

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Compilation of Meeting Agendas and Minutes
of the
Commission and its Subcommittees

As of September 28, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

This document is a compilation of Agendas and Approved Minutes
of the Commission and its Subcommittees

The Special Commission on Local and Regional Public Health was created by Chapter 3 of the Resolves of 2016 to “assess the effectiveness and efficiency of municipal and regional public health systems and to make recommendations regarding how to strengthen the delivery of public health services and preventive measures.”

The 25-member Commission has held eight meetings through September, 2018:

- 1) an introduction to local public health in Massachusetts, history/background on the legislation, and a review of the Commission charge (June 2017)
- 2) information on shared services among local public health authorities in the United States (September, 2017)
- 3) discussion of 1) a minimum set of local public health services that every Massachusetts resident can expect and 2) data that makes the case for improvements in the local public health system (November 2017)
- 4) making the case for public health; a review of history and challenges in the Massachusetts Public Health system and a review of the roadmap (January, 2018)
- 5) Standards Subcommittee educates and proposes adoption of the Foundational Public Health Services model (February, 2018)
- 6) subcommittee progress report out, review of status report, and discussion and planning for listening sessions (April, 2018)
- 7) review of status report and planning for listening sessions (May, 2018)
- 8) discussion of comments on the status report, compiled from the Listening Sessions in June, updates from the 5 subcommittees, update of roadmap and review of final report structure (September, 2018)

The Commission has five subcommittees that were created and to which members were appointed at the September 2017 meeting: Data, Structure, Standards, Workforce Credentials, and Finance. The subcommittees have held several meetings to address the elements of the charge to the Commission.

This document is a compilation of the agendas and minutes of meetings held through September 28, 2018. It will be updated monthly.

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Year-to-Date and Planned Meetings

Meeting	Date (Location)
Commission	June 23, 2017 (Westborough)
Commission	September 15, 2017 (Framingham) #1
Commission	September 15, 2017 (Framingham) #2
Data Subcommittee	September 15, 2017 (Framingham)
Workforce Credentials Subcommittee	September 15, 2017 (Framingham)
Structure Subcommittee	September 15, 2017 (Framingham)
Finance Subcommittee	September 15, 2017 (Framingham)
Workforce Credentials Subcommittee	October 23, 2017 (Worcester)
Standards Subcommittee	October 23, 2017 (Worcester)
Data Subcommittee	October 31, 2017 (West Boylston)
Commission	November 3, 2017 (Westborough)
Structure Subcommittee	November 3, 2017 (Westborough)
Standards Subcommittee	November 3, 2017 (Westborough)
Workforce Credentials Subcommittee	December 8, 2017 (Worcester)
Standards Subcommittee	December 8, 2017 (Worcester)
Data Subcommittee	December 11, 2017 (Boston)
Structure Subcommittee	December 12, 2017 (Worcester)
Data Subcommittee	January 3, 2018 – with Standards (Worcester)
Standards Subcommittee	January 3, 2018 – with Data (Worcester)
Commission	January 12, 2018 (Westborough)
Workforce Credentials Subcommittee	January 24, 2018 (Worcester)
Commission	February 16, 2018 (Westborough)
Workforce Credentials Subcommittee	February 27, 2018 (Worcester)
Structure Subcommittee	March 9, 2018 (Shrewsbury)

Workforce Credentials Subcommittee	March 19, 2018 (Worcester)
Data Subcommittee	March 23, 2018 (West Boylston)
Commission	April 6, 2018 (Westborough)
Workforce Credentials Subcommittee	April 30, 2018 (Worcester)
Commission	May 4, 2018 (Westborough)
Workforce Credentials Subcommittee	May 21, 2018 (Westborough)
Listening Session	June 4, 2018 (Greenfield)
Listening Session	June 5, 2018 (Westborough)
Listening Session	June 8, 2018 (Waltham)
Listening Session	June 11, 2018 (Peabody)
Listening Session	June 13, 2018 (Lakeville)
Listening Session	June 15, 2018 (Westfield)
Workforce Credentials Subcommittee	June 22, 2018 (Westborough)
Structure Subcommittee	June 22, 2018 (Westborough)
Finance Subcommittee	June 22, 2018 (Boston)
Data Subcommittee	June 22, 2018 (Westborough)
Data Subcommittee	August 13, 2018 (Boston)
Workforce Credentials Subcommittee	September 10, 2018 (Worcester)
Standards Subcommittee	September 10, 2018 (Worcester)
Finance Subcommittee	September 11, 2018 (Boston)
Commission	September 20, 2018 (Westborough)
Commission	October 26, 2018 (Framingham)

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

INAUGURAL MEETING

Friday, June 23, 2017 | 1:00-3:30 PM

AGENDA

1:00 WELCOME AND INTRODUCTIONS

Monica Bharel, MD, MPH, Commissioner, Massachusetts Department of Public Health (MDPH)
Chair, Special Commission on Local and Regional Public Health

1:10 OPEN MEETING LAW AND CONFLICT OF INTEREST

Alexandra Rubin, JD, Deputy General Counsel, Office of the General Counsel, MDPH

1:30 LOCAL PUBLIC HEALTH IN MASSACHUSETTS

Eileen Sullivan, Chief Operating Officer, MDPH

1:50 REVIEW OF CHAPTER 3 OF THE RESOLVES OF 2016

Cheryl Sbarra, JD, Director of Policy and Law, Massachusetts Association of Health Boards

2:20 BREAK

2:30 MEETINGS ROADMAP, STAKEHOLDER ENGAGEMENT, AND COMMUNICATION PLANS

Ron O'Connor, Director, Office of Local and Regional Health, MDPH

3:00 SUBCOMMITTEES AND TASKS FOR NEXT MEETING

Phoebe Walker, Director of Community Services, Franklin Council of Governments

3:25 NEXT MEETING | LOCATION AND DATE

Monica Bharel, MD, MPH, Commissioner, MDPH

3:30 ADJOURN

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Minutes

Date: Friday, June 23, 2017
Time: 1:00 p.m. to 3:30 p.m.
Location: Massachusetts Division of Fisheries and Wildlife Field Headquarters
1 Rabbit Hill Road, Westborough, Massachusetts

Present: MDPH Commissioner Monica Bharel (Chair), Senator Jason Lewis, Representative Hannah Kane, Representative Steven Ultrino, Charles Kaniecki, Terri Khoury, Laura Kittross, David McCready, Dan Morgado, Maria Pelletier, Cheryl Sbarra, Bernard Sullivan, Phoebe Walker, Steve Ward, Sam Wong

Absent: Senator Richard Ross, Harold Cox, Justeen Hyde, Eileen McAnneny, Lauren Peters

Quorum: A quorum (at least 13 members) was present

Non-voting representatives of members: Kathleen MacVarish (for Harold Cox), Doug Howgate (for Eileen McAnneny)

MDPH Staff: Eileen Sullivan, Alexandra Rubin, Ron O'Connor, Jessica Ferland, Erica Piedade, Shelly Yarnie

Visitors: Sharon Cameron, Edward Cosgrove, Michael Coughlin, Elizabeth Doyle, Melanie O'Malley, Maddie Ribble

Call to Order: MDPH Commissioner Monica Bharel (Chair) called the meeting to order at 1:05 p.m.

***Note:** In these meeting minutes, "Commission" refers to the Special Commission on Local and Regional Public Health.*

WELCOME AND INTRODUCTIONS

Monica Bharel, MD, MPH, MDPH Commissioner and Commission Chair

- Welcomed Commission members to the inaugural meeting and asked members to introduce themselves
- Reviewed the meeting agenda
- Expressed the importance of examining the work with a "community-level lens" and using the resulting information to create recommendations
- Highlighted quarterly local public health webinars as part of her communication plan with local public health

OPEN MEETING LAW AND CONFLICT OF INTEREST

Alexandra Rubin, JD, Deputy General Counsel, Office of the General Counsel, MDPH

- Provided an overview of conflict of interest and open meeting laws
- Explained that a quorum is half of the Commission Members plus 1 (13 members for the this Commission)

- Stated that a quorum needs to be present in the room if a member participates remotely as permitted by the open meeting law
- Emphasized that items require approval by vote of the Commission before they can be implemented
- Indicated that every effort should be made to ensure transparency

Comments and Discussion

- In response to a question about member “meeting proxies”, a Commission member may send a representative to a meeting to listen and report to the member. The representative may not participate in discussions or vote and does not count toward the quorum.

LOCAL PUBLIC HEALTH IN MASSACHUSETTS

Eileen Sullivan, Chief Operating Officer, MDPH

- Provided an overview of the Massachusetts local public health (LPH) structure, mandated duties, workforce, and services
- Described the challenges faced by local public health in meeting their statutory and regulatory responsibilities including lack of an adequately trained and skilled workforce, inadequate funding, and limited support from their communities as public health responsibilities increase
- Presented a chart showing the distribution of Massachusetts cities and towns communities based on groupings of population size

Comments and Discussion

- In response to a question about if the population distribution chart was based on number of communities or total population within each grouping, it was explained that the percentages are based on the number of communities.
- In response to a question about a comparison between Massachusetts and other states, one difference between Massachusetts and other states regarding local board of health governance structure is that many states have a state-funded county public health system.

REVIEW OF CHAPTER 3 OF THE RESOLVES OF 2016

Cheryl Sbarra, JD, Director of Policy and Law, Massachusetts Association of Health Boards (MAHB)

- Reviewed the Massachusetts Public Health Regionalization Working Group recommendations and the legislation that resulted in the creation of the Special Commission on Local and Regional Public Health
- Provided the history of regionalization efforts as a response to meeting the challenges of delivering ten essential public health services across the state
- Presented the following local board of health (LBOH) challenges
 - 70% of LBOH who responded to a survey reported inadequate staff to meet obligations
 - LBOH stretched thin since 9/11 and budgets do not keep up with inflation
 - Disparities across communities in capacity of LBOH to provide essential services
 - Workforce is aging out; certain professionals in short supply
 - Staff salaries and positions vary across municipalities
 - Some municipalities have LBOH members with no or limited public health training
- Reviewed the following recommendations of the Public Health Regionalization Working Group
 - Develop different organizational structures to accommodate the different regions

- Develop an agreed upon set of governing principles
- Provide adequate funding for districts
- Develop standards for training and credentialing of LBOH staff
- Ensure all districts have sufficient services
- Build on existing legislation for supporting regionalization
- Use the many documents on these topics that already exist as a starting point
- Review the efforts of national organizations which are also looking at local public health infrastructure and workforce development issues including the U.S. Centers for Disease Control and Prevention, National Association of County and City Health Officials, Association of State and Territorial Health Officers, Public Health Accreditation Board, and National Association of Local Boards of Health
- Reviewed Chapter 3 of the Resolves of 2016 and the charge to the Commission
 - Assess capacity of LPH to meet statutory requirements
 - Evaluate state and local resources
 - Evaluate current and future workforce, including credentialing, standards, and training
 - Evaluate existing regional efforts and various models of service delivery
 - Examine progress towards achieving the recommendations by the Regionalization Advisory Commission (Chapter 60 of Acts of 2009)
 - Assess capacity of the MDPH Office of Local and Regional Health
 - Decide whether or not to hold public hearings and receive testimony
 - Submit written report by July 31, 2017

Comments and Discussion

- A member asked about the availability of data on 1) the number of towns that do not have a full time health inspector and 2) the public health services provided by each municipality.
- It was stated that models are needed to determine staffing needs, i.e., staff to population ratio and staff positions.
- There was discussion about the challenges in assessing a true picture of staffing across the 351 cities and towns given the lack of a requirement to report staffing to MDPH.
- It was recommended that models for providing and funding other services be examined. For example, a surcharge on homeowners insurance funds training for first responders. There might be comparable approaches to fund local public health staff training.
- It was stated that there are no mandates/incentives for cities and towns to regionalize public health services and that many communities are resistant to changes associated with regionalization.
- It was raised that some LBOH oversee a wider range of services than others (e.g., animal control and solid waste removal). As a result, sharing public health services across communities can be complicated.
- It was suggested that members define baseline expectations for local public health services across the board as a starting point.

MEETINGS “ROADMAP”, STAKEHOLDER ENGAGEMENT, AND COMMUNICATION PLANS

Ron O’Connor, Director, Office of Local and Regional Health, MDPH

- Proposed a roadmap for the Commission to complete its work
 - Meetings 1-2 Develop a common understanding of the issues and process
 - Meetings 3-4 Assess local public health

- Meetings 5-6 Develop recommendations
- Meeting 7 Approve the final report
- Proposed stakeholder dialogues as an opportunity for stakeholders to provide
 - input on local public health strengths, challenges, and innovations (Fall 2017) and
 - feedback on the Commission's draft recommendations (Spring 2018)
- Emphasized that the communication plan is intended to keep stakeholders (i.e., membership and interest groups) informed through multiple and varied communication channels
- Stated that DPH staff support for the Commission will include the Office of Local and Regional Health (OLRH) and the DPH Intra-Agency Local Public Health Working Group. The Boston University School of Public Health has assigned an Activist Lab Fellow to support OLRH in its Commission work for the 2017-2018 academic year.

Comments and Discussion

- It was recommended that funding and finance issues be integrated throughout the Commission's deliberations. The importance of understanding the cost of local public health services, the impact of competing demands for municipal resources, and viable funding or financing models was mentioned.
- Several members indicated that local control and funding for services are important issues for local public health
- Some members expressed the opinion that disparities in local public health capacity across the state are unacceptable.
- A member suggested an extension of the Commission's deadline because it might not be able to complete its work in one year.
- A member stated that timing of the Commission report is critical if the members want recommendations considered in FY2019 legislative session
- It was recommended that the Commission 1) focus on tasks that can be completed in the proposed one-year time frame and 2) use recommendations to suggest further studies/models and action steps (e.g., fiscal models).
- Members were reminded that 1) mechanisms do not always exist to assure the provision of some required LBOH services and 2) consequences/enforcement structures are not in place for LBOH that do not meet their statutory and regulatory responsibilities.
- More information was requested regarding the proposed stakeholder dialogues with an emphasis on ensuring that people are engaged and connected to the Commission's work through such opportunities
- Commission members were encouraged to share Commission information with their constituents, membership associations, other stakeholders, etc.
- It was proposed that the Office of Local and Regional Health assist with disseminating information.
- The question was asked if the stakeholder dialogues will be freestanding meetings or sessions held in conjunction with other planned forums (e.g., Massachusetts Health Officers Association Annual Conference, Massachusetts Municipal Association meeting, etc.).
- It was emphasized that the outreach plan should 1) ensure that individuals and groups in rural or isolated communities have access to and opportunities for engagement in stakeholder dialogues and 2) include a wide range of stakeholders beyond those typically associated with public health.
- It was asked if webinars or surveys could be used to collect and share information.

