report, a report of the Local Health 2000 Commission, convened by MA Commissioner of Public Health David H. Mulligan in 1994, made several recommendations with regard to the regionalization of public health services in Massachusetts. The 28-member Commission represented elected and appointed local health board members, local health department staff, graduate schools of public health and nursing, and civic and public health organizations. Among its recommendations: "Develop local and regional public/private partnerships for health in cooperation with the Community Health Networks...that addresses specific health disparities identified by local communities; assures efficient, cost-effective, and coordinated delivery of public health services locally and regionally including prevention, surveillance, quality assurance, and health assessment; and increases incentives and support for intermunicipal coordination of local health policy and service provision."

These subcommittees recently completed several comprehensive reports which are summarized below.

- As described above, introduced key legislation (which was signed into law in January 2009 by Governor Deval Patrick) that removes several legal roadblocks and enables local communities to pool resources and provide public health services across multiple municipalities.
- Framed two different models for organizing regional service systems (though other models will be considered).
- Created an incremental plan to begin to phase in regionalization.
- Secured a 2-year Robert Wood Johnson grant to create a public health “practice-based research network” (described below) to support our regionalization efforts.
- Encouraged the 5 Coalition of Local Public Health associations to provide feedback to the national Public Health Accreditation Board (PHAB) on draft standards for voluntary state, local and territorial health department accreditation.

Advice from the Field to the Working Group: The following is a summary of the feedback provided by local health and other public health practitioners during the Massachusetts Public Health Regionalization Project’s February 29, 2008 panel discussion.

- Be open-minded and creative
- Be clear that the regionalization project began as a local, grass-roots initiative, not a state mandate
- Involve municipal governing bodies (e.g. Boards of Selectmen, Mayors, MA Municipal Association)
- Focus on prevention and not just inspectional services
- Continue to focus on the public health system (that integrates state and local agencies) and the provision of the ten essential public health services
- When creating Performance Standards, include those for Board of Health members and volunteers.
- Protect local contributions and ensure that they cannot be replaced by state contributions
- Clarify proposed funding formulas (amounts and eligibility), with the goal to provide public health services to all residents

Working Group Sub-Committee Reports: In response, it was determined that the MA Public Health Regionalization Project’s Working Group will act more as an oversight body, while its members will form sub-committees with Leads and discrete tasks. Each sub-committee has since reported back to the Working Group on their progress. *The following is a summary of the Working Group subcommittee final reports, completed June 2009.* The full text of these reports can be found online at <http://sph.bu.edu/regionalization>.

Case study of successful regional efforts. This subcommittee researched successful examples of regional efforts among the Commonwealth’s local health agencies. (See *Tri-Town case example above and other examples in Appendix 3.*)

Incentive Funding Formula and District Minimums. This subcommittee, working with consultant Patrick M. Bernet, PhD of Florida Atlantic University, devised a hypothetical regionalization incentive payment formula that would be administered by MDPH. It is based on the premise that state funding should be provided to encourage the creation of more public health districts. Funding would be made to public health districts, rather than to individual municipalities. Payments would be made based on the combined populations of participating communities within each district.

The formula begins with a basic per capita payment, then adjusts that payment based on degree of regionalization, poverty and population density. Adjustment amounts are based on formulas that compare the district to the rest of the state.

- The degree of regionalization adjustment provides an incentive to communities to integrate health departments as fully as possible in order to achieve the highest economies of scale and provide the highest level of service for their residents.
- The base per town adjustment recognizes that some district start-up costs are proportional to the number of towns involved. This adjustment also encourages towns with small populations to join districts. In this way, a town of just 600 people, which would not yield significant reimbursement in terms of a per capita payment, still becomes attractive as a potential district partner.
- The population density adjustment provides more money to less densely populated districts. In this way, small, rural communities are incentivized to form districts. This adjustment takes into consideration the reality that more rural areas face particular challenges in forming professional health departments and providing a consistent level of public health protection to their residents.
- The poverty adjustment provides higher payments to poorer districts in proportion to the rest of the state. In this way the formula recognizes that poorer communities face additional challenges both in funding health departments and providing adequate public health services for their residents.
- Finally, the state cap adjustment takes into consideration the possibility of a fixed state budget. The payment to all districts will proportionately decrease if total computed payments exceed the state cap.

Based on Dr. Bernet's research, including comparisons with regional health entities in other states, the subcommittee derived recommendations for the minimum size of a regional health district in the Commonwealth. These recommendations serve to set standards for state funding of health districts, to ensure that the public's money is used as efficiently and effectively as possible.

Note: a district would need to meet only one of the following thresholds.

- Population recommended minimum: 50,000.
- Land area recommended minimum: 155 square miles.
- The one-county exception: All cities and towns in a particular county could combine to form one county-wide health district.

It is important to remember that meeting one of these requirements would be just one of the steps in becoming a qualifying health district, and that any communities that wanted to use existing legislation to combine in ways that did not meet them would still be free to do so; they just would not qualify for the state incentive funding.

Workforce Credentialing. This subcommittee was charged with researching and recommending minimum educational background and professional credentials for staff positions that would populate a regional health district.

Caveats:

- These suggested credentials are goals for the future of the field of public health; they are not to be used as an excuse for eliminating or demoting current staff.
- There is no good way to compare length of experience and educational background. Neither experience nor a certain level of education is any guarantee of performance on the job.
- These educational criteria are listed as minimum educational preparation for these positions; they in no way indicate that an individual is prepared to take on a particular position.