SUBCOMMITTEES AND TASKS FOR NEXT MEETING

Phoebe Walker, Director of Community Services, Franklin Regional Council of Governments

- Presented the following proposed subcommittees
 - Data
 - Standards
 - Structure
 - Credentials
 - Finance
 - Others?
- Raised the question of identifying data sources needed for each subcommittee
- Asked that Commission members indicate interest in serving on the suggested subcommittee(s)
- Acknowledged that the content of subcommittees intersect

Comments and Discussion

- In response to a comment that the Commission needs participation from the Department of Environmental Protection (DEP), It was stated that there is a seat for a DEP representative that is in the process of being filled
- It was stated that a critical subcommittee task is to identify LBOH services, the source for those services in statute, regulation, or local bylaw, and the amount of time required for each.

NEXT STEPS

- Summarize the goals of the subcommittees
- Compile and distribute a list of members' subcommittee interests to Commission members
- Members were asked to send information on data sources/data sets and requests for data sets to Ron O'Connor, Director of the Office of Local and Regional Health
- Share the slide presentations with Commission members
- Send the Public Health District Incentive Grant report to members
- Determine if non-members can serve on subcommittees
- Determine if the Open Meeting Law applies to subcommittees.

ADJOURN

Commission Chair Commissioner Monica Bharel adjourned the meeting at 3:30 p.m.

Approved by the Special Commission on Local and Regional Public Health, September 15, 2017

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Documents and Exhibits Used During the June 23, 2017 Meeting

- June 2017 Welcome Letter from MDPH Commissioner Monica Bharel to members
- Meeting agenda
- Membership list
- Member biographical sketches

Open Meeting Law and Conflict of Interest

- Open Meeting Law Guide
- Commonwealth of Massachusetts Open Meeting Law
- Attorney General's Office Open Meeting Law Notes
- Summary of the Conflict of Interest Law for State Employees

Local Public Health in Massachusetts

- Local Public Health in Massachusetts
- Local Public Health Keeps Us Healthy and Safe: What we do. Why We Do It.
- Strengthening Local Public Health in Massachusetts: A Call to Action
- 10 Essential Public Health Services
- Manual of Laws and Regulations Relating to Boards of Health
- Strengthening the Local and Regional Public Health System

Review of Chapter 3 of the Resolves of 2016

- Chapter 3 of the Resolves of 2016 – Charge and Report
- Resolve Establishing the Special Commission on Local and Regional Public Health

Meetings Roadmap, Stakeholder Engagement, and Communication Plan

- Draft Meetings Roadmap

Subcommittees and Tasks for the Next Meeting

- Subcommittee Suggestions Based on Commission Charge

Annotated Bibliography

- Annotated Bibliography of Documents Related to the Special Commission Charge

Slide Presentations at the Meeting
(Distributed to Members after the Meeting)

- ***Conflict of Interest and Open Meeting Law***, Alexandra Rubin, Deputy General Counsel, MDPH
- ***Local Public Health in Massachusetts***, Eileen Sullivan, Chief Operating Officer, MDPH
- ***Review of Chapter 3 of the Resolves of 2016***, Cheryl Sbarra, Director of Policy and Law, Massachusetts Association of Health Boards
- ***Meetings Roadmap, Stakeholder Engagement & Communication***, Ron O'Connor, Director, Office of Local and Regional Health, MDPH

Suggested Subcommittees, Phoebe Walker, Director of Community Services, Franklin Regional Council of Governments

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Agenda

Friday, September 15, 2017

1:00 p.m. to 3:30 p.m.

Massachusetts Emergency Management Agency
400 Worcester Rd, Framingham, MA

1. Welcome and Introductions
2. Votes
 - a. Minutes of June 23, 2017 meeting
 - b. Authorization for remote participation in meetings (we need to establish remote participation so that it is in place for this Commission – in case we need it)
3. National Perspective on Local and Regional Public Health
 - a. Pat Libbey, Do-Director. Center for Sharing Public Health Services
 - b. Grace Gorenflo, Center for Sharing Public Health Services
4. Plans for stakeholder outreach using established meetings and events
5. Subcommittees
 - a. VOTE: Creation of sub-committees
 - b. VOTE: Appointment of Special Commission members to sub-committees
 - c. VOTE: Description and charge of each sub-committee (there will be a draft description of each sub-committee; it will be important for these descriptions to be adopted by the Commission)
 - d. VOTE: Non-members on sub-committee (Commission needs to decide to allow non-members on sub-committees)
6. Plans for next meeting
7. Adjourn
1. Sub-committee meetings – we will work out a schedule of 30-minute meetings from 3:30-4:30 based on interest survey and follow-up with members to determine preference(s).

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Minutes

Date: Friday, September 15, 2017
Time: 1:00 p.m. to 3:00 p.m.
Location: Massachusetts Emergency Management Agency
400 Worcester Road, Framingham

Present: Commissioner Monica Bharel (Chair), Representative Hannah Kane, Sharon Cameron, Harold Cox, Justeen Hyde, Charlie Kaniecki, Terry Khoury, Laura Kittross, Carmela Mancini, Eileen McAnneny, David McCreedy, Kevin Mizikar, Maria Pelletier, Lauren Peters, Bernard Sullivan, Cheryl Sbarra, Mark Smith, Phoebe Walker, Steven Ward, Jason Wentworth, Sam Wong

Absent: Senator Jason Lewis, Senator Richard Ross, Representative Steven Ultrino

Quorum: A quorum was present

MDPH Staff: Damon Chaplin, Jessica Ferland, Ron O'Connor, Erica Piedade, Eileen Sullivan, Shelly Yarnie

Visitors: Eddy Atallah, Ed Cosgrove, Barry Keppard, Melanie O'Malley, Maddie Ribble

Presenters: Grace Gorenflo, Patrick Libbey

Call to Order: MDPH Commissioner Monica Bharel (Chair) noted that a quorum was present and called the meeting to order at 1:05 p.m.

Ron O'Connor, Director, Office of Local and Regional Health, provided the following reminders and updates:

- Open Meeting Law (OML) and Conflict of Interest (COI) forms need to be completed. Members who had not completed the forms were given the opportunity to complete the forms at the meeting.
- Members, who are new to boards and commissions in Massachusetts, may contact Ron if they have any questions.
- Subcommittees are subject to the Massachusetts Open Meeting Law
- Executive branch agency assignees (e.g., Commissioners) may appoint a designee to represent them at meetings. For example, DPH Commissioner Bharel may designate a member of DPH senior staff to represent her as chair of the Special Commission. Representatives of named organizations and appointees by the Governor and legislative leadership may not assign a designee who counts towards the quorum and can vote.

VOTE: Eileen McAnneny moved to approve the minutes of the June 23, 2017 meeting. Lauren Peters seconded the motion. The motion passed unanimously by voice vote. Jason Wentworth abstained.

VOTE: Representative Hannah Kane moved to allow remote participation in meetings of the Special Commission subject to the guidelines established by the Office of the Attorney General. Harold Cox seconded the motion. The motion passed unanimously by voice vote.

Presentation: Cross-Jurisdictional Sharing: What is it and how to make it work

Pat Libbey and Grace Gorenflo, Center for Sharing Public Health Services

Summary: Mr. Libbey provided a brief overview of local public health in Massachusetts and defined the spectrum of cross-jurisdictional sharing arrangements, strategies, and pre-requisites that support improved local public health systems and infrastructure development. A key questions asked during the presentation was, “What are the key drivers of cross-jurisdictional sharing in Massachusetts”? These drivers include

- Workforce Development
- Funding and Sustainability
- Health inequities – particularly Inequities across cities and towns in the provision of local public health services
- Lean fiscal environment
- Aging workforce

More information about the presentation is available upon request.

Comments and Discussion

- In response to a question about a definition of “high quality services” for local public health, a member followed up that some communities or sub-populations need more services (equity) In response, Cross-Jurisdictional Sharing is a means to a goal. Pre-requisites for success are:
 - Clarity of objectives
 - Defining Efficiency vs. Effectiveness
 - Utilizing the Spectrum of CJS using a balanced approach with mutual benefit
- A member asked how would this approach be helpful for working with other entities within a jurisdiction, such as the Planning Department.
In response: This is still in the research process so not able to provide an answer based on research
- A member asked the presenters to reflect on different approaches to entering into shared services; whether mandated or by choice?
In response, most of the work we have done is with those who have entered voluntarily. There is usually pushback when the mandate comes from above. It is most helpful when the community “personality” is known so groupings are made by pairing “like communities” rather than by proximity on the map.
- A member asked, “When considering applying for federal grants, the general cut off point is a population size of 75,000. The average population of communities in Massachusetts is in the mid-teens, which would be a barrier in competing for federal support. Do you have any recommendations?”
In response, Use of a third party or Council of Governances can be effective here.

- A member commented that it feels like we missed a step, such as asking and answering the question of “What is working and what is not working?” Maybe this presentation is out of sequence; it feels like this is the solution.

In response, CJS is a tool to help get to the goal. The succession of steps may be a separate topic, but this tool is one that can assist in moving the work forward.

- A member asked for clarification on a slide that mentioned cost cutting vs. cost savings to Cross-Jurisdictional Sharing?

In response, it is more of maximizing on the money spent. CJS may be a useful tool to build on the return of the investment.

- A member commented that people who have spent their lives and careers in Massachusetts don’t realize how far down on the spectrum of CJS Massachusetts compares nationally.

In response, Massachusetts has the largest number of individual jurisdictions in the country.

- C: In thinking about solutions, the idea of “Where do we want to go?” is very important. Clarifying the goals and end game is critical.
- A: “If every tool is a hammer, then every problem is a nail.” The questions to ask are:
- What is it that we want local public health to do?
- What are reasonable expectations for Massachusetts residents?

- A member asked what are pitfalls that others have made related to this issue?

In response, Change management is very difficult. On-going communication and clarity are very important including communicating with stakeholders what is known, as well as what is not known.

VOTE: Charlie Kaniecki moved to table discussion of the “proposed plans for stakeholder outreach” agenda item to the next meeting. Eileen McAnneny seconded the motion. The motion passed unanimously by voice vote.

VOTE: Jason Wentworth moved to accept the draft “Proposed Subcommittees Plan” which includes the creation of subcommittees, the description and charge of each subcommittee, a list of members to be appointed to the subcommittees, postponement of the Standards Subcommittee scheduled for September 15th at 3:00 p.m., and the role of non-Special Commission members. Justeen Hyde seconded the motion. The list of members appointed to subcommittees was amended as follows: Carmela Mancini was added to the Data Subcommittee, Kevin Mizikar was moved from the Finance Subcommittee to the Structure Subcommittee, and Eileen McAnneny and Lauren Peters were added to the Finance Subcommittee. The motion passed unanimously by voice vote.

Next Special Commission Meeting

Proposed date of November 3rd and proposed the use of the whole day. Subcommittees can meet in the morning followed by the Special Commission meeting as a whole in the afternoon. Subcommittees may also meet before November 3, 2017, but meetings need to be in-person, have a quorum, and are subject to the open meeting law.

Commissioner Bharel announced that, for any other business of the Special Commission on this day, Eileen Sullivan will be her designee as Chair.

VOTE: Phoebe Walker moved to adjourn the meeting. Terri Khoury seconded the motion. The motion passed unanimously by voice vote.

The meeting was adjourned at 2:55 p.m.

Approved by the Special Commission on Local and Regional Public Health, November 3, 2017

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Data Subcommittee

Agenda – September 15, 2017

3:00 p.m. to 3:50 p.m.

- 3:00 Call to Order
- Member introductions
- Discussion of subcommittee charge and tasks
- Consideration of additional members or subject matter experts
- Brief summary report to Special Commission on September 15th
- Plans for next subcommittee meeting
- 3:45 Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Data Subcommittee Meeting Minutes

September 15, 2017

Massachusetts Emergency Management Agency
400 Worcester Road, Framingham

Members present: Justeen Hyde, Cheryl Sbarra, Phoebe Walker, Mark Smith, Carmela Mancinci,
David McCready
Members Absent: None
Staff: Shelly Yarnie
Non-member: None

The meeting was called to order at 3:00 p.m. A quorum was present.

Key Topics and Issues Discussed

Local Public Health Data in Massachusetts

Very important to gather data to help inform what the Data Subcommittee needs to do next. Subcommittee discussed not wanting to waste time justifying that the system is “broken”. The goal is to get the data and evaluate it. Discussion consisted of:

- Data Subcommittee feels there is no unanimity on what they need to do or what must be done
- “System is flawed”
- State does not fund restaurant inspections and other core public health services
- No agreement on what local public health should be doing (policy promotion, system change, and essential public health services?)

Local Public Health Data in Other States

- Share Connecticut data in comparison to Massachusetts data
- Very little policy work being done in Connecticut)

Information Wanted on Local Public Health Data in Massachusetts

- Subcommittee needs data from DPH Food Protection Program, MAVEN, Lead Determinator List, and Beach and Water Testing
- Obtain DPH data, explore what it says and see how system works
- Explore data that the state collects on what we do not know

Preliminary Discussion of “Solutions”

- Explore data on what we do not know

- Compare data points (data that Massachusetts collects) of what “shining star” health departments may look like (e.g., compare Massachusetts data points with Kansas data points)
- Data compared to another state as a model? (e.g., data that state X collects and its rationale for collecting it)

Key Questions

- We need to start the Data subcommittee charge by indicating the 10 essential services are not being delivered by LPH Departments in MA?
- Provide a list of what we do not know?
- Comparison of Connecticut/Massachusetts data (explore Justeen Hyde’s recent study in Connecticut)

Decisions Made

VOTE: Cheryl Sbarra moved to appoint Justeen Hyde and Phoebe Walker as co-chairpersons of the Data Subcommittee. David McCready seconded the motion. Justeen Hyde and Phoebe Walker agreed to accept the appointments. The motion passed unanimously.

The Data Subcommittee will serve as a data review function for each area of the Special Commission charge. The Subcommittee will look at the areas and provide input if needed.

- Workforce Credentials- Justeen will check on certain changes in this area
- Finance- Ron is leading
- Structure-
- Standards- Feed the specific areas reports if needed. Justeen has data from 2011 that will be helpful around capacity and resources.

Action Steps

- OLRH staff will:
 - Obtain data from Food Protection Program, Mike Moore
 - Explore and review MAVEN’s
 - Communicable Set of Standards for Reporting
 - Timeline of receipt for disease in a jurisdiction
 - Quality of contact for reaching out to an infected individual
 - Consistency/quality of service
 - How many towns on MAVEN
 - Nurse/Dr report
 - Obtain Lead Determinator List
 - Obtain beach and water testing data
- Mark Smith will obtain DEP data
- Justeen Hyde will circulate Local Public Health studies such as recent Connecticut study
- Plans for next Data Subcommittee meeting

- Some of the group preferred to meet in the morning on the same day of the next Special Commission meeting (tentatively, November 3rd) while others preferred to meet on another day.
- Several documents need to be shared with the group in preparation for the next meeting.
- OLRH staff will poll subcommittee members for a meeting date before November 3rd.

The meeting adjourned at 3:45 p.m.

Approved by the Special Commission on Local and Regional Public Health Data Subcommittee, October 31, 2017

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Finance Subcommittee

Agenda – September 15, 2017

3:00 p.m. to 3:50 p.m.

3:00 Call to Order

Member introductions

Discussion of subcommittee charge and tasks

Consideration of additional members or subject matter experts

Brief summary report to Special Commission on September 15th

Plans for next subcommittee meeting

3:45 Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Finance Subcommittee Meeting Minutes
September 15, 2017
Massachusetts Emergency Management Agency
400 Worcester Road, Framingham

Members present: Eileen McAnneny, Lauren Peters, Sam Wong

Members Absent: Sen. Jason Lewis, Rep. Steven Ultrino

Staff: Eileen Sullivan, Ron O'Connor

Non-member: Maddie Ribble

The meeting was called to order at 3:00 p.m. A quorum was present.

Key Topics and Issues Discussed

Local Public Health Financing in Massachusetts

Because there is no requirement for local boards of health to report their budgets to the state, the subcommittee discussed ways to obtain information on local public health financing in Massachusetts:

- When she was at the Institute for Community Health, Commission member Justeen Hyde conducted interviews with local public health officials. Budget information was part of those interviews
- Does the Massachusetts Municipal Association have information on local budgets including public health spending?
- How do local budgets differ across communities?
 - Public health services covered differ
 - Line items differ
 - Location of public health within municipal budgets differs

Local Public Health Financing in Other States

- NACCHO Annual Local Public Health Profiles has budget information
- How do other states fund local public health? Do any states have budget reporting requirements?

Information Wanted About Local Public Health Financing in Massachusetts

- What is local public health spending on required/core services?
- Does overhead spending by public health districts differ from that of stand-alone local public health authorities? The presumption is that overhead costs are distributed across the member communities in public health districts.
- What role do grants and other extramural funding play on local public health financing? How are grant dollars allocated? Are grant dollars reported in municipal budgets?
- What is the percent of each municipal budget that is spent on public health? What are per capita expenditures on local public health?
- What is the percentage of funds spent on core services versus “discretionary” services? How does this information reflect disparities in service delivery across communities?

Service-specific Information that Might Serve as an Indicator of the Strength of Local Budgets

- Number of restaurant inspections per FTE: does the DPH Food Protection Program have this data?
- Inspectional services budgets in municipalities that have a separate department. Can funding for public health inspections be disaggregated from total inspectional services budget?
- What functions are solely the responsibility of local public health (e.g., restaurant inspections and tuberculosis case management).

Preliminary Discussion of “Solutions”

- Are there legislative solutions that will allow municipalities to retain fees and fines revenue without a town meeting vote?
- Explore Municipal Modernization, Community Compact Cabinet, Determination of Need Community Health Initiatives, and Hospital Community Benefits as possible sources of seed funding rather than sustainable funding. Are there any settlement funds available through the Attorney General’s Office?

Key Questions

- Is there an expectation that local public health will provide the ten essential public health services?
- What should residents expect for local public health services? Is there a minimum set of services that is necessary to achieve an equitable system?
- What services should Massachusetts require?

Decisions Made

No votes were taken during this meeting.

Action Steps

OLRH staff will:

- Explore a role for Boston University School of Public Health Activist Fellow in reviewing local budgets.
- Review information about local health financing in other states (including NACCHO reports) including mechanisms for retained fees/fines revenue
- Obtain data from the food protection program and tuberculosis control.
- Lauren Peters will talk with Sean Cronin (Executive Office of Administration and Finance, Division of Local Services) about local budgets.

VOTE: Eileen McAnneny moved to adjourn the meeting. Sam Wong seconded the motion. The motion passed unanimously. The meeting adjourned at 3:20 p.m.

Approved by the Special Commission on Local and Regional Public Health Finance Subcommittee on June 22, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Structure Subcommittee

Agenda – September 15, 2017

3:00 p.m. to 3:50 p.m.

3:00 Call to Order

Member introductions

Discussion of subcommittee charge and tasks

Consideration of additional members or subject matter experts

Brief summary report to Special Commission on September 15th

Plans for next subcommittee meeting

3:45 Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Structure Subcommittee Meeting Minutes

September 15, 2017

Massachusetts Emergency Management Agency
400 Worcester Road, Framingham

Members present: Harold Cox, Kevin Mizikar, Charlie Kaniecki, Terri Khoury, Bernie Sullivan, Rep. Hannah Kane, Jason Wentworth
Members absent: None
Staff: Damon Chaplin
Non-members: Pat Libbey, Grace Gorenflo, Ed Cosgrove

The meeting was called to order at 3:00 p.m. A quorum was present.

Key Topics and Issues Discussed

- Distribution of subcommittee member contact information
- Subcommittee goal statement (What do we want to achieve?)
- Shared service arrangements in Massachusetts (existing list)
- Massachusetts Public Health District Incentive Grant Program (PHDIG)
- Shared services arrangements in other states (Pat Libbey and Grace Gorenflo)
- Existing funding mechanism for local public health districts in Massachusetts (M.G.L Chapter 111 Section 27c)
- Local Public Health Standards (10 essential public health services)

Sub-committee members shared their contact information

Subcommittee goal setting

- Compile a list of regional structures in Massachusetts and other states, including their governance systems, any evaluation data, and any details on funding systems and requirements.
 - Best model depends on what you are trying to accomplish
- I. **Shared service arrangements in Massachusetts**
- Provide a list of Public Health Districts in Massachusetts.
 - Provided a list of shared service arrangements in Massachusetts.
 - Provided overview of Public Health District Incentive Grant program (P.H.D.I.G.)
 - Massachusetts Regionalization Working Group (MRWG)
 - Public health is not the only available shared service model.
 - What other shared service delivery components are being implemented across bureaus?
 - Could the Visiting Nurses Association (VNA) service model be considered a third party shared service provider? No. A comprehensive shared service arrangement is defined by:

- How the service is delivered.
- Governance Structure
- Who is being served and are communities being blended.

II. Massachusetts Public Health District Incentive Grant Program (PHDIG)

- Review PHDIG one page reports from the Massachusetts Public Health Regionalization Working Group to gain an understanding of how some public health districts are formed and managed in Massachusetts.

III. Review shared service arrangements in Other States

- Connecticut
- Virginia
- New Jersey
- Washington State
 - They have state, regional and local services.
- Oregon
 - Up to health department to decide if they would prefer to share services or not.
- Ohio
 - Every health department in Ohio must be accredited to receive state funds. As a result, health departments are looking for opportunities to share services to become accredited.
- Best model depends on what you are looking to accomplish.
- Council of Government model may work as a third party administrator

IV. Existing funding for local public health districts in Massachusetts

- **MGL Chapter 111 Section 127c**
 - Funding for districts already exists
 - No performance standards required.
 - No state appropriation because whole population could not be funded.
 - Barnstable County has a \$.01 sales tax to support local public health.

V. Local Public Health Standards (questions may be best answered by the Standards committee)

- Is there an expectation that local public health will provide ten essential public health services?
- What should the state require as a minimum standard of performance for local health departments and how will this standard be supported?
- What are the mandated public health services for Massachusetts?
- Is there a minimum set of services that is necessary to achieve an equitable system?
 - Although the goal may be to have every health department perform the 10 essential public health services. Mandated services may be the next best option.

Key Questions

- How many cross-jurisdictional sharing arrangements are there in Massachusetts?
- Is there a preferred structure that works best for Massachusetts?
- What services should Massachusetts require?
- What are our needs and what are we trying to accomplish?

Decisions Made

VOTE: Charlie Kaniecki moved to appoint Bernie Sullivan as chairperson of the Structure Subcommittee. The motion was seconded by Harold Cox. Bernie Sullivan agreed to accept the appointment. The motion passed unanimously.

VOTE: Charlie Kaniecki moved to schedule the next meeting of the Structure Subcommittee in the morning before the next scheduled Special Commission meeting (tentatively, afternoon of November 3rd). The motion was seconded by Harold Cox. The motion passed unanimously.

Action Steps

- Charlie Kaniecki will provide an overview of Connecticut Health Department infrastructure at next meeting.
- Bernie Sullivan will provide an overview of Barnstable County Health Department infrastructure at next meeting.
- Damon Chaplin and Harold Cox will provide PHDIG one-pagers from Justeen Hyde and an overview of District Incentive Grant Program at the next meeting.
- OLRH staff will
 - Provide subcommittee with a list of 10 essential public health services and local public health mandated reporting
 - Review information about local public health structure in other states (e.g., National Profile reports) including home rule and Dillon states.
 - Coordinate with other subcommittee staff to obtain local public health data from board members (Massachusetts Association of Health Boards) and health officers (Massachusetts Health Officers Association).
 - Coordinate with Harold Cox to provide subcommittee with PHDIG one page summary reports.

VOTE: Charlie Kaniecki moved to adjourn the meeting. The motion was seconded by Harold Cox. The motion passed unanimously. The meeting adjourned at 3:45 p.m.

Approved by the Special Commission on Local and Regional Public Health Structure Subcommittee,
November 3, 2017

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Development and Credentials Subcommittee

Agenda – September 15, 2017

3:00 p.m. to 3:50 p.m.

3:00 Call to Order

Member introductions

Discussion of subcommittee charge and tasks

Consideration of additional members or subject matter experts

Brief summary report to Special Commission on September 15th

Plans for next subcommittee meeting

3:45 Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Minutes

September 15, 2017

Massachusetts Emergency Management Agency
400 Worcester Road, Framingham

Members Present: Sharon Cameron, Laura Kittross, Maria Pelletier, Steven Ward
Member Absent: Charlie Kaniecki
Staff: Erica Piedade
Non-member: Melanie O'Malley

The meeting was called to order at 3:05pm. A quorum was present.

Key Topics and Issues Discussed

Interest and Experience in Workforce Development

Each member described the reason why they had chosen this subcommittee and shared some of the experiences that drove their interest in examining workforce credentialing:

- Experience with rural communities which often are represented by small boards of health (BOH) or selectmen who often have no background or experience or who have limited budgets resulting in limited staff who may or may not be adequately trained.
- Experience with urban areas which often “silo” services, such as inspectional services resulting in the “public health” framework being lost.
- Work with developing standards and requirements for the two most common and critical local public health positions: Certified Health Officer (CHO) and Registered Sanitarian (RS).
- Work in the community health field wherein the majority of staff is required to meet standards or be licensed or credentialed.
- Public health policy perspective that will be beneficial to developing policies on credentialing.

Standards and Requirements

There are no requirements for professionals working in Local Public Health (LPH) including experience, standards or credentialing. Looking at existing credentials will be helpful.

- There are two common positions in the field which requirements for credentialing, CHO and RS. The CHO requirements and exam are being currently reviewed and updated.
- Creating a professional roadmap for LPH professionals would help identify what needs to be put into place for expanding the pool and ensuring a pipeline.
- Looking at examples of other fields will help in creating a roadmap for credentialing and professional development (building inspector, animal control, public health nurses, etc.).
- Looking at other states and national credentialing bodies to set a Gold Standard for Mass.

- Explore how a defined credentialing process could be in sync with accreditation standards.
- Study any similar successful cases of credentialing a profession in Mass. such as the building inspector.
- Consider developing an overarching credentialing model that is doable and reasonable, such as building on currently experienced and trained staff, having a grandfathering clause, having additional recommendations for specialization.

Key Questions

- What credentials exist
 - In Massachusetts?
 - in other similar states (such as New Jersey, Wisconsin, and Ohio)?
 - have been recommended by national organizations, such as NACCHO and PHAB?
- What is the desirable “Gold Standard” for staffing and credentials for such staff and how do we ensure it is reasonable?
- How do we create a Roadmap that increases the workforce pool, builds on the existing workforce, and ensures equitable access to advancement?
- Recognizing that there may be pushback, what successful examples exist in Massachusetts of credentialing a profession that can be used as a playbook?

Decisions Made

Laura Kittross was selected as Chair of the subcommittee.

Action Steps

The Chair will try to schedule an alternative meeting date, since many could not make the morning of Nov. 3.

OLRH staff will send the following documents to all members:

- Andrade, Craig (2008). *Public Health Workforce Credentialing for Massachusetts: Analysis and Recommendations*.
- Moulthrop, Donna (2009). *Report of the Subcommittee on Credentialing, Massachusetts Public Health Regionalization Working Group*.
- Local Public Health Institute of Massachusetts Subcommittee (2010). *Competency Report*.
- Current Health National Center for Innovations (2016). *Fact Sheet*.

VOTE A motion to adjourn the meeting was made and seconded. The motion passed unanimously. The meeting adjourned at 3:50 p.m.

Approved by the Special Commission on Local and Regional Public Health Workforce Credentials Subcommittee, October 23, 2017

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Agenda

September 15, 2017 | 3:50 p.m. to 4:00 p.m.
Massachusetts Emergency Management Agency
400 Worcester Road, Framingham, Massachusetts

3:50 Call to Order
Brief reports from Special Commission subcommittees

4:00 Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Minutes

Date: Friday, September 15, 2017
Time: 3:50 p.m.
Location: Massachusetts Emergency Management Agency
400 Worcester Road, Framingham

Present: Eileen Sullivan (Chair designee for Monica Bharel), Representative Hannah Kane, Sharon Cameron, Harold Cox, Justeen Hyde, Charlie Kaniecki, Terry Khoury, Laura Kittross, Carmela Mancini, David McCready, Kevin Mizikar, Maria Pelletier, Lauren Peters, Bernard Sullivan, Cheryl Sbarra, Mark Smith, Phoebe Walker, Steven Ward, Jason Wentworth, Sam Wong

Absent: Senator Jason Lewis, Senator Richard Ross, Representative Steven Ultrino, Eileen McAnneny

Quorum: A quorum was present

MDPH Staff: Damon Chaplin, Jessica Ferland, Ron O'Connor, Erica Piedade, Shelly Yarnie

Visitors: Eddy Atallah, Ed Cosgrove, Barry Keppard, Melanie O'Malley, Maddie Ribble, Grace Gorenflo, Patrick Libbey

Call to Order: Eileen Sullivan, designated chair, called the meeting to order at 3:50 p.m.

Sub-committee Reports

Representatives of each of the following subcommittees provide brief reports on their meetings held at 3:00 p.m.: Data (Phoebe Walker), Finance (Lauren Peters), Structure (Bernie Sullivan), and Workforce Credentials (Laura Kittross). Minutes of each subcommittee meeting will be posted on the DPH Open Meeting Notices web page.