This subcommittee based its recommendations on a draft document several years in the making by the Local Public Health Institute of Massachusetts' Advisory Council, though with changes in light of creation of regional health districts.

1) Environmental Health Professional

- Bachelor's degree with a science concentration AND
- Registered Sanitarian/Registered Environmental Health Specialist (RS/REHS) credential

OR

- Associate's or Bachelor's degree with science concentration AND
- Registered Environmental Health Technician (REHT) credential

Note: Additional certifications and/or credentials may be required based on job responsibilities and regulations.

2) Governing Body (Also check City or Town Charter)

- Two – three years relevant work experience AND
- Training in legal issues and roles & responsibilities (such as MAHB Certification classes or Foundations for Local Public Health course)
- College degree with a science, environmental or public health concentration preferred

Note: Other advanced degrees (i.e. DVM, MD, MPH, MS, MSN) could be substituted for relevant work experience.

3) Head of the Regional Health District

- Advanced degree in public health or a related field AND
- Five years of public health or other relevant experience AND
- Professional Certification in leadership, management, or administration

Note: A practicum conducted for the MA Public Health Regionalization Project by Craig Andrade, a DrPH student at the BU School of Public Health, discusses credentials required around the country for the head of a regional health district and was used in determining these credentials. This study, "Public Health Workforce Credentialing for MA: Analysis and Recommendations," is available at <http://sph.bu.edu/regionalization>.

4) Public Health Nurse

- Graduation from an accredited school of nursing; BSN preferred AND
- Current Registered Nursing License active and in good standing AND

- Three to five (3-5) years public health and/or community health experience

Note: ANCC certificate or other certification in public health encouraged.

The subcommittee understands it may be a challenge at times to find enough people with these educational and experiential credentials to fill these positions. It is the subcommittee's hope the creation of this list of credentials will inspire both educational institutions and students to prepare themselves so that a greater pool of candidates will emerge over the next five to ten years.

Template Regional Health District Bylaws. The Template Health District Bylaws are intended to give a model governance agreement to communities working together to form Regional Health Districts. They are drawn from both the Mass. General Law governing the creation of districts and the bylaws of many existing districts here in Massachusetts. They include the following Articles: I. Association and Purpose; II. Membership; III. Governance of the District; IV. Officers; V. Executive Committee; VI. The District Health Director; VII. Duties of the Host Agency; VIII. Amendments; and an Optional Nursing Article. The Template Bylaws also include explanatory notes throughout, including relevant examples from existing public health districts.

When considering forming a health district with one or more communities, this subcommittee recommends specific steps be taken to create the health district governance structure:

1. Convene a working group of representatives from each town, including representatives of each community's Board of Health.
2. Agree on decision-making rules for the process; will you use Roberts Rules? Will decisions be made by consensus, or by majority vote?
3. Review the template by section, personalizing it for your communities.
4. Decide which items to choose in the sections that give choices. Please note that some things are legal requirements and cannot be changed.
5. When you have consensus on a final product, take the bylaws back to your respective boards of health and Town Counsels for review and approval.
6. Vote at Town Meeting or City Council to join the District.

Legal Review of Matching Requirements. When states provide funding to supplement local spending in public health and other areas of local government, there is a possibility that local governments use these funds to replace local spending. The result is no new spending on the very services the State wanted to encourage. This subcommittee describes measures that Massachusetts and other states use to prevent decreases in local spending. This report focuses primarily on the Massachusetts Library Statute, the Massachusetts Community Preservation Act, Connecticut Public Health statutes and Ohio Public Health statutes.

Massachusetts Library Statute: MGL Chapter 78 section 10A authorizes the state treasurer to pay monies appropriated from the Local Aid fund to cities and towns that have met certain minimum standards of free public library service. State funding for libraries is intended to supplement local spending, not replace it. To accomplish this, the Commonwealth requires that no city or town may receive state money for public libraries in any year when the appropriation of the city or town for free public library

service is below an amount equal to the average of its appropriation for the three years immediately preceding, increased by two and one-half percent.¹¹

Massachusetts Community Preservation Act. The Massachusetts Community Preservation Act¹² enables cities and towns to adopt a real estate tax surcharge of up to 3% to fund the preservation of open space, historic sites and affordable housing.¹³ The Community Preservation Act requires a city or town to establish a separate account known as the Community Preservation Fund. The Community Preservation Act is intended to augment municipal funds, not replace existing funding. To that end, the total state contribution to each city or town cannot exceed the amount raised by the municipality's surcharge on its real property levy.¹⁴ In addition, only those cities and towns that adopt the maximum surcharge of 3% are eligible to receive additional state monies through the equity and surplus distributions.¹⁵

Connecticut. Connecticut provides funding for public health to district departments of health as well as to both full and part-time municipal health departments.¹⁶ To be eligible for state funding, health departments must provide a public health program which includes public health statistics, health education, nutritional services, maternal and child health, communicable and chronic disease control, environmental services, community nursing services and emergency medical services.¹⁷ The requirement that cities and towns allocate at least one dollar per capita for health department services guarantees that state monies are not used to replace local spending on public health.