VOTE: Phoebe Walker moved to amend the charge of the Standards Subcommittee to include "make recommendations to the Special Commission on expectations for a minimum set of services to be provided by local public health authorities". David McCready seconded the motion. The motion passed unanimously by voice vote.

Sam Wong moved to adjourn the meeting. Laura Kittross seconded the motion. The motion passed unanimously by voice vote.

Meeting adjourned at 4:10 p.m.

Approved by the Special Commission on Local and Regional Public Health, November 3, 2017

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Agenda

October 23, 2017
10:45 a.m. to Noon

Worcester Division of Public Health, Room 109
25 Meade Street, Worcester, Massachusetts

10:45 Call to Order

Member introductions

VOTE: Approve minutes of September 15, 2017 meeting

11:00 A. Review and discussion of previous Massachusetts recommendations

- Craig Andrade: *Public Health Workforce Credentialing for Massachusetts* (2008)
- Donna Moulthrop: *Report of the Subcommittee on Credentialing, MA Public Health Regionalization Working Group* (2009)
- Local Public Health Institute *Competency Report* (2010)
- Others

B. Review and discussion of credentials available

- Massachusetts
- National

C. Review subcommittee work plan

- VOTE: Approve work plan

11:50 Next Steps

12Noon Motion to Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Minutes

October 23, 2017

Worcester Division of Public Health

25 Meade Street, Worcester

Members Present: Sharon Cameron, Laura Kittross, Maria Pelletier, Steven Ward, Charlie Kaniecki
Member Absent: **None**
Staff: Erica Piedade and Ron O'Connor
Non-member: Melanie O'Malley

The meeting was called to order by Laura Kittross, Subcommittee Chair, at 11:00 a.m. A quorum was present.

VOTE: Maria Pelletier moved to approve the minutes of the September 15, 2017 meeting of the Workforce Credentials Subcommittee. Steve Ward seconded the motion. The motion was approved by unanimous vote.

Key Topics and Issues Discussed

Workforce Credentials Subcommittee Draft Work Plan

Subcommittee members reviewed and discussed the draft work plan. Discussion items included:

- Preliminary web review of workforce credentials in other states did not yield useful information.
- Equivalence between Registered Sanitarian and Registered Environmental Health Specialist (National Environmental Health Association).
- History of the licensing of town building inspectors (about 20 years ago). Charlie Kaniecki agreed to research the process and report to the subcommittee.
- Status of Certified Health Officer (CHO) credentials. Steve Ward agreed to review CHO qualifications and report to the subcommittee.
- Implementation of workforce credentials by legislation or regulation change? Concern expressed that changes in regulations might be challenging.

VOTE: Charlie Kaniecki moved to adopt the work plan as written. Sharon Cameron seconded the motion. The motion was amended to 1) allow for modifications to the plan as needed and 2) add another item: Assess the current local public health workforce status with regards to time and cost. The motion passed unanimously.

Review of Studies on the Local Public Health Workforce

- Concern expressed that many studies focus on the qualifications of local public health directors and administrators rather than inspectors. Capacity/credentials of inspection staff are important. For example, the model by which building inspectors within Inspectional Services Departments do housing inspections without adequate understanding of public health issues
- Three training levels/phases discussed:: online (introductory), classroom, and field
- Page 13 of the Local Public Health Institute Competency Report (2010) lists 17 workforce competencies at the awareness and performance levels. Performance level competency requires a field component in addition to classroom.
- Focus on competency-based training rather than training to meet credentials
- “Public Health Academy” has been discussed for several years.
- Is a blend of DPH-supported training and private training desirable (e.g., animal control officer training includes public and private sources)
- What would DPH role be in credentialing? Does DPH have the infrastructure? With adequate funding, DPH could manage a credentialing system for the local public health workforce.
- Credentials matter in court cases involving public health matters.
- Local health departments experience challenges with worker turnover. Staff are trained but leave within a few years
- Suggestion made to require awareness level training on the 17 competencies for all; additional training/credentials based on need
- Suggestion that Massachusetts Public Health Inspector Training (Housing) should be required for anyone who conducts housing inspections.
- Credentialed training will need certified training entities
- Research questions:
 - What credentials does the local public health workforce currently hold?
 - How do we get to structure?
 - What is the cost of the LPHI “Foundations” course?
 - What credentials should be expected of a local public health director? Is CHO adequate if it does not include administrative skills?

Decisions Made

Amended and adopted Workforce Credentials Work Plan (see attached).

Action Steps

- Charlie Kaniecki will review history of licensing of building inspectors
- Steve Ward will review certified health officer credential
- OLRH staff will inquire about cost of Foundations course

- The next meeting will be held on November 28, 2017 from 9:30 a.m. to 11:00 a.m. at a location to be determined.

VOTE: Maria Pelletier moved to adjourn the meeting. Steve Ward seconded the motion. The motion was approved by unanimous vote

The meeting adjourned at 12:00 p.m.

Approved by the Special Commission on Local and Regional Public Health Workforce Development Subcommittee, December 8, 2017

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Standards Subcommittee

Meeting Agenda

October 23, 2017
9:00 a.m. to 10:30 a.m.

Worcester Division of Public Health, Room 109
25 Meade Street, Worcester, Massachusetts

- | | |
|-------|---|
| 9:00 | Call to Order |
| | Member introductions |
| 9:05 | Select Subcommittee Chair(s) |
| 9:10 | Review and discuss subcommittee charge and tasks |
| 9:30 | Draft recommendations to Special Commission on Local and Regional Public Health on expectations for a minimum set of services to be provided by local public health authorities |
| 10:25 | Set next meeting date |
| 10:30 | Adjourn |

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Standards Subcommittee Meeting Minutes

October 23, 2017

Worcester Division of Public Health

25 Meade Street, Worcester

Members Present: Sharon Cameron, Laura Kittross, Terri Khoury, Maria Pelletier, Phoebe Walker, Steven Ward,
Member Absent: Cheryl Sbarra, Bernard Sullivan
Staff: Erica Piedade and Ron O'Connor
Non-member: Charlie Kaniecki, Melanie O'Malley

The meeting was called to order by Ron O'Connor at 9:00 a.m. A quorum was present.

Introductions and Nomination of the Subcommittee Chair

Being the first meeting of the Standards Subcommittee, introductions were the first course of business followed by a discussing would be the Chair of the subcommittee. The members nominated Cheryl Sbarra. Ron O'Connor agreed to contact Cheryl to see if she would accept which she has accepted.

Key Topics and Issues Discussed

Subcommittee members reviewed Subcommittee Tasks as designated by the Commission Members during the meetings of Sept. 15 and June 23:

- Make recommendations to the Special Commission on Local and Regional Public Health on expectations for a minimum set of services to be provided by local public health authorities.
- Review available studies which provide information on the capacity of local public health authorities to carry out their statutory powers and duties.
- Review national performance standards for local and regional public health authorities.
- Compare the capacity of local and regional public health authorities against performance standards and recommendations of national organizations included U.S. Centers for Disease Control (CDC), National Association of County and City Health Officials (NACCHO), Association of State and Territorial Health Officials (ASTHO), and American Public Health Association (APHA).
- Discussed identifying data, reports and studies on national performance standards, and drafting a work plan.

Establishing Minimum Standards:

- Minimum standards should at least ensuring that the public is safe, i.e., need to meet the regulatory/statutory requirements.
- Recommended looking at national standards that have been put to the test.

- Concern expressed that national standards may be “ideal” and may not be attainable for small towns or even bigger towns with limited budgets.
- Will research other states (Illinois, Ohio, CT, New Hampshire, Oregon), but also ensure that states that have Home Rule like Massachusetts are included (New Jersey). Finding and looking at regional studies, i.e., New England, was also seen as useful.
- Specifying what operationalizing the minimum standards looks like, especially regarding staffing to required activities or population, will be critical. Towns or cities which have well trained and credentialed staff, but not adequate staff, still will not be able to provide required services.
- Public Health Nurses have a manual on standards with ratios, i.e., 1 public health nurse to 5,000 people, which has incorporated the 10 essential services and Healthy People 2020 goals. Statute for food inspectors also includes ratios. Understood that formulas would need to be cognizant of different needs of towns and cities, i.e., some may not have restaurants or camps.
- A two tier approach was raised: require minimum standards that include the 10 essential services and 3 core functions as outlined by the CDC (<https://www.cdc.gov/stltpublichealth/publichealthservices/essentialhealthservices.html>) and tier two be accreditation to work towards. Want to ensure recommendation supports an integrated approach to public health/population health approach.
- Proposed that the table created by the Berkshire Health Alliance for the training of Boards of Health (BOH) should be crosswalked with the Massachusetts Association for Health Boards (MAHB)’s document that summarizes the statutory requirements for BOH and then incorporate the 10 essential services as a starting point for defining minimum standards.
- Will connect with other subcommittees such as Structure, Workforce Credentials, and Finance. For example, teaching and academic institutes need to be included in a plan for the training of local public health workforce, starting with trades schools and moving towards higher education to assist in ensuring there are continuous training opportunities for staff so they can fulfill the requirements; funding targeted to BOH and sustainable (explore Cherry Sheets model, Barnstable model, Mosquito Health Districts); and infrastructure that supports the implementation of the Commission recommendations, including DPH.
- Need data to demonstrate problem (not meeting the statutory requirements/public health mandate; lack of equity), impact of not dealing with the problem (not providing restaurant inspection could result in major health issue damaging tourist economy) and possible impact of implementing recommendations. Three county survey data exists and can be used as model for getting data from the rest of the state.
- Need strategies on how to educate and acquire support from stakeholders for adopting required minimum standards for local public health, including legislation with realistic funding. Begin by defining what is wanted (minimum required standards) and then develop steps on how to get there.
- Raised that states provide funding for local public health with requirements attached such as mandated reports. It was pointed out that in the 1980s legislation was passed under M.G.L. Chapter 111, Section 27C: *Reimbursement of Regional Health Districts; Qualification; Formula for Allocation of State Funds for Operating Expenses*. The lesson to be learned is that the recommendations by the subcommittee and Commission need to be attainable and to have backing for implementation.

- Will look at Connecticut and the pathway they have taken regarding current legislation and learn from the pitfalls encountered.

Presentation at Commission Meeting on Nov. 3

Other subcommittees will have 2 minutes to provide update followed by the Standard Subcommittee presenting recommended standards.

- Present context, problem and then recommendations.
- Present the table that summarizes statutory requirements, after it is cross-walked with the MAHB document and the 10 essential services/3 core functions as the bases for the proposed required standards for all BOH.
- Present accreditation standards, i.e., Public Health Accreditation Board (PHAB) Standards, as a bar to be worked towards (<http://www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/>).
- Subcommittee Statements on Standards: *All citizens should be covered by a Public Health System that meets the required minimum standards including statutory mandated services. The Subcommittee recognizes the value and importance of meeting and working towards national standards as demonstrated through accreditation, including PHAB.*

Decisions Made

Presenting the two tiered approach (proposed minimum standards and working toward accreditation) was decided up. The Subcommittee Statements on Standards was developed.

VOTE: Laura Kittross moved to adopt the Subcommittee Statements on Standards. Phoebe Walker seconded the motion. The motion passed unanimously.

Action Steps

- Ron will put slides together based on the discussion and will send to Phoebe for review and editing.
- Ron will send out to all Subcommittee Members after Phoebe reviews and members will send Ron comments or edits.
- Finalized slide deck will be sent to members.
- Subcommittee will meet on Nov. 3 at 12:30pm to decide who will present.
- The next meeting will be determined.

VOTE: Phoebe Walker moved to adjourn the meeting. Maria Pelletier seconded the motion. The motion was approved by unanimous vote.

The meeting adjourned at 10:55 a.m.

Approved by the Special Commission on Local and Regional Public Health Standards Subcommittee, November 3, 2017

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Data Subcommittee

Meeting Agenda

Tuesday, October 31, 2017

2:00pm-3:30pm

Massachusetts Department of Public Health – West Boylston Site
180 Beaman Street | West Boylston, Massachusetts

- 2:00pm Call to Order
- 2:05 Member introductions
- 2:10 VOTE: Approve minutes of September 15, 2017 meeting
- 2:15 Review DPH progress on data collection and choose what to highlight at Commission meeting on November 3, 2017 in our report out.
- 3:00 Review draft list of minimum standards for public health from Standards Subcommittee and discuss any data available for each.
- 3:15 National Models: NACCHO Operational Definition of a Functional Local Health Department and 10 Essential Public Health Services -- Discuss whether any additional data exists anywhere to evaluate MA level of success in meeting either.
- 3:25 Set next meeting time, adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Data Subcommittee Minutes

Tuesday, October 31, 2017
2:00pm-3:30pm

Massachusetts Department of Public Health – West Boylston Site
180 Beaman Street | West Boylston, Massachusetts

Members present: Justeen Hyde, Carmela Mancini, Cheryl Sbarra, Mark Smith, David McCreedy & Phoebe Walker
Members Absent: None
Staff: Shelly Yarnie and Ron O'Connor (phone)
Non-member: None

The meeting was called to order at 2:05pm. A quorum was present.

1. Member introductions took place

2. Minutes: VOTE: Approve minutes of September 15, 2017 meeting

Phoebe Walker moved to approve the September 15 minutes with a minor edit on Page 1. Second bullet under LPH Data in Other States shall read: *Regional-stand-alone districts have weaker connections to local decision makers in Connecticut*. Cheryl Sbarra seconded the motion. All agreed. The motion passed unanimously.

3. Review DPH progress on data collection and choose what to highlight at Commission meeting on November 3, 2017 in our report out.

- Data Subcommittee will report on Friday, November 3 about “what we know about the Local Public Health system in Massachusetts”
- Subcommittee went over November 3 agenda and Data Subcommittee presentation format and goal
- Many challenges collecting data

Data Subcommittee reviewed slides prepared by Phoebe Walker and Justeen Hyde from information Shelly Yarnie was able to obtain from DPH staff/programs. An update on data collection efforts from the following programs were discussed followed by a vote on specific further data requests needed.

- *A) Food Protection Program-* 2016 raw data was obtained, data is self-reported from boards of health and has not been verified by Massachusetts Department of Public Health (DPH) Food Protection Program. DPH Office of Local and Regional Health intern analyzed the data and put into pie charts. We are now going to request 2015 data to provide an estimate.

VOTE: The committee requests 2015 city/town retail food inspection report; Permission to report on 2016 data on number of inspections/year. Phoebe Walker moved to approve the request/proposal. Cheryl Sbarra seconded the motion. All agreed. The motion passed unanimously.

- *B) Communicable Disease*, very challenging to obtain information on MAVEN, the mandatory online communicable disease reporting system. No capacity in the system currently to know how well the local responsibilities are being fulfilled. Obtaining a measure of completeness of follow up for even one disease (like Pertussis) would be helpful.

VOTE: The committee requests the following data from MAVEN:

- % of towns that acknowledge receipt of communicable disease in town in a timely manner,
- % of closed investigations,
- % of cases lost to follow up,
- At least one quality indicator (e.g., pertussis)

Cheryl Sbarra moved to approve the request/proposal. Dr. Mancini seconded the motion. All agreed. The motion passed unanimously.

- *C) Beach Water Quality Testing*- Shelly Yarnie reviewed the 2016 Annual Report. In 2016, a total of 15,605 water samples were collected from 586 marine and 594 fresh water beach sampling locations.

Subcommittee feels data is not reliable because the report indicates that everyone is doing the water quality testing, but we don't know if the communities are meeting the frequency requirement. A town could submit just once per summer for a weekly requirement and be counted as meeting the requirement in this report.

- *D) Lead*- Shelly Yarnie was able to provide the committee with a list of Code Enforcement Lead Determinators (LD). 121 towns are not listed as having access to a LD. In a Childhood Lead Exposure Data brief- 2016 of the 22 communities listed as high risk for lead poisoning, one has no LD listed.

Subcommittee feels data obtained is not useful as it does not provide actual towns with LD due to data limitations (for example, the agent for a regional health district is only listed in his/her home town).

- *E) Emergency Preparedness*: Quarterly response drills are conducted by the Office of Preparedness and Emergency Management (OPEM).

VOTE: The committee requests Health and Homeland Alert Network quarterly response drills data - most recent data that OPEM can share.

- BOH response rates to quarterly drills,
- # of towns with updated Emergency Dispensing Plan
- # of towns Emergency Dispensing Site plan connected to electronic- Community Emergency Plan
- Any other metric for local health preparedness that U.S. Centers for Disease Control is measuring

David McCready moved to approve the request/proposal. Cheryl Sbarra seconded the motion. All agreed. The motion passed unanimously.

- *F) Safe Drinking Water*: Not much that we can say we know. Massachusetts Department of Environmental Protection (DEP) does not track Soil Evaluator information. DEP does not have any information on private wells.

Mark Smith will go back and check into Title 5 data at DEP.

The Data Subcommittee reviewed Justeen Hyde's presentation slides. She provided highlights of 3 articles. She emphasized the "Mean Capacity Score Among Each of the 10 Essential Public Health Services" and believes this is the best tool for the Standards Subcommittee, it is an all self-evaluation 25 question tool.

Presentation format and who would present on Data on November 3 was discussed and decided as a team effort/approach.

Review draft list of minimum standards for local public health from Standards Subcommittee and discuss any data available for each.

Phoebe Walker shared Standard Subcommittee Recommendation “Three Tiers of Standards”
Data Subcommittee can comment where appropriate

Colorado is a decentralized state and mandated 10 essential services for every health department in 2010 or 2011. Data Subcommittee should explore.

Minimum standards recommendation from Standards Subcommittee:

- 1st Tier: Legally required duties of a Massachusetts Local Health Departments
- 2nd Tier: What everyone deserves: Coverage by a health department that meets the 10 essential services
- 3rd Tier: Gold standard: National Accreditation

Is there a metric/rubric to determine 3 tiers? (this would fall to OLRH to measure)
How do you evaluate standards/metrics and translate into capacity

National Models: NACCHO Operational Definition of a Functional Local Health Department and 10 Essential Public Health Services -- Discuss whether any additional data exists anywhere to evaluate Massachusetts level of success in meeting either.

Set next meeting time, adjourn

The Commission meeting on Friday, November 3 will help inform when the Data Subcommittee meets next.

The following are tentative dates, location to be determined at a later time.

- Monday December 11, 10-11:30am
- Tuesday, January 9, 1:30-3pm

Documents and Exhibits Used During the October 31, 2017 Meeting

PowerPoint slides: Data Subcommittee Report

Approved by the Special Commission on Local and Regional Public Health Data Subcommittee,
December 11, 2017

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Standards Subcommittee

Meeting Agenda

Friday, November 3, 2017
12:30 p.m. to 1:00 p.m.

Massachusetts Division of Fisheries and Wildlife
1 Rabbit Hill Road, Westborough, Massachusetts

12:30 Call to Order

VOTE: Nomination of Cheryl Sbarra, Subcommittee Chair

VOTE: Approve minutes of October 23, 2017 meeting

Review and discuss Standards Subcommittee presentation at the November 3, 2017 meeting of the Special Commission

Next steps

Set next meeting date

1:00 Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Standards Subcommittee Meeting Minutes

November 3, 2017

Massachusetts Division of Fisheries and Wildlife
1 Rabbit Hill Road, Westborough, MA

Members Present: Terri Khoury, Maria Pelletier, Phoebe Walker, Cheryl Sbarra, Bernie Sullivan, Steven Ward
Members Absent: Sharon Cameron, Laura Kittross
Staff: Erica Piedade and Ron O'Connor
Non-member: None

The meeting was called to order at 12:30 p.m. A quorum was present.

Appointment of Subcommittee Chair

At the October 23, 2017 Standards Subcommittee meeting, members recommended Cheryl Sbarra as subcommittee chair. She indicated her willingness to serve after that meeting.

VOTE: Phoebe Walker moved to appoint Cheryl Sbarra as Chair of the Standard Subcommittee. Terri Khoury seconded the motion. The motion passed unanimously.

Presentation of Standards Subcommittee Report to the Special Commission

Subcommittee members reviewed the slide presentation on the recommended minimum standards. Cheryl Sbarra, Ron O'Connor, Terri Khoury and Steve Ward decided they would present and answer questions as a group, each taking a different section or topic of the slide set.

Adjourn

VOTE: Terri Khoury moved to adjourn the meeting. Cheryl Sbarra seconded the motion. The motion passed unanimously.

The meeting adjourned at 1:00 p.m.

Documents and Exhibits Used at the November 3, 2017 Meeting

Slide Presentation: Standards Subcommittee Report, Special Commission on Local and Regional Public Health, November 3, 2017

Approved by the Special Commission on Local and Regional Public Health Standards Subcommittee, December 8, 2017

Structure Subcommittee

Meeting Agenda

Friday November 3, 2017

11:00 a.m. - 12:30 p.m.

Massachusetts Division of Fisheries and Wildlife
1 Rabbit Hill Road, Westborough, Massachusetts

11:00 a.m. Call to order

VOTE: Approve minutes of September 15, 2017 meeting

Discuss cross-jurisdictional sharing in Massachusetts

Discuss cross-jurisdictional sharing in other states

Discuss strategic approach to cross-jurisdictional sharing in Massachusetts

Summary of the Merrimack Valley Health District

Next steps

12:30 p.m. Adjourn

Structure Subcommittee Meeting Minutes

November 3, 2017

Massachusetts Division of Fisheries and Wildlife
1 Rabbit Hill Road, Westborough, MA

Members Present: Bernie Sullivan, Chair, Representative Hannah Kane, Kevin Mizikar, Terri Khoury, Lorraine O'Connor (for Jason Wentworth)
Members Absent: Harold Cox, Charlie Kaniecki
MDPH Staff: Ron O'Connor, Erica Piedade, Eddy Atallah (student)
Non-Members: Barry Keppard

The start of the meeting was delayed until 11:30 a.m. for lack of a quorum. Ron O'Connor, Director of the MDPH Office of Local and Regional Health, provided an overview of cross-jurisdictional sharing in Massachusetts for the members present at 11:00 a.m. The members did not deliberate on matters during this information-sharing session.

Call to Order: The meeting was called to order at 11:30 a.m. A quorum was present.

VOTE: Representative Hannah Kane moved to accept the minutes of the September 15, 2017 meeting of the Structure Subcommittee (amended to include attendance of Barry Keppard as a non-member). Terri Khoury seconded this motion. The motion passed unanimously by voice vote.

Key Issues and Topics Discussed

- **Existing Health Districts/ Shared Services.** Members discussed an overview of the 16 Massachusetts health districts and other cross jurisdictional sharing arrangements prepared by DPH staff. Members commented that the summary of the 16 entities can be enhanced by reviewing the documents that created districts (e.g., legislation that created Nashoba Associated Boards of Health and Barnstable County Department of Health and the Environment) and other documents that describe the legal framework and history. Eastern Franklin County and Franklin Regional Council of Governments were noted as additional examples for further research. That research will also help in understanding revenue sources for districts.

Standardized information that characterizes each health district would be helpful to better understand the different models and could lead to a classification system for Massachusetts. For example, member towns of the Central Massachusetts Regional Public Health Alliance (CMPHA) have different inter-municipality agreements (IMAs) with different expiration dates.

A chart of health districts and shared services can be created that will include the 3 areas of legislation that address shared service. Information regarding health districts created in 1980's is limited; these districts (Quabbin, Foothills, and Eastern Franklin) may or may not have been funded with state incentive funds.

A member asked if the role of large coalitions that receive categorical funding (i.e. tobacco, substance use/abuse, mosquitoes) should be considered in developing a list of shared service arrangements (e.g.; the Cape Ann area has about 17 different coalitions that provide public health services; is this a "shared service"?). Standards adopted by the Commission will help to define how grants (i.e., tobacco control, etc.) can contribute to our understanding of public health services sharing across communities. The Cape Ann/ North Shore sunscreen awareness program was noted as a very successful inter-community program. A member indicated that there are concerns about the administrative burden associated with community programs. In addition to organization and facilitating meetings and providing administrative support, individuals who are hired for these programs might become town employees with associated employee benefits costs.

What national data do we have on cities and towns staffing and structure? The National Association of County and City Health Officials and the Association of State and Territorial Health Officials have data that will be useful to the subcommittee. DPH staff will review data from other states. Colorado, Connecticut, Vermont, and Rhode Island were cited as states to review. Charlie Kaneicki recently reported (by email prior to the meeting) that there is legislation on regionalization in Connecticut that is currently stuck. Colorado is another useful example. DO they use marijuana tax dollars to support their public health budget?

- **Funding:** The American Public Health Association recommended last year that marijuana tax dollars be used to fund public health infrastructure but specifics were not shared at the meeting.

Structure Subcommittee needs to work with the Finance Subcommittee to ensure that recommendations on structure are supported by the Finance Subcommittee recommendations. The Finance Subcommittee plans to meet by the end of December. DPH will facilitate connections between Finance and other subcommittees.

The **Merrimack Valley Health District** was cited as a useful case study. There were opportunities for success, but it failed when the Mayor of Methuen cut the health director salary line item in the health department budget. Buy-in from municipal leadership is essential.

- **Collaboration with hospitals.** Discussion moved to the role of approaches that include partnerships with hospitals/ health centers. Subcommittee might explore experiences with local public health – health care alliances. For example, hospitals have funding for community activities (Community Benefits or Determination of Need (DoN) requirement).

CMPHA as a whole does not engage with hospitals with the exception of Community Health Improvement Planning (CHIP).

Local public health is slowly building relationships with hospitals, particularly around Community Health Assessment, CHIP, and use of funds under Community Benefits or DoN.

Chelsea was cited as an example of a public health approach to community health needs assessment that included health systems and municipality.

Decisions Made

The subcommittee did not make any decisions at this meeting.

Action Items/ Next Steps

1. Review Standards Subcommittee recommendations for minimum set of services to inform additional discussion of structure
2. Review information from Data Subcommittee
3. DPH staff will review use of Colorado marijuana tax revenue
4. DPH staff will review APHA marijuana tax revenue recommendations
5. DPH staff will review data from other states
6. DPH staff will review request for a char of public health districts/ shared services that includes enabling legislation, funding, etc.
7. Send Doodle poll for next meeting
8. Lorraine O'Connor will check if she is the permanent replacement for Jason Wentworth as the MDAR designee
9. DPH staff will review the legal formation of public health districts in Massachusetts
10. DOG staff will check with the town of Montague to see if original documents are available
11. DPH staff will review the revenue structure for Barnstable County and Franklin Regional Council of Governments

VOTE: Representative Hannah Kane moved to adjourn the meeting. Kevin Mizikar seconded the motion. The motion passed unanimously by voice vote.

The meeting adjourned at 12:15 p.m.

Documents and Exhibits Used During the November 3, 2017 Meeting

1. Structure Subcommittee November 3, 2017 meeting agenda
2. Structure Subcommittee Minutes from September 15, 2017 meeting
3. Massachusetts Public Health Districts and Shared Services Arrangements
4. Spectrum of Cross-jurisdictional Sharing Arrangements (Center for Public Health Services)

Approved by the Special Commission on Local and Regional Public Health Structure Subcommittee, December 12, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Agenda

Friday, November 3, 2017

1:00 p.m. to 3:30 p.m.

Massachusetts Division of Fisheries and Wildlife
1 Rabbit Hill Road, Westborough, Massachusetts

- 1:00 Call to Order
Welcome and Introductions
Review Agenda
- 1:05 **VOTE:** Minutes of September 15, 2017 1:00 p.m. meeting
VOTE: Minutes of September 15, 2017 3:50 p.m. meeting
VOTE: New subcommittee member assignments
- 1:10 Subcommittee Status Reports
- Workforce Credentials
 - Structure
 - Finance
- 1:20 Report of the Standards Subcommittee
- Recommendation for a minimum set of services to be provided by Massachusetts local public health authorities
- 1:40 Discussion of Recommendation of the Standards Subcommittee
- 2:40 **VOTE:** SCLRPH statement on a minimum set of services to be provided by Massachusetts local public health authorities
- 2:45 Report of the Data Subcommittee
- Overview of Existing Data on the Capacity of Local Public Health in Massachusetts to Meet Standards
- 3:20 Next steps/Plans for next meeting
- 3:30 Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Minutes

Date: Friday, November 3, 2017
Time: 1:00 p.m. to 3:00 p.m.
Location: Massachusetts Division of Fisheries and Wildlife
1 Rabbit Hill Road, Westborough, MA

Members Present: Eileen Sullivan, Chair (designee of DPH Commissioner Monica Bharel), Senator Jason Lewis, Representative Hannah Kane, Justeen Hyde, Terri Khoury, Carmela Mancini, Eileen McAnneny, David McCready, Kevin Mizikar, Lorraine O'Connor (designee of DEP Commissioner Martin Suuberg in place of Assistant Commissioner Jason Wentworth), Maria Pelletier, Bernard Sullivan, Cheryl Sbarra, Mark Smith, Phoebe Walker, Steven Ward, Sam Wong

Members Absent: Sharon Cameron, Harold Cox, Charlie Kaniecki, Laura Kittross, Representative Steven Ultrino, Senator Richard Ross (non-voting representation by Greg Casey, Chief of Staff)

Quorum: A quorum was present

DPH Staff: Jessica Ferland, Ron O'Connor, Erica Piedade, Shelly Yarnie

Visitors: Greg Casey (Chief of Staff for Senator Richard Ross), Eddy Atallah, Ed Cosgrove, Barry Keppard, Melanie O'Malley

Call to Order: Eileen Sullivan, Chair (designee of DPH Commissioner Monica Bharel), called the meeting to order.