Ohio. In Ohio, boards of health and district health departments are entitled to receive state health district subsidy funds. No payment shall be made unless: The board or department provides such information concerning services and costs as is requested by the director of health; the certificate of the health department or board of health has been endorsed by the director of health; the board or department complies with public health council rules; and the cities and towns provide adequate local funding for public health services. Ohio guarantees that state monies will not be used to replace local spending by prohibiting it under state law¹⁸ and by requiring local matching funds of at least three dollars per capita in order to receive state health subsidies.¹⁹

This information will be used by MDPH to consider how best to ensure that eventual state dollars are used specifically to improve local public health.

Needs Report. This subcommittee was charged with identifying the need and presenting a case for the regionalization of public health services. Their research substantiates previous research highlighted at the beginning of this report that found regionalization would address the inequitable delivery of public health services and the ways the current system does not work in Massachusetts, and yield a more robust public

¹¹ M.G.L.A. 78 s.19A (2008)

¹² M.G.L.A. 44B s.1 et seq. (2000)

¹³ M.G.L.A. 44B s.3 (2006)

¹⁴ M.G.L.A. 44B s.10(f) (2000)

¹⁵ M.G.L.A. 44B s.10(h)(1) (2000)

¹⁶ C.G.S.A. s.19a-202 (2007), C.G.S.A. s.19a-202a (2003), C.G.S.A. s.19a-245 (2007)

¹⁷ CT ADC s.19a-76-2 (1999)

¹⁸ OH ST s.3709.32 (1988)

¹⁹ OH ADC s.3701-36-03(A)(8) (2005)

health system. Specific examples of current local health department challenges this subcommittee cites include the low number of food establishments undergoing regular inspections (as reported in a recent MDPH Bureau of Environmental Health Food Protection Program study), the lack of capacity for regulation of the more than 200,000 private household drinking water wells; the more than 100 emergency incidents LBOH have responded to in the past 18 months; and the drop in MA ranking from 1st to 8th over the past year in percentage of people ages 19 to 35 receiving immunizations (United Health Foundation report).

The range of skills and capacity required to carry out the multitude of responsibilities of a local board of health are extensive and growing, against a backdrop of cuts in funding for local public health and new emergency preparedness responsibilities. It was found few LBOH throughout the Commonwealth have the capacity to provide all of these services to the residents of their communities.

It is the subcommittee's conclusion that regionalization can facilitate the sharing of public health resources across communities with different types of public health expertise. It can address growing problems associated with staffing shortages and staff training levels. And it can support the capacity for cities and towns to effectively respond to emergencies while lessening the impact to the core programs necessary for disease and injury prevention.

Other subcommittee initiatives in progress, some of which are now folded into the work of the Practice-Based Research Network (described in Section III), include;

- **Legislation**. Draft legislation. Provide consultative services to the legislature and others.
- **Employee protection issues**. Research employee protection, labor and union issues, and develop recommendations for incorporating into our proposed models.
- **Evaluation of pilots**. Set up metrics for measuring success; conduct the review and determine the effectiveness of 3 pilot public health districts.
- **Performance standards/Agency accreditation**. Research performance and agency accreditation standards (in conjunction with the Public Health Accreditation Board). Consider things that are MA specific (such as use of MAVEN—the on-line surveillance system currently being implemented) as well as minimum staffing levels based on population and/or other measures (e.g. number of food establishments, number of septic systems). The Practice-Based Research Network is devising a performance assessment tool to be used in conjunction with three pilot health districts to be created.
- **Social marketing**. Promote and advocate for our work to audiences outside of local and state governmental public health agencies.

Recent Public Health Regionalization Efforts by Local Municipalities

Economic recession has accelerated the pace of municipal exploration of how to share services and merge health departments. These efforts are in various stages of development. Some, like co-hiring a public health nurse by Belmont and Lexington and merging the health departments of Melrose and Wakefield, have been recently completed and are now operating (see details below). Others, such as a proposed combination of the Peabody and Salem health departments and possible formation of public health districts in western Massachusetts and the Metrowest Boston area, are

under active discussion. A proposed merger of the Amesbury, Salisbury, and Newburyport health departments was initiated last winter by municipal executives, but recently floundered after being rejected by the Newburyport City Council. Amesbury and Salisbury are reportedly exploring alternative possibilities. The City of Worcester is also involved in a major planning process about how to restructure its public health services, aided by a task force appointed by the city manager.

These initiatives complement existing public health districts in the Commonwealth. Currently, Massachusetts has eleven regional public health entities serving about ten percent of the state's population.²⁰ All participating communities in each of these districts retain their local boards of health.

The following are examples of more recent public health regionalization efforts initiated by local communities and driven by municipal budget cuts. *Please see Appendix 3 for examples of more established regional health districts in Massachusetts.*

- Belmont and Lexington. In spring, 2008, both Belmont's and Lexington's Town Meetings approved a plan to combine a public health nurse position. The Belmont Health Department had tried unsuccessfully to hire a part-time, non-benefited nurse for nearly two years, and Lexington had been looking to fill a 30-hour a week role. The new full-time position with benefits will split time between the two towns (3 days a week in Lexington, 2 in Belmont) but will be available to either town any day of the week for emergency situations. In this five-year agreement, the nurse will be employed by Lexington, and Belmont will contribute to the position's salary and benefits.²¹
- Melrose and Wakefield. These two towns signed a 3-year contract beginning July 1, 2009, which combined their public health departments. Under the agreement, Melrose's health director now directs the Melrose-Wakefield Health Department. This agreement maintains each town's local board of health as policy-making entities. Also serving both communities is Melrose's full-time sanitary inspector, part-time public health nurses from the two communities, two new sanitary inspectors (who have replaced the Wakefield health agent position), and Wakefield's administrative assistant. Wakefield will pay Melrose quarterly for its share of services provided by these joint staff members. This arrangement increases both towns' access to a public health nurse from 9 to 18 hours a week. Wakefield's town manager believes these changes will yield more grant opportunity and outreach programs in smoking cessation, childhood obesity and alcohol/drug abuse prevention, as well as more restaurant inspections.²² With populations of similar demographics and size, Melrose and Wakefield already shared a public health nurse who worked part-time in each community. Further, the Melrose public health inspector had begun to conduct inspections in Wakefield as well. The two towns ran a couple of similar programs, namely targeted flu clinics and tobacco control. According to Melrose Mayor Robert J. Dolan, "*We are breaking down the man-made barriers of border and looking at it*