VOTE: Kevin Mizikar moved to approve the minutes of the two September 15, 2017 meetings. Carmela Mancini seconded the motion. The motion passed unanimously.

Subcommittee Updates

Members were asked if they were interested in joining additional subcommittees, especially the Finance Subcommittee which needs more members.

No one requested to be added to a subcommittee. A vote was not taken.

Workforce Credentials Subcommittee Update – Erica Piedade for Laura Kittross, Chair

The subcommittee has discussed educational standards, training, and credentialing issues and preliminary ideas to move forward with the Commission charge:

- Focus on identifying educational standards, training, and credentialing beginning with the field staff.
- Preliminary recommendations:
 - Setting minimum training requirements for public health staff, especially for those who conduct inspections, such as a core competency course (i.e., Local Public Health Institute (LPHI) Foundations for Local Public Health Practice course) and field training;
 - Considering requirements for position-specific credentials such as Certified Pool/Spa Operator (CPO), ServSafe, Massachusetts Public Health Inspector Training (MAPHIT) Housing certification; and

- For managerial/director role identifying educational standards, training and credentialing as strongly recommended versus mandated.
- Explore the costs and benefits for mandating educational standards, training and credentials for critical positions and the process and structure needed for implementing mandates.

Structure Subcommittee Update – Bernie Sullivan, Chair

Subcommittee has reviewed the 16 existing public health districts and shared services arrangements in Massachusetts. Each has a unique structure and history. Recommendations of the Standards Subcommittee will be needed in order define effective and efficient structures that can meet the standards.

Finance Subcommittee Update – Ron O’Connor, OLRH Staff

The subcommittee has not met since its initial meeting in September. It is trying to schedule a meeting before the end of the calendar year. Currently there is no chair.

Standards Subcommittee Update – Slide Presentation - Cheryl Sbarra (Chair), Terri Khoury, Steve Ward, and Ron O’Connor (OLRH staff)

- A brief history and timeline on the evolution of public health practice was provided to frame the need to set standards.
- The charge was reviewed and the subcommittee explored three tiers for recommending a standard:
 - Tier 1/Minimum Standards: Legally required duties of a Massachusetts Local Health Department/BOH
 - Tier 2/“What everyone deserves”: Local Health Department/BOH that provides the Ten Essential Public Health Services
 - Tier 3/“Gold Standard”: National accreditation through the Public Health Accreditation Board.
- Subcommittee defined each tier and provided examples including how the Association of Public Health Nurses operationalized the Ten Essential Public Health Services into public health nursing standards. Discussion included an acknowledgement that Tier 1, the status quo, was not a desirable standard given how national standards have evolved.
- The Standards Subcommittee recommended the following minimum set of local public health services which every resident deserves: *Every Massachusetts resident should be served by a local public health authority that effectively and efficiently provides the Ten Essential Public Health Services.*
- The subcommittee provided this additional Statement on Standards: *All citizens should be covered by a public health system that meets the required minimum standards including statutory mandated services. The Subcommittee recognizes the value and importance of meeting and working towards national standards as demonstrated through accreditation by the Public Health Accreditation Board.*
- The Commission members were asked to consider accepting the Subcommittee’s recommendation: Ten Essential Public Health Services (“Tier 2) as the minimum package of services with Tier 3 being the aspirational goal.

Comments and Discussion

1. How much of a difference is there between the tiers?

- Tier 1 just focuses on inspections/enforcement requirements. Some local health departments cannot even fully meet those mandatory requirements.
Using the NACCHO’s “Operational Definition of a Functional Local Health Department” as a minimum

standard of performance for all local health departments in Massachusetts will ensure that residents across the state receive a nationally recognized set of public health services.

- Based on Justeen Hyde’s research:
 - When examining the 10 Essential Services, 2 out of the 10 focus on enforcement and surveillance, and the rest are really about “how do we do our job” within an evidence based framework, collaborating across critical fields, and consistently evaluating the work and standards for performance.
 - Approximately 25% of municipalities/ districts are performing at the Tier 2 level.

2. *How is effective service delivery measured?*

- Colorado has mandated that LPH have outcome measures.
- Current Massachusetts reporting is inconsistent.
- There are no consequences in Massachusetts for not meeting statutory requirements.
- We could build a local public health system with measures that, if funded, could require reporting.

3. *Why change the Massachusetts local public health system?*

- Some local health departments cannot even meet legal requirements (“Tier 1”).
- Tier 1 services do not change rate of diabetes, pediatric asthma, or other preventable, chronic diseases.
- Ten Essential Public Health Services (“Tier 2”) as the minimum set of services will be significant in improving health outcomes and where measurable change can actually begin.
- Accreditation (“Tier 3”) will be a big shift for local public health. Most local health departments are not ready for accreditation. With Ten Essential Public Health Services, there can be a measureable impact on health outcomes.

Data Subcommittee – Slide Presentation– Phoebe Walker and Justeen Hyde, Co-Chairs

1. *What do we know about how well local public health is working?*

- Currently there is no dashboard or one tool to show the status of LPH performance in meeting required duties.
- Main challenges
 - Some data is missing/not collected; Information is collected but sometimes not complete.
 - Lack of funding with incentives for meeting requirements and reporting.
 - No consequence for underperformance or non-compliance.
 - Some mandatory reporting isn’t being done.
- Presented local public health data from DPH; identified additional data sets that will inform a better understanding of the capacity of the local public health system.
- Department of Environmental Protection-related local public health data was less available.
- 30% of municipalities submit retail food inspection reports to DPH. Of those, 46% appear to perform the required 2 inspections per year.

Some observations:

- The capacity to complete and report required food inspections appears greater with increasing population size (e.g., communities with over 26,000 people with a larger budget and larger staff).

- Need to consider capacity of rural communities. Small towns tend to be supported if municipal leadership understands the importance of local public health.
- Data Subcommittee needs to determine if there is enough data to make the case for “Tier 2”. If not, what other data is needed?
- Most of the data reflects capacity to address environmental health. The case for the Ten Essential Public Health Services requires data related to chronic disease.
- Community health centers have health promotion/chronic disease prevention data at hand which helped make the case for having community health workers.

2. *How does Massachusetts compare to other states?*

- We need to describe what Massachusetts would look like if local public health has the capacity to provide Ten Essential Public Health Services (EPHS). There is a need to explore other states that adopted EPHS.
- Staffing levels are a concern. How does local public health do the work in a meaningful way if staffing is not adequate? There is a need to explore national standards for ratio of population to staff for various functions.

3. *Other data issues*

- Explore health outcome data for the towns against indicators of the capacity of local public health to provide required services.
- DPH has health outcomes data (e.g., disease incidence and health care utilization data like healthcare systems rather than from local public health).
- What data-based arguments are needed to build a case for change in the local public health system?

Additional Comments/Discussion about Making the Case for Change

[Note: “Tier 1” – services required by Massachusetts statute or regulation
“Tier 2” – Ten Essential Public Health Services]

Are we aiming for Tier 1? Shouldn’t that be the baseline?

- There are important differences between Tier 1 and 2. Tier 1 technically can have trained professionals that focus on regulatory requirements. Tier 2 is a different approach in engaging populations and requires a leap in skill sets.
- Tier 1 is the current problem – it is just saying, “Do your job.” Tier 2 ensures that they are doing their job and moves beyond status quo.
- The missing component is what does it take to get from one tier to the next – tangible targets, for example, in 3 years all meet current requirements, and in 5 years provide ten essential public health services?
- A take-away is – what would Tier 2 look like. Subcommittees can use Tier 2 to show what it looks like.
- Getting from Tier 2 to 3 is not that hard, but getting from Tier 1 to Tier 2 might take the most effort.
- Tying beneficial outcomes to the tiers would help. Integrate pre-, current, and post- data outcomes for people to be able to see a gained benefit or reward.
- Need to show the benefits of having services meet the Ten Essential Public Health Services with community data.
- Need to show benefits and harm avoided as part of the case for change.

Next Steps

The Commission decided it needed to have more information before deciding if it should accept the Ten Essential Public Health Services as a standard in forthcoming work. It was agreed that each Subcommittee could use the Ten Essential Public Health Services as a bar to see what resources would be needed to get BOHs across the state to be able to operationalize it.

Data Subcommittee will meet with key DPH managers to review available data at their December 11, 2017 meeting.

Next Special Commission Meeting

Members were asked to indicate their availability for either January 12 or 19, 2018. Once responses have been tallied, a meeting date will be confirmed and communicated with Commission members.

VOTE: Sam Wong moved to adjourn the meeting. David McCready seconded the motion. The motion passed unanimously by voice vote.

The meeting was adjourned at 3:00 p.m.

Approved by the Special Commission on Local and Regional Public Health, January 12, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Documents and Exhibits Used During the November 3, 2017 Meeting

- Agenda for Special Commission on Local and Regional Public Health Meeting
- Draft minutes from the two September 15th meetings for approval by Commission members
- *Operational Definition of a Functional Local Health Department*, NACCHO 2005
- Updated Roadmap
- *Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century*
- *Berkshire County Boards of Health Association Local Boards Of Health Core Duties*
- Presentation from Sept. 15th meeting: Cross-Jurisdictional Sharing: What it is and How to Make it Work
- Subcommittee Membership and Descriptions document
- Meeting minutes from September 15th meetings of subcommittees

Slide Presentations at the Meeting

- **Standards Committee Report**, Cheryl Sbarra (Chair), Terri Khoury, Steve Ward
- **Data Committee Report**, Phoebe Walker, Justine Hyde

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee

Meeting Agenda

December 8, 2017

9:00 a.m. to 10:30

Worcester Senior Center
128 Providence St, Worcester

9:00 Call to Order

VOTE: Approve minutes of October 23, 2017 meeting

9:10 Review and discussion of Standards Subcommittee recommendations

9:20 Review of Workforce Credentials preliminary draft recommendations

10:20 Next Steps

VOTE: On Action

10:30 Motion to Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Minutes

December 8, 2017

Worcester Senior Center

128 Providence St., Worcester

Members Present: Sharon Cameron, Charlie Kaniecki, Laura Kittross, Steven Ward

Member Absent: Maria Pelletier

Staff: Ron O'Connor, Erica Piedade

Non-members: Rae Dick, Melanie O'Malley

Call to Order: Laura Kittross, the Chair noted that a quorum was present and called the meeting to order at 9:05am.

Vote: Steve Ward moved to approve the minutes of the October 23, 2017 meeting. Charlie Kaniecki seconded the motion. The motion passed unanimously.

Review and Discussion of the Standards Subcommittee Presentation to the Special Commission on November 3, 2017: An overview of the presentation and discussion was provided to the Subcommittee members who were not in attendance. The Special Commission discussion focused on needing to make a case for instituting the proposed standards but agreed that Subcommittees should use the 10 Essential Services as a basis for moving forward. Workforce Credentials Subcommittee members discussed the concerns that were raised at the November 3 meeting, i.e., what harm would result in leaving the system the way it is, why shouldn't the focus be on ensuring all BOHs meet the minimum, what would the benefits compared to cost be in raising the bar, and what measures exist to capture benefits. Laura Kittross agreed to do some preliminary work on making the case for supporting initiatives that would ensure a well-trained, competent, and adequate workforce.

Vote: Laura Kittross made a motion to allow non-Commission members to freely participate in the discussion. Sharon Cameron seconded the motion. The motion passed unanimously.

Review and Discussion of the Preliminary Draft Recommendations: The discussion focused on the four identified positions and the training each position should be required to have (document attached).

- Inspectional Staff – mandate type of training and credentialing
- Public Health Nurse (PHN) – question was raised if it was necessary to have a public health nurse or if the PHN needed to be a RN;
- Directors – strongly recommend training; lots of different definitions of what a director is which needs further research in order to make clearer recommendations (Erica Piedade will review workforce documents on director credentialing recommendations for the next meeting);

- Board of Health Members – it was stated that trainings can be mandated and should be so they understand their statutory responsibilities; agreed that if undertook inspections must be trained though it was agreed that Board Members should focus on oversight and not be doing the work of staff (regulatory language may need changing);
- Clerical Support Staff – this position was added based on a strong argument and agreement of the value of a well-trained Clerical Support Staff; such staff needs to know what and what not a BOH is responsible for, how to respond to public records retention and requests, public inquiries, filling out forms, etc.

Key discussion points included:

- Requiring a “Foundations Course” similar to the LPHI Foundations Course as training along with identifying the required credentials; exceptions for taking the “Foundations Course” could be made if the professional had certifications that demonstrated the knowledge and skill-set being required; this would especially be a requirement any BOH staff who does inspectional services;
- Should a RS, REHS, or CHO be a required credential and should they be required to maintain the credentials which would be an added expense; CHO regulations have been finalized, exam being rolled out, and requires a BA and 30 hours of science credits;
- Requiring a bachelor’s degree versus not requiring a bachelor’s degree was raised; concern with requiring a bachelor’s degree was that it reduces the pool; current local public health workers in towns where salaries are low may not be able to make the monetary or time investment to pursue a bachelor’s; towns may not be able to provide a competitive salary to recruit or retain individual; recommending credentialing and raising the bar would be within the context of the Special Commission also looking at financial feasibility and sustainability for towns so important to define what the best options for local public health be;
- Should think in the context of pathways and pipeline, i.e., gradation of requirements from new in the field without experience versus many years of experience but with no credentials to highly credentialed; can recommend that within the first year or within 2-5 years of hire will need credentials;
- “Academy” type model that is in place for fire fighters might be a good model to introduce; there would be a cost attached to ensure sustainability, but many local public health workers pay to be certified and towns pay to have their fire fighters trained; if towns share services they also share training expenses and when there is a turnover they still have staff to step in;
- For required credentials should there be continuing education requirements so staff are supported in going to conferences and trainings and keep up with best practices; everyone agreed that the recommendations should be clear and simple;
- The Public Health Nurse’s role in local public health has changed; competitive salaries and recruitment issues are concerns; as stated above considering LPNs as well as RNs need to be discussed;
- Consider who will do the certification or credentialing, DPH or an “LPH Training Academy”; DPH currently is responsible for the RS and CHO credentialing process; “Academy” may be simpler or more flexible in meeting changing landscape;
- In making the case may need to map out current status and what needs to happen to get to where the bar is being set; may need a quick survey regarding BOH # of staff, positions of staff, salaries, number and types of inspections, population being served, grants applied for; and
- When recommendations are finalized will need legislative language to support this.

Action Steps:

Laura Kittross will work on making the case for supporting workforce development.

Erica Piedade will review workforce documents on local public health that focuses on “directors” and will bring definitions and recommendations for training and credentialing for that position to the next meeting. She will also research the “fire personnel training academy” for considering a “public health workforce training academy”

Sharon, Charlie and Steve will review the Draft Recommendations document to see what is missing regarding the different recommended positions and training and should there be others such as a MA PHIT Camp or training on preparation for working with courts.

Sharon, Charlie and Rae will look at the *Competency* document pages 2-10 and 13-26 to see if the LPHI “Foundations Course” includes all the areas.

Sharon will come up with questions for the survey and will send them out for feedback.

Proposed Meeting Date: January 24, 2018 in coordination with and after the Standards Subcommittee Meeting.

Vote: A motion to adjourn the meeting was made and seconded. The motion passed unanimously. The meeting adjourned at 10:50a.m.

Documents and Exhibits Used at the December 8, 2017 Meeting

December 8, 2017 Meeting Agenda

October 23, 2017 Meeting Minutes

Workforce Credentials Subcommittee Work Plan

Workforce Credentials Subcommittee Draft Recommendations – First Draft 11/28/17

Standards Subcommittee Slides from November 3, 2017 Presentation

Approved by the Special Commission on Local and Regional Public Health Workforce Credentials Sub-Committee on January 24, 2018.

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Standards Subcommittee

Meeting Agenda

Friday, December 8, 2017
10:30 a.m. to Noon

Worcester Senior Center
128 Providence Street, Worcester

1. Call to Order
2. VOTE: Minutes of October 23 and November 3, 2017 meetings
3. Update: the case for a higher standard for a minimum set of local public health services
4. Discussion of Foundational Public Health Services
5. VOTE: Revised recommendation to Special Commission on minimum set of services
6. Next meeting

Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Standards Subcommittee Meeting Minutes

December 8, 2017

Worcester Senior Center

128 Providence St., Worcester, MA

Members Present: Sharon Cameron, Terri Khoury, Laura Kittross, Cheryl Sbarra, Steven Ward
Member Absent: Maria Pelletier, Phoebe Walker
Staff: Erica Piedade and Ron O'Connor
Non-member: Charlie Kaniecki and Melanie O'Malley

The chair, Cheryl Sbarra, called the meeting to order at 10:50 a.m. A quorum was present.

VOTE: To approve the October 23 meeting minutes.

Motion: Sharon Cameron, Second: Laura Kittross and Steve Ward

The motion passed unanimously.

VOTE: To approve the November 3 meeting minutes.

Motion: Cheryl Sbarra, Second: Terri Khoury

In Favor: Terri Khoury, Cheryl Sbarra, Steven Ward

Abstained: Sharon Cameron and Laura Kittross

The motion passed with a majority approval.

Presentation and Discussion on the Foundational Public Health Services (FPHS)

Cheryl Sbarra provided a brief summary of the Commission response to the Standards Subcommittee presentation on November 3, 2017. In response to the questions about the case for making a change, especially for instituting the recommended standards, and measurability, Cheryl Sbarra proposed that the Standards Subcommittee consider the Foundational Public Health Services (FPHS). FPHS will help the subcommittee make the argument for the standards being proposed. She handed out copies of the slide set that she then presented to the Subcommittee members.

Discussion regarding having FPHS as the recommendation for the minimum set of local public health services:

- *Foundational Public Health Services (FPHS)* was developed by the Public Health National Center for Innovations (PHNCI); PHNCI was established by the Public Health Accreditation Board (PHAB) with funding from Robert Wood Johnson Foundation.
- FPHS was endorsed by the National Association of County and City Health Officials (NACCHO) in 2012; NACCHO has been working on developing national standards since 2005.
- Kansas Health Institute (KHI) report studied 8 states that instituted the FPHS in order to determine if Kansas should adopt FPHS; study provides information about Kansas, Colorado, Kentucky, North Carolina, North

Dakota, Ohio, Oregon, Texas and Washington and the effort by each state to identify a minimum package of essential services to adopt as a standard.

- The FPHS responds to the concerns raised at the November 3 Commission meeting regarding measuring outcomes and assessing the cost for the minimum package of local public health services.
- The FPHS integrates the 10 essential services into its model and goes further by defining what operationalizing the model actually entails. It is a natural transition from the Subcommittee recommendation of the 10 Essential Public Health Services to the FPHS as the standard to recommend. FPHS is aligned with the 10 Essential Public Health Services in a way that provides cost estimates and measures of foundational services.
- The FPHS has also been aligned with the PHAB criteria.
- The appendix of the KHI report lays out operationalization of services at the local, regional and state levels; recommended services include clinical and lab services which are most feasibly provided through the sharing of services among communities.
- An agreed-upon minimum set of services (the “standard”) will enable other Commission subcommittees to recommend the structure, workforce, and financial support needed to meet the standard.
- OLRH staff members are researching how Washington, Colorado and Oregon made the case and were able to have the FPHS as a standard for the minimum package of services.
- In the presentation to the Commission, FPHS would substitute for the 10 Essential Services; it was agreed that the first tier (meeting statutory and regulatory requirements) was not acceptable if we are to have 21st century services; the case for change needs to be made; the system needs to be modernized.
- Caution was emphasized with regard to the use of the term “modernization” because it might be seen as a “luxury” with regard to competing priorities and lack of adequate resources.
- In looking at other states, Ohio requires health departments to be certified by a certain date in order to receive state funding; some states use different tax revenues to support LPH, i.e., Colorado and the cannabis tax; the Finance Subcommittee would be tasked to develop recommendations for the financing of the recommendations made by the Commission.

VOTE: To revise the recommendations made in the presentation to the Special Commission to incorporate FPHS as the recommended minimum package of services.

Motion: Steve Ward, Second: Laura Kittross

The motion passed unanimously.

Discussion on Revising the Presentation:

- Texas, as a decentralized state similar to Massachusetts, will be examined to learn how they were able to institute FPHS as their standard.
- Questions regarding the need for change came from the non-public health representatives, so the work needs to focus on making a clear case to the non-public health professionals on the Commission.
- CDC has slides on demonstrating the value and impact of public health over the centuries and includes relevant data which would help non-public health people understand how public health works; good public health is often invisible because it is working well.

- Chronic diseases are the major causes of morbidity and mortality and have very high health costs for individuals, states and the nation and need to be the number one issue addressed as part of Public Health 3.0; the state needs LPH as a partner in order to be successful at combating chronic disease;
- The capacity in every community to control communicable disease is important because communicable diseases do not stop at the borders of towns.
- A proposal to schedule a joint meeting with the Data Subcommittee to coordinate making the case was made.
- The purpose of the joint meeting of the subcommittees will be to combine Standards Subcommittee messages about the importance of public health and the Foundational Public Health Services with the Data Subcommittee messages about current local public health capacity.

VOTE: To meet with the Data Subcommittee members to discuss and prepare a presentation on making the case for FPHS as the minimum set of local public health services.

Motion: Cheryl Sbarra, Second: Laura Kittross

The motion passed unanimously.

Action Steps:

- Laura Kittross will research CDC presentations and information on public health impact.
- OLRH Staff will continue researching states similar to Mass. that have instituted FPHS.
- Ron O’Connor will reach out to the Data Subcommittee Chairs to inform them of the proposal to have a joint meeting.

Adjourn:

- VOTE: Adjourn the meeting
- Motion: Steve Ward
- Second: Terri Khoury
- The motion passed unanimously
- The meeting was adjourned at 1:00p.m.

Documents and Exhibits Used During the December 8, 2017 Meeting:

- Slide Presentation: *Foundational Public Health Services*
- FPHS Fact Sheet: www.phnci.org
- NACCHO’s Statement of Policy, Foundation Public Health Services: www.NACCHO.org
- *State-By-State Comparison of Foundational Public Health Services, Technical Report January 2017*, Kansas Health Institute: www.KHI.org
- *Defining and Constituting Foundational “Capabilities” and “Areas” Version 1(V-1), Executive Summary*, Public Health Leadership Forum, March 2014: <http://www.iom.edu/Reports.aspx?Activity={C466A30C-76B9-4E9A-87D1-06C854B779DA}>
- Lampe S, Van Raemdonck L, et al. Minimum Package of Public Health Services: The Adoption of Core Services in Local Public Health Agencies in Colorado. *American Journal of Public Health*. 2015; 105:S252-S259.

Approved by the Special Commission on Local and Regional Public Health Standards Subcommittee, January 3, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Data Subcommittee

Meeting Agenda

Monday, December 11, 2017

10:00 am-12 pm

Massachusetts Department of Public Health
250 Washington Street, Conference Room 3A | Boston, Massachusetts

- 10:00 a.m. Call to Order
- 10:05 Member introductions
- 10:10 VOTE: Approve minutes of October 31, 2017 meeting
- 10:15 Discussion: how can we best meet the charge from the full Commission to make a “business case” for setting a higher minimum standard for local public health in Massachusetts?
- 10:45 Review DPH health outcomes data against local public health infrastructure data. Can we lay two kinds of maps on top of each other?
- 11:00 Update on DPH Data requests
- Retail Food Inspection
 - Beach Water Testing
 - Massachusetts Virtual Epidemiologic Network (MAVEN)
 - Lead Poisoning Prevention – Lead Determinators
 - Health and Homeland Alert Network
- 11:55 Set next meeting date
- 12noon Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Data Subcommittee Minutes

Monday, December 11, 2017
10:00am-12:00pm

Massachusetts Department of Public Health – West Boylston Site
250 Washington Street | Boston, Massachusetts

Members present: Justeen Hyde, Carmela Mancini, Cheryl Sbarra, Mark Smith, David McCready & Phoebe Walker
Members Absent: None
Staff: Shelly Yarnie, Ron O’Connor, Jana Ferguson, Kerin Milesky, Kevin Cranston, Gillian Haney and Eileen Sullivan
Non-member: None

The meeting was called to order at 10:15pm. A quorum was present.

12. **Member introductions** took place

13. **Minutes: VOTE: Approve minutes of October 31, 2017 meeting**

Phoebe Walker moved to approve the October 31 minutes. David McCready seconded the motion. All agreed. The motion passed unanimously.

Phoebe Walker reviewed the Gliecher’s Formula, a model to provide successful organizational change. It is challenging to overcome dissatisfaction and change absent of this formula in place.

14. **Discussion: how can we best meet the charge from the full Commission to make a “business case” for setting a higher minimum standard for local public health in Massachusetts?**

How can we clarify that how local public health is working now is broken?
We don’t know what we don’t know

Cheryl Sbarra shared the recent Standards meeting observation:

- Part of problem is some members of the Special Commission on Local and Regional Public Health do not understand local public health in Massachusetts. The historical context/knowledge is limited among these members. Knowledgeable Commission members need to provide a historical perspective.

Justeen Hyde shared the following comments:

21st century vision is not just ensuring that mandated services are provided in every municipality. While there are gaps at the level of mandated services that need to be addressed, the Commission needs to set its sight on the ten essential public health services and how to get there. The Department of Public Health (DPH) is now an accredited health department and it did not need a local public health vision on accreditation.

Some people have no interest in a vision of 21st century public health- especially when some restaurants are not being inspected across the state.

15. Review DPH health outcomes data against local public health infrastructure data. Can we lay two kinds of maps on top of each other?

This agenda item was tabled to discuss at a later time.

16. Update on DPH Data requests

- Retail Food Inspections
- Beach Water Testing
- Massachusetts Virtual Epidemiologic Network (MAVEN)
- Lead Poisoning Prevention- Lead Determinators
- Health and Homeland Alert Network

Health and Homeland Alert Network (HHAN)

Kerin Milesky, Director, Office of Preparedness and Emergency Management, provided an overview/background on the HHAN system. Two data sheets that provide update on HHAN Response Status FY 17/Budget Period 5 and Emergency Dispensing Site Plans in MA highlights are as follows:

HHAN Response Status FY 17/BP5

- HHAN response rates range from 66%-80% by region
- Areas of concern are communities unable to respond to the drills. There is opportunity to pull out communities not able to respond so that research is done and explored further as to why no response. Sometimes there is no person in place. The goal is to ensure many points of contact are in place for each community
- Town level data shows smaller towns not doing well. Can we do mapping?
At this time looking for measures
- What is implication of a town who does not respond? What is responsiveness?
Towns with least responsiveness know that the state will take over especially when emergent issues occur on a Friday afternoon, weekend and holidays

Comments:

- We need good data and compelling stories in ways which the system failed (for policy implications) to inform local action
- Chery Sbarra shared Eileen MacAnneny shared the system is so broken we need to go to a state system?

The Data Subcommittee requested Kerin share a compelling story

Shelly has community level information – we don't want to highlight negative stories

The overlay of regional and population data is ideal

Emergency Dispensing Site Plans in MA

Total number of Emergency Dispensing Site Plans in MA

- Every city/town is required to have a EDS plan in place
- There are 249 EDS plans across the state

Kerin Milesky reviewed the data in detail

Phoebe shared the HHAN Response Status FY 17/BP5 provides a far better proxy measure.

Jana Ferguson, Bureau of Environmental Health, provided an update on the following programs: Retail Food Inspections, Beach Water Testing and Lead Poisoning Prevention- Lead Determinators.

Retail Food Inspections

- Requirements for Food Protection Program is mandated in Local Board of health statutes
- Food data is collected annually, 40% response rate
- Lots of push back on training and collection of data, "LBOH will say they are too busy"
- In 2010 an evaluation was done on # of inspectors, # of permits etc. but we do not know how accurate the data is
- DPH does not see Inspectional Reports.
- We cannot use the Food Inspection Data, it is self-reporting and has not been verified.
- If someone does not get information, then there is a breakdown in the system
- Currently using OLRH and HHAN contact list for better communication and response
- It is a challenge getting responses
- Infrastructure piece is difficult. Need to develop

Jana's observation: Going forward counting permits is not useful for us. We are not interested in Fast Food restaurants but more interested in high risk operations such as fermented kitchens/innovative kitchens such as Sushi bars, Food Trucks, Wellness Kitchens. These area tracks more closely with Foodborne Illness.

Data Subcommittee request: Permission to report on 2016 data? As we need to obtain permission from the Commissioner's Office

Beach Water Testing

Annual Report done on Beach and Water Quality Testing on a yearly basis. All Marine Beach testing is provided to DPH by a laboratory.

Food permits change constantly, beaches and lakes do not change and we can determine when we have not received such info.

Lead Poisoning Prevention- Lead Determinators (LD)

Small amount of LD listed by towns are not on a current list. Having a LD in a town does not indicate whether the doctor is providing the screening. Lots of physicians feel lead is not an issue. A recent clean up if the database occurred, after the clean up the database went from 8600 to 126.