²⁰ Current regional public health entities include Barnstable County Health Department, Nashoba Associated Boards of Health, Quabbin Health District, Tri-Town Public Health Department, Franklin Regional Council of Governments' Regional Health Inspection Program, the Eastern Franklin Health District, the Foothills Health District, Melrose/Wakefield, Concord/Lincoln/Carlisle, Wenham/Hamilton, and Marion/Rochester.

²¹ Cassie Norton, "Lexington, Belmont to share nurse position," Lexington Minuteman 30 April 2008.

²² John Laidler, "Melrose, Wakefield combine health departments," Boston Globe 21 July 2009.

as a service district...” Wakefield Town Administrator Stephen P. Maio said, “*It’s really a win-win for both communities.*”²³

- Beverly, Danvers, Marblehead, Peabody, Salem. Building upon a history of collaboration, town administrators from these five towns held an initial meeting in autumn, 2008. They agreed as an initial step to aggregate data detailing their respective health departments’ budgets, staffing, number of inspections, etc. They also agreed to seek guidance on moving forward from the MA Department of Public Health.²⁴ Discussions involving possible collaboration between Salem and Peabody are still underway. According to Salem Mayor Kimberly L. Driscoll, “*Certainly, public health concerns do not end at the Salem city line. And given the likelihood of having to cut budgets either this year or next, I think it is worthwhile to explore a regional approach to delivery of these services as a means to preserve the current level of programs we offer within our community.*”

Efforts to Support Regionalization at the MA Department of Public Health

In recent years, the state department of public health has encouraged regional cooperation through its emergency preparedness (EP) and tobacco control programs and other efforts:

- Beginning in 2002, federal funds allowed MDPH to create a state-wide network of seven regions and fifteen sub-coalitions to coordinate planning and response for public health emergencies, including bioterrorism and pandemic influenza. All of the state’s local public health boards and departments are included in the system, which has—with few exceptions—not only helped to improve emergency preparedness, but has also built capacity for cooperation among cities and towns on additional issues, such as public health mutual aid and infectious disease control. The EP coalition network is the closest Massachusetts comes to having a regional public health system, but it is wholly dependent on federal funding, which comes with very specific and limited requirements.
- For close to a decade, tobacco control programs were an important source of operating support and cooperation across municipal boundaries for local public health. These programs were hard hit by state budget cuts in fiscal years 2003-2004, resulting in dramatic losses in local public health capacity. Memories of those losses make many local public health officials wary about the sustainability of new state funding to promote regionalization proposed by the Working Group. Nevertheless, even with uneven funding in recent years, tobacco control programs continue to provide important resources for cooperation among neighboring cities and towns.
- In the early 1990s, MDPH created a statewide system of Community Health Network Areas to coordinate health promotion involving the health care, public health, and human service systems in cooperation with businesses, public safety officials, and other partners. The department also funds a network of Regional Centers for Healthy Communities to promote substance abuse prevention and other community health efforts. Recently, MDPH has been working to strengthen relations between these networks and local public health authorities, and to make

²³ Daniel DeMaina, “Melrose, Wakefield discuss combining city services,” Melrose Free Press 8 January 2009.

²⁴ John Laidler, “Mayors look at merging public health,” Boston Globe 4 December 2008.

its regional health offices—which host program staff from various MDPH bureaus—more responsive to local public health needs.

The Working Group continues to explore and recommend ways that MDPH and MDEP can better encourage and support regional collaboration and the formation of health districts. These recommendations as well as next steps are described in the following section, *Moving Forward*.

III. Moving Forward

Momentum is building to develop a regional public health system for Massachusetts that protects local board of health policy autonomy while taking advantage of opportunities to utilize limited municipal resources most effectively. The passage of Chapter 529 showed support from the legislature and the administration for applying principles of shared municipal services to the public health arena. A broad array of stakeholders organized through the MA Public Health Regionalization Project has been developing consensus about how regionalization might take shape here. The state's public health professional associations are helping to build support for the concept among local health authorities. Municipal officials have also started to embrace the idea, especially as the economic recession has provided an incentive for shared or consolidated service provision.

Recommendations from the State Public Health Commissioner

At the same time, the MDPH commissioner has made strengthening the local public health infrastructure a top priority and supports regionalization, provided that it is implemented with understanding and respect for the important roles of local public health. In a February 20, 2009 letter to the Coalition of Local Public Health (comprised of members of the MA Association of Health Boards, MA Association of Public Health Nurses, MA Environmental Health Association, MA Health Officers Association, and MA Public Health Association), Massachusetts Public Health Commissioner John Auerbach expresses concern that, given the economic climate and with cuts to local communities impacting many municipal departments across the Commonwealth, towns are considering regionalization as a vehicle to reduce costs in the local public health arena. He states, "We are aware that officials in some communities are considering forming health districts in order to share public health services and costs across municipal boundaries. In general, we applaud these efforts, but we caution that forming health districts should be explored as a way to improve the scope and quality of public health services using currently available resources, not as a way to achieve short term cost savings."

The Commissioner states that local public health services should not bear a disproportionate share of budget cuts compared to other municipal services. He stresses that "it is important to develop a regional system of public health districts through which communities can cooperate to make best use of limited available resources. We stand ready to assist communities interested in exploring the potential benefits of forming health districts. It is particularly important now, however, as we make difficult budgetary decisions at all levels, to protect local public health services through careful planning that takes into consideration both immediate and future impacts of reductions under consideration."

Legal Considerations

As noted above (p.8), the recent adoption of Chapter 529 of the Acts of 2008 removed previous barriers in state law (MGL Chapter 111, Sections 27A-C) to forming public health districts. Most communities working on regionalization, however, are using a different state statute. MGL Chapter 40, Section 4A enables local chief executives to negotiate inter-municipal agreements on a wide range of issues with approval by their respective legislative bodies. Because Chapter 40 does not require local Board of Health approval for executing agreements to share public health services, using the law to develop public health districts carries the risk that municipal leaders with limited understanding of LBOH responsibilities and authority may devise plans that compromise

public health protection in the service of short term cost savings. Chapter 529 provides a stronger legal framework for public health regionalization, but it carries extra responsibilities for municipalities. Without state funding to support the formation and operation of public health districts, the MA Public Health Regionalization Project Working Group is concerned that municipalities will continue to by-pass opportunities to strengthen our public health system that were included in Chapter 529. For communities using Chapter 40, the Working Group recommends that it is imperative to involve Boards of Health in all phases of planning and implementing inter-municipal agreements involving public health.

Recommendations to the State

In its white paper, the Pioneer Institute makes recommendations to the state to encourage regionalization among localities (of various services, including public health provision), such as:

- Provide transparent cost breakdown to highlight service areas where regionalization can yield the greatest cost savings.
- Provide targeted feasibility study grants.
- Provide bonus funding for communities that are regionalizing.
- Develop best practice standards and tie state aide formulas to those standards, not actual cost compensation.
- Provide a variety of regionalization opportunities for communities.
- Make efforts to convince unions that cost-savings are in their long-term interest.
- Provide third party mediators for regionalization agreement negotiations.²⁵

The Regionalization Working Group also agrees that the State should reorganize its assets and seek new resources to protect and promote health in cooperation with local public health boards and departments. The following are the Working Group's recommendations to MDPH regarding MDPH's role in supporting our proposed regionalization plan:

- A. Continue recent progress in coordinating services delivered through the six regional MDPH offices to provide stronger support for Local Boards of Health.
- B. Promote workforce development and training, including strengthening management and operations of the Local Public Health Institute of Massachusetts (Institute). Integrate MA Department of Environmental Protection into Institute training. Add a field training component for mandated services that require inspections and investigations.
- C. Work with the Regionalization Working Group and the Coalition for Local Public Health to create educational and credentialing standards for the public health workforce.
- D. Secure funding and/or reallocate resources to increase technical assistance for LBOH in areas such as environmental health (food protection, community sanitation, indoor air quality, etc.), school health, public health nursing, communicable disease control, laboratory services, vital records and health statistics, and legal enforcement.

²⁵ "Regionalization: Case Studies of Success and Failure in Massachusetts," Pioneer Institute 43 (2008):3.

- E. Continue improved management of emergency preparedness and pandemic flu planning in cooperation with LBOH, including mutual aid legislation, risk communications, exercises and drills, and protection of vulnerable populations.
- F. Improve social marketing about public health with the goal to heighten local understanding of the field, including the ten essential elements of public health provision, and to encourage increased municipal funding for LBOH.
- G. Provide adequate resources and support for required responsibilities (e.g. food safety and other community sanitation regulations, syringe disposal, disease surveillance and reporting).
- H. Continue respectful communications with and responsiveness to LBOH, e.g. through the Local State Advisory Council and CLPH.
- I. Integrate with other MDPH systems, structures, and programs, e.g.:
 - a. CHNAs
 - b. Regional Centers for Healthy Communities
 - c. Emergency Preparedness regions
 - d. Tobacco Control coalitions
 - e. Mass in Motion

The Working Group will also research any similar changes to recommend at MDEP.

Recommendations to Municipalities Considering a Regional Approach

Communities that wish to retain authority over local public health issues may find the Tri-Town Health Department's shared services approach an attractive model for the delivery of essential public health services. Municipal and public health leaders who are considering such an approach are advised to begin with an assessment of state and local mandates, current service levels and revenue streams, community health needs and wellness goals. The results of such an assessment can then be used to facilitate conversations among local boards of health about the strengths and gaps in service provision, similarities and differences in local mandates, regulations, and governance. *Please see Appendix 5 for a tool that local communities can use to facilitate these initial assessments.* Developing a common understanding of what local boards of health offer to citizens is essential from the outset.

If local Boards of Health decide to purchase services from another municipality, the funding mechanism may be worked out in a variety of ways. The challenge lies in figuring out how to fund services that only some communities within a collaborative want or need. These communities may look to the state to see what they offer and if the services can be covered by state officials. They may also set up fee-for-service options or obtain grant dollars for local communities to cover these costs.

Finally, communication with the public and municipal leaders is critical to the success of a regional approach to public health service provision. Regular communication through annual town reports, dissemination of information to municipal leaders, and updates to the public through websites and community meetings are just a few of the ways that public health leaders can obtain support for and feedback about public health services. Local governance in Massachusetts can provide an important incentive to keep the public educated and knowledgeable about local public health.

Ultimately, the MA Public Health Regionalization Project Working Group strongly encourages towns to create public health districts that meet our district minimums described above (p.11).

Practice-Based Research Network

As the Working Group moves to the next phase of planning, we recognize the need to evaluate the process and the pilot regions that are formed. To this end, in the fall of 2008, the MA Public Health Regionalization Project received a 2-year grant from the Public Health Practice-Based Research Network (PBRN) Initiative, sponsored by the Robert Wood Johnson Foundation. Our broad objective for this project is to bring a subset of the larger Working Group together to identify research and evaluation needs, develop strategies for assessment and review, and incorporate a meaningful research component into our work. Our likelihood of gaining buy-in and support across all sectors of local government rely on the ability of the Working Group to demonstrate a clear process for decision-making, capacity-building potential, cost-effectiveness, improvements in service delivery, and ultimately reductions in health disparities and improvements in health outcomes across the Commonwealth.

The research funded by this project will help the State and several local health departments understand

- what the process of moving from a local to a regional public health delivery system entails,
- strategies and information needed to inform decisions about this move,
- the financial costs and advantages associated with different service delivery models, and
- which model is most appropriate for specific towns and regions.

Ultimately, the formative research will help lay the groundwork for a future case-control study of public health systems improvement resulting from the adoption of regional public health service models throughout Massachusetts.

Please see Appendix 6 for the 2-year PBRN timeline, designed to illustrate activities and delineate milestones over the course of the project.

Working Group Goals for 2010

In addition to the work of the PBRN and recommendations to MDPH, other fall 2009 through 2010 activities of the MA Public Health Regionalization Project Working Group designed to move our agenda forward include:

- Hold several regional meetings throughout the Commonwealth with local public health officials, emergency preparedness coalitions and public health association boards of directors to discuss this status report and its recommendations.
- Meet with state legislators in an effort to broaden our base, build upon their past support of our efforts, strategize how best to move forward, and create a funding stream for local health districts.
- Present a workshop on public health regionalization at the January 2010 Massachusetts Municipal Association meeting.
- Work with the Health and Human Services administration to provide input into their regionalization conceptualization.

- Create a Rapid Response communications team to enable the Working Group to immediately address regionalization portrayals within various media outlets throughout the Commonwealth.
- Support local communities' investigations into, planning for or transition to a regional model of public health service delivery, including distributing resources designed to facilitate the process under Chapter 529 (e.g. Template By-Laws).
- Continue to work with MDPH to further refine the regionalization structure, including being responsive to the Working Group's subcommittee findings.
- Continue the work of some of the Working Group subcommittees, including employee protections, performance standards and agency accreditation, and social marketing.

To learn more about the Massachusetts Public Health Regionalization Project, various regionalization efforts currently underway, or if you might be interested in being part of one of the pilot regions for the Practice-Based Research Network, please contact Kathleen Macvarish, Director of Practice Programs, Boston University School of Public Health. Kathleen can be reached at kmacvar@bu.edu or 617-638-5032.

IV. Appendices

Appendix 1

Massachusetts Public Health Regionalization Project

Project Goal: To strengthen the Massachusetts public health system by creating a sustainable, regional system for equitable delivery of local public health services across the Commonwealth.

Guiding Principles

- The system must respect existing legal authority of local health agencies
- As a voluntary initiative, communities need incentives not mandates to participate
- One size does not fit all; different models of regional structures and operations will allow communities to cluster in ways that will meet their needs
- Full implementation of the system will require adequate and sustained state funding
- The system will augment, not reduce, the existing local public health workforce

Critical Elements

1. Providing the ten essential public health services* to ALL residents of Massachusetts through an integrated public health system that offers a legal foundation, governance structures, and financial incentives for forming regions (districts)
2. Clarifying the roles and responsibilities at local, regional and state agency levels to strengthen and support an integrated system
3. Establishing standards for local, regional and state performance including: workforce credentials; performance measures and agency accreditation
4. Recommending a system to routinely deliver comprehensive training programs for the local public health workforce; training activities must be coordinated with performance standards and measures and include supervised field training

*The Ten Essential Public Health Services can be found on the Centers for Disease Control and Prevention website at <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm>.

Appendix 2

Massachusetts Public Health Regionalization Project

Working Group Members

Conveners:

Harold Cox, Boston University School of Public Health, Associate Dean for Public Health Practice
Kathleen MacVarish, Boston University School of Public Health, Director of Practice Programs

Association and Community Representatives:

Charlotte Stepanian, Massachusetts Public Health Nurses Association* & Merrimac Board of Health

Cheryl Sbarra, Massachusetts Association of Health Boards*

Donna Moultrup, Massachusetts Health Officer's Association* & Belmont Board of Health

Frank Singleton, Massachusetts Public Health Association* & Lowell Health Department

Jim White, Massachusetts Environmental Health Association* & Natick Board of Health

Kerry Dunnell, Cambridge Public Health Department, Advanced Practice Center

Phoebe Walker, Franklin Regional Council of Governments

Sandy Collins, Coalition for Local Public Health, Local State Advisory Council & Westford Health Department

* denotes organizations that constitute the Massachusetts *Coalition for Local Public Health*

Massachusetts Department of Environmental Protection:

John Felix, Office of the Commissioner

Massachusetts Department of Public Health:

Geoff Wilkinson, Office of the Commissioner

Mike Coughlin, Office of Emergency Preparedness

Mike Moore, Food Protection Program

Suzanne Condon, Bureau of Environmental Health

Timothy McDonald, Office of Emergency Preparedness

Massachusetts Statehouse:

Danielle Cerny, Office of Senator Susan Fargo, Chair of Public Health Committee

Timothy O'Neill and Aliya Cater, Office of Representative Jeffrey Sanchez, Chair of Public Health Committee

Practice-Based Research Network Steering Committee Members

Harold Cox, Chairman

Cheryl Sbarra

Donna Moultrup

Geoff Wilkinson

Jim White

John Grieb

Justeen Hyde

Kathleen MacVarish

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John Grieb, Consultant (Organizational)

Justeen Hyde, PhD, Institute for Community Health (Evaluation and Research)

Laura Richards, JD, Massachusetts Association of Health Boards (Legal)

Patrick Bernet, PhD, Healthcare Finance (Finance)

Appendix 3

Examples of Established Regional Health Districts in Massachusetts

Nashoba Associated Boards of Health. The Nashoba Associated Boards of Health was created in 1931. Its membership includes the following towns: Ashburnham, Ashby, Ayer, Berlin, Bolton, Boxborough, Dunstable, Groton, Harvard, Lancaster, Littleton, Lunenburg, Shirley, and Townsend. Nashoba functions as the agent for the elected boards of health in its member communities. The fourteen member towns elect an Executive Committee under mutually agreed to by-laws.

Local boards retain full authority. Nashoba conducts the day-to-day inspections and provides the boards with its findings and recommendations. Nashoba is a public non-profit agency. Its support comes from funds from its member towns called assessments, and fees charged to users of the agency's services. The assessments and fees are decided by a vote of the members of the association.

Nashoba services include nursing, social work, dental and environmental programs. Since its founding, Nashoba has expanded its service range from traditional tasks such as social work, nursing visits and disease prevention to now include AIDS education, well permitting, and general environmental protection. As a result, its staff has grown to over 175 individuals including Registered Sanitarians, Certified Health Officers, Registered Nurses, Registered Physical Therapists, Registered Social Workers, Registered Dental Hygienists, and Certified Home Health Aides.

“Other success stories provide valuable lessons for other municipalities considering regionalization efforts. The Nashoba Associated Boards of Health serves as a long-standing example of how shared services can be both cost effective and provide greater depth and duration of services.”

--*Pioneer Institute for Public Policy Research, October 2008*

Barnstable County Department of Health and Environment. Established under a Special Act of the State Legislature in 1926, the Barnstable County Department of Health & Environment provides public health and environmental services for the 15 towns in Barnstable County, encompassing all of Cape Cod. The overall mission of the Department is to protect the public health as well as to promote the physical, mental and social well being of the residents of Barnstable County. The Department's programs include public health administration, environmental health, water quality testing, public health nursing, community septic loan program, and state grants like the Cape Cod Regional Tobacco Program and the Cape and Islands Lyme Disease Prevention Project.

Quabbin Health District. The Quabbin Health District is a regional health department serving Belchertown, Ware, and Pelham. It was established by town meeting vote in 1980, and is the joint effort of the local boards of health to provide their towns with public health professionals and services. The primary duties of the district center on enforcing provisions of the State Sanitary Code and Environmental Code under the jurisdiction of the Board of Health. It also provides technical assistance and educational services to residents and other municipal departments. The Quabbin Health District serves approximately 25,000 residents in an area of about 120 square miles. The following are some of the major services provided by staff of the district: percolation tests and soil evaluations; septic system application review for new construction and repairs; septic system installation inspections; well application review for new construction and repairs; food service inspections; temporary food service permits; and housing inspections.

Appendix 4

Local Public Health Regionalization Scenarios

The following scenarios are designed to illustrate the potential values of these different models of regionalization. They do not represent actual towns or cases, though they include elements that reflect real challenges and opportunities. The scenarios also assume that state funds proposed by the Working Group to help form and support public health districts will be available, which is not yet the case.

Situation A: One part-time public health nurse supports ten communities. She is paid by the case for her services; that is, she effectively does not get paid unless a public health emergency like an infectious disease outbreak occurs in one of her communities. She is not paid to conduct any disease prevention or other public health activities. She is also not paid to take part in any of the emergency dispensing site and other infectious disease preparedness planning. This leaves her towns better prepared than those without a public health nurse, but far from well-protected.

A Solution: The communities could form a “Shared Services” District for regional public health nursing or epidemiological services and qualify for funds from the state to support these more comprehensive activities. The formation of this type of district could also help the communities apply for grants to bring new services to the cities and towns.

Situation B: A number of communities provide regional emergency preparedness services through one MDPH Emergency Preparedness Region. Of these communities, only one has an epidemiologist on staff. To better provide essential services to their residents, these communities are interested in conducting regional epidemiologic activities such as the collection, analysis, interpretation, and distribution of local health data and communicable disease outbreak investigation.

A Solution: Same as above.

Situation C: In one small town the Board of Health (BOH) has no Health Agent. Volunteer BOH members are charged with conducting restaurant inspections, reviewing septic plans, and handling the rest of the public health work for the town. Given that the BOH members have other full time employment, they are only able to inspect half of the town’s restaurants over the course of a year, and only at night and on the weekend, and can’t reliably submit reports to MDPH. They also have no time to attend trainings to become proficient in the program areas for which they are conducting inspections. This leaves residents and visitors vulnerable to food-borne and environmental pathogens, and leaves the BOH members unable to do all the other work with which they are charged, such as investigating and addressing a severe hoarding case that everyone in town knows about.

A Solution: The town and its neighbors could form a “Comprehensive Services District” to share professional staff. By combining state funds with town funds (and updating their fee schedule) they could afford to share a full time Health Agent, leaving the BOH members free to set policy, prepare for emergencies, conduct hearings and other BOH business.

Situation D: A town has one Health Agent with no septic system experience or credentials, so the BOH relies on one of its volunteer BOH members to review septic plans. The member, while familiar with excavation, soils, and construction, is not able to

keep trained or certified on the latest developments of septic technology. A septic system is designed and installed with the BOH's approval, only to fail almost immediately. Thousands of dollars must be spent to rectify the situation, and the BOH is brought to court.

A Solution: With a neighboring community that has BOH staff with significant septic expertise, the towns decide to form a "Shared Services District." The town in this example would join for the purposes of receiving only septic expertise, while another neighboring community might join and use the district for both housing and septic activities, and keep their Health Agent for camps, pools, food, and communicable disease work.

Appendix 5

A Tool for Local Communities: “Questions to Help Start the Regionalization Conversation”

Several of Massachusetts’ local health departments have already begun the process of consolidating and/or sharing public health services, staff and other resources. And a few towns have been operating as a regionalized public health entity for some time.

The following questions are meant to be used as a guide for communities that are interested in exploring regionalization of their community’s local public health services. They may be used during a first meeting with local public health leaders, including Board of Health members. Also included is a list of recommended documents that you may want to bring to a first or second meeting.

Description of Communities

1. What is the population size of your community?
2. How would you describe your community? (e.g., age distribution, socio-economic characteristics, stability of population, key health issues/concerns)
3. How would you describe your community’s level of political involvement and interest in local public health issues?

Local Public Health Department

Budget

1. What is your public health department’s annual operating budget?
 - a. Have there been increases or decreases to the budget over the last 3 years?
 - b. Do you anticipate increases or decreases next year?
2. What percentage of the health department’s annual budget comes from municipal funds?
 - a. What percentage comes from fees, fines, etc.?
 - b. What percentage comes from external contracts and grants?
3. What programs and services are provided by the public health department?
 - a. Are these services primarily funded by municipal funds, contracts and grants, or fees?
4. What other municipal departments provide public health services?

Staffing

1. How many people are employed by the local public health department?
2. What is the educational background of the public health director?
 - a. What are the educational background and/or credentials of other key public health employees?
3. What are staff roles and responsibilities?

Current Strengths and Challenges

1. What do you see as the strengths of your local public health department?

2. What challenges does your department face in meeting local and state responsibilities?

Governance

1. Are your Board of Health members elected or appointed?
 - a. What is the typical duration of a LBOH member's term?
2. How often does your local Board of Health meet?
3. What role does your Board of Health play in making decisions about public health programs and services?
4. What role does your Board of Health play in making and enforcing municipal regulations and codes?

Recommended documents to bring to first meeting:

1. Organizational chart/diagram for public health department
2. Copy of municipal codes and regulations pertaining to local public health
3. Annual Town Report
4. Fee Schedule

Appendix 6

Practice-Based Research Network 2-Year Timeline

- Throughout the 2-year project, the PBRN Steering Committee, a subcommittee of the Working Group, will meet monthly and report back to the Working Group at our bi-monthly meetings. Initial meetings in Months 1 and 2 kicked off this project, defined roles and responsibilities, as well as communication and decision-making protocols. Additional conference calls, meetings and email communications occur as needed.
- Months 3 through 7 involve exploring research ideas, prioritizing and planning the research agenda, including selection of the quality improvement tool, determining the criteria for pilot site selection, preparing the educational and training materials for the pilot sites, and developing marketing tools to make local health departments aware of this opportunity. We will engage outside consultants to assist us in developing the selection criteria and marketing activities.
- Months 8 through 12 will involve marketing and outreach, and selection and preparation of the pilot sites.
- Months 13 through 15 will be spent conducting assessments of each pilot site and compiling the data. We also will be working with outside consultants to determine our indicators of success in the areas of health service delivery and, ultimately, health outcomes.
- Months 16 through 20 will include post-assessment meetings, as we disseminate results to participating communities within the 3 pilot groups via in-person presentation format. During these meetings, we will prioritize areas that need to be addressed in preparation for piloting a regionalization model, describe the various models and select one that is the best fit for each pilot group, and create an action plan for moving forward. We also will bring other key, local stakeholders into this process from outside the public health arena.
- Months 21 through 24 will be spent preparing for dissemination of our research results on the national level. This may include generation of a white paper, presentations at national conferences, and submission of journal articles.
- During the course of the entire two-year project, we will disseminate interim progress reports and results statewide through the PBRN, the Coalition for Local Public Health, and the MA Department of Public Health. This will be done via websites, newsletters and presentations.
- The entire second year of the PBRN project also will include time spent developing a sustainability plan, including exploring other opportunities for support from both public and private sources.