Massachusetts Virtual Epidemiologic Network (MAVEN)

Kevin Cranston, Assistant Commissioner and Director, Bureau of Infectious Disease and Laboratory Sciences and Gillian Haney, (Title) provided an overview of data on Salmonellosis cases.

Communities not on MAVEN have to do with capacity issues (cost issue with broadband, not having individual available) others have much higher priority.

They looked at different entities and provided a Salmonellosis Data sheet (Foodborne infection)

- Expectation- Is the person a food handler; need to get them offline. Turnaround time was 4 days in this case.
- 5-6% not on MAVEN receive reports by mail/fax

Justeen asked: What are good indicators of communicable disease on a local issue?

- Look at community, unexpected or not
- During high profile events; MDPH will step in and will not wait for Local Board of health
- Maven has rich source of data and we need to use data to make case
- Towns on MAVEN are doing well- we need to explore why they are doing well
- The number of Lead Determinators list is not important than higher rate of children with elevated blood level- it tells a story (income, race, social determinants of health)
- To improve quality, the MAVEN data was shared with the Board of Health Inspector and was very controversial

On-going discussion about data needs continues

- Any data from local public health we have not collected
- What is health priority at the town level we can layer over
- We need to explore LPH with community grants
- Most funding is regional except Boston
- We don't want to shame small towns due to their capacity
- What is useful for data collection on a town level? Asthma, Chronic Disease, What is the negative outcomes
- PHIT- "Public Health Information Tool" is a resourceful data tool at the town level
- Environmental Public Health Tracking has lots of available data. PHIT will pull from it
- PHIT is taking over MassCHIP
- Not a good time to ask for money from the Governor
- We can make a case upon immediate need, keeping public safe
- What is the danger of not addressing infectious disease?

What to do next?

- Mark, "we need real examples of stories, additional funding will help with proven inefficiencies"
- Justeen, "what are we working towards? Mandated services or 21st Century comprised of public health, interventions and community"?
- Cheryl, Data Subcommittee needs to meet with Standards and determine foundational areas; we might be able to come up with a vision. We can meet on 12/18/17 or 1/3/18
- Carmela, "we need more examples like Salmonellosis. Chronic disease such as Asthma, ER visits in a specific town with a Tobacco Cessation can help with ER prevention
- David, "any towns with examples of primitive success stories (any notable responses, shining stars, we must dig for it)"
- Eileen, "connecting Data and Standards together is important. Pull together layering/mapping of health outcomes and funding. Most of data is there around the health department. Work with Abby, Commissioner of Population Health. She understands local public health as she is a Board of Health member at Worcester DPH. We must show the broken systems and the health impacts."
- Jana, "look at Environmental Tracking Tool in connection with Standards (look at points of interest)
- We can make a business case exploring other states such as Oregon, Ohio and Colorado
- Standards/Data must make case- if not then we do not meet on 1/12/18
- Areas to explore; PHIT, unnecessary hospitalization data, Ron will check in with Natalie Nguyen

Set next meeting time, adjourn

The next meeting will take place on January 3, 2018 and will be comprised of the Data and Standards Committee. Locations to be determined

Documents and Exhibits Used During the December 11, 2017 Meeting

- Gleicher's Formula
- Health and Homeland Alert Network Data Sheet
- Massachusetts Virtual Epidemiologic Network Salmonellosis Case

Approved by the Special Commission on Local and Regional Public Health Data Subcommittee, January 3, 2018

**Structure Subcommittee
Meeting Agenda**

Tuesday December 12, 2017
12:30 p.m. -2:00 p.m.
Massachusetts Division of Fisheries and Wildlife
1 Rabbit Hill Road, Westborough, Massachusetts

12:30 p.m. Call to order

VOTE: Approve minutes of November 3, 2017 meeting

Update: the case for a higher standard for a minimum set of local public health services

Discuss cross-jurisdictional sharing in other states

Discuss strategic approach to cross-jurisdictional sharing in Massachusetts (i.e., roles of local boards of health) including consequences of making no changes in the current system

Next steps

2:00 p.m. Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Structure Subcommittee Meeting Minutes

December 12, 2017

Massachusetts Department of Fisheries and Wildlife

1 Rabbit Hill Rd., Westborough, Massachusetts

12:30 p.m. – 2:00 p.m.

Members present: Bernie Sullivan, Chair, Representative Hannah Kane, Kevin Mizikar, Terri Khoury, Lorraine O'Connor (for Jason Wentworth)

Members absent: Harold Cox, Charlie Kaniecki

MDPH Staff: Damon Chaplin

Non-members: None

Call to Order: The meeting was called to order at 12:45 p.m. A quorum was present.

VOTE: Representative Hannah Kane moved to accept the minutes of the November 3, 2017 meeting of the Structure Subcommittee. Kevin Mizikar seconded the motion. The motion passed unanimously by voice vote.

Key Issues and Topics Discussed

- **Local Public Health structures in other states.**

Members reviewed and discussed the following topics:

- Seven state profiles from the NACCHO 2013 National Profiles of Local Health Departments, including Connecticut, Texas, Colorado, New Jersey, Ohio, Washington, and Massachusetts.
- A focus on programs and services seems most relevant based on our need to identify service requirements for local boards of health.
- Programs and services, activities, and finance sections of the profiles provide an important insight into how other states support and prioritize local public health activities and services.
- Public health nurses are the experts in managing communicable disease and all local health departments would benefit from an improved coordinated effort with their public health nurse.
- There is a Robert Wood Johnson report identifying a staffing benchmark for local public health nurses of 1/5000 people.
 - Those ratios may be cost prohibitive for most health departments. We should begin looking at alternate ways of acquiring services through innovative approaches and interactions with community hospitals and health centers.
- Health insurers should have some “skin in the game” as well.
- What is the average per capita spending on public health in Massachusetts?
- The difference in wealth between municipalities is dramatic. Members were skeptical of a municipality’s willingness to spend additional funding on local public health when communities are faced with other competing priorities.

- **Making the case**

Member comments:

The American Health Rankings recently nominated Massachusetts as the Healthiest State in the country - what problem are we trying to solve?

- Although the America Health Rankings indicate Massachusetts as the healthiest state overall, we should be cautious of its general implications of state wide health equity and efficiencies. In addition to a lack of health equity, promotion and wellness, members provided key examples:
 - In some cases, individual rural communities with less than 50,000 people are paying more for public health services (per capita) than their larger counterparts with populations of 100,000 or more.
 - Members of the Central Massachusetts Public Health Alliance (Grafton, Holden, Leicester, Millbury, Shrewsbury, West Boylston, and Worcester) would not have been able to afford the expertise and services provided to them through their alliance with the City of Worcester and the Department of Health and Human Services had they not formed a public health alliance.
- The return on investment in public health is two-fold:
 - 1) Investments in public local health will produce a healthier, more vibrant work force
 - 2) a healthier more vibrant workforce produces a stronger local economy.

Members agreed with the rationale, but still had reservations about

- 1) The Commissions ability to get buy-in from municipal officials;
 - 2) A minimum set of standards
 - 3) The role of local boards of health throughout this process.
- The delivery mechanism of local public health services is less important to municipal leadership than the preservation of local board of health powers.
 - The Nashoba Associated Boards of Health (NABH) may be the best regional example of local public health control and service within the state.
 - Chairman Bernie Sullivan commented that he worked at NABH for 12 years and the city officials never felt like the Health Director (HD) was “theirs”.
 - However, communities with niche services like Title V regulations, beaches and wells may be very sensitive to conversations around limited access to public health officials and those particular services.

Closing remarks:

- Members came to a consensus that a comprehensive/cafeteria style model with a baseline set of minimum services were municipalities could also receive additional niche services (i.e. Title V inspection) if needed was probably a good starting point for local public health infrastructure design and planning based on the Foundational Public Health Services.
- Members asked for a deeper evaluation of public health districts which may support these findings (i.e. The Nashoba Association of Boards of Health, the Montachusett Public Health Network, the Central Massachusetts Regional Public Health Alliance, and the Franklin Regional Council of Governments)

Decisions Made

The subcommittee did not make any decisions at this meeting.

VOTE: Representative Hannah Kane moved to adjourn the meeting. Kevin Mizikar seconded the motion. The motion passed unanimously by voice vote.

The meeting adjourned 2:00 p.m.

Action Items/Next Steps

1. Evaluate Public Health Districts.
 - A. Nashoba Association of Boards of Health
 - B. Montachusett Public Health Network
 - C. Central Massachusetts Regional Public Health Alliance,
 - D. Franklin Regional Council of Governments
2. What is the average per capita spending on public health in Massachusetts
3. What problem are we trying to solve?
4. The Commissions ability to get buy-in from municipal officials
5. What are going the be the minimum set of standards going forward
6. How can municipal officials retain their local board of health powers during this transitions?

Documents and Exhibits Used During the December 12, 2017 Meeting

1. Structure Subcommittee November 3, 2017 meeting agenda
2. Structure Subcommittee November 3, 2017 meeting minutes
3. NACCHO State Profiles for OH, TX, CT, WA, CO, NJ and MA
4. CJS Spectrum
5. Massachusetts Public Health Districts and Shared Services
6. Final Governance Authority
7. Regional Governance Principles update
8. Regionalization-status-report 9-1-09

Approved by the Special Commission on Local and Regional Public Health Structure Subcommittee, March 9, 2018

**Joint Meeting of the
Standards and Data Subcommittees**

Meeting Agenda

January 3, 2018
10:00 a.m. to 11:30 a.m.

Worcester Senior Center
128 Providence Street, Worcester

1. Call to Order
2. Introductions
3. Review agenda
4. Standards Subcommittee VOTE: minutes of December 8, 2017 Standards Subcommittee meeting
5. Data Subcommittee VOTE: Minutes of December 11, 2017 Data Subcommittee meeting
6. Making the case for public health and local public health (review draft slide presentation by Laura Kittross)
7. Making the case for change in the Massachusetts local public health system
 - a. Discussion of capacity of local public health to meet statutory responsibilities
 - b. Discussion of capacity of local public health to meet national standards and other expectations of a 21st century local health department
8. Review next steps for Data and Standards Subcommittees in the context of the October 2017 revision to the Commission roadmap; coordinate presentation at January 12, 2018 meeting of the Commission
9. Next meetings of each subcommittee (or another joint meeting)
10. Adjourn

**Joint Meeting of the
Standards and Data Subcommittees**

Meeting Minutes

January 3, 2018

Members Present: Sharon Cameron (Standards), Justeen Hyde (Data-Co-Chair), Laura Kittross (Standards), Carmela Mancini (Data), David McCready (Data), Maria Pelletier (Data), Cheryl Sbarra (Standards – Chair; Data), Mark Smith (Data), Phoebe Walker (Data-Co-Chair; Standards), Steven Ward (Standards)

Member Absent: Terri Khoury (Standards)

Staff: Ron O'Connor, Erica Piedade and Shelly Yarnie

Non-member: None

The meeting was called to order by Phoebe Walker at 10:03 a.m. A quorum was present for each subcommittee. Phoebe Walker, Co-Chair of the Data Subcommittee and Cheryl Sbarra, Chair of the Standards Subcommittee, jointly facilitated the meeting.

It was agreed that Justeen Hyde could participate remotely in accordance with the vote of the Special Commission to allow remote participation, as needed.. Justeen Hyde joined the meeting at 10:15am.

Votes on Prior Meeting Minutes

STANDARDS SUBCOMMITTEE VOTE: Steve Ward moved to approve the minutes of the December 8, 2017 Standards Subcommittee meeting. Laura Kittross seconded the motion. The motion passed with one abstention (Phoebe Walker)

DATA SUBCOMMITTEE VOTE: David McCready moved to approve the minutes of the December 11, 2017 Data Subcommittee meeting. Carmela Mancini seconded the motion. The motion passed unanimously.

Focus and Goals of January 12, 2018 Special Commission Meeting

A recommendation was made to add the following items to the agenda: 1) January 12th Commission Meeting and 2) expected meeting outcomes. A review of the questions and concerns from the November 3rd Commission meeting would also be helpful for planning for the January 12th meeting.

The expected outcome for the meeting is that everyone leaves with the same understanding and clarity regarding the Commission's charge. Presentations will include an overview of the impact of public health (PH) on health, the role of Local Public Health (LPH), the rationale for national public health standards and how Massachusetts measures up to those standards, and a progress report by each subcommittee that includes accomplishments and next steps. This information should contribute to complete the case for addressing the existing system challenges through system change. The slide presentation on PH and LPH was developed to address the questions about the need for change raised at the November 3rd meeting. The presentation is not about solutions, but rather, underscoring the reason for the establishment of the Commission which was based on the understanding that there was and is a critical need for addressing the challenges of LPH.

It was mentioned that Massachusetts is ranked the healthiest state in the nation; Massachusetts also has the highest per capita health care spending. Addressing the current LPH system inefficiencies and disparities is

critical. It was recommended that the slides on the history of PH be condensed with an emphasis on a comparison between the leading causes of death in 1900 with leading causes of death in 2010. The skyrocketing costs of managing chronic diseases and not being prepared for the impact of climate change/weather disasters (increase of tick-borne diseases, flooding, and related increased responsibilities) be included. Responsibilities for BOH and staff increase over the years, yet resources and training opportunities do not keep up and in some cases decrease.

Members discussed whether to include the Robert Wood Johnson chart on “What is Health?” (<http://www.countyhealthrankings.org/what-is-health>). The chart shows that clinical care accounts for 20% in health outcomes versus physical environment, socio-economic factors and health behaviors. It was agreed not to include the chart but rather emphasize that if there were standards and LPH had the resources to meet the standards, this would impact health outcomes for all individuals which in turn would reduce long term health and social costs. The slide presentation on public health and local public health will address some of the “constructive skepticism” that arose at the last meeting. It was agreed that the presentation optimally should be about 20 minutes by using a shorter version of the full slide set but the full slide set (in color) would be sent to Commission members before the meeting. It was also agreed that this presentation should address the “skepticism” and, therefore, allocating 45 minutes, including time for answering questions, would be reasonable. The question of how to move forward if everyone was not on board was asked. The group agreed that consensus was desirable but not necessary, though it was important to address concerns such as questions regarding “cost-benefit” or presenting a business model. It was agreed that if anyone had figures on costs associated with making the case for change, they should send them to Laura Kittross who agreed to do the presentation.

The Data Subcommittee had a meeting with DPH on December 11th to discuss Massachusetts data that would support making the case. The meeting provided clarity on what data is available and what proxy measures could be used to link (signs/symptoms) the lack of a functioning LPH infrastructure with negative outcomes without calling out specific towns. Such measures could include: no food reports submitted, not active on MAVEN, or HHAN drills. The next step would be to continue compiling the data and then overlaying health indicators, such as, asthma, preventable conditions, hypertension, lead levels, vaccines provided (flu/preventable diseases), and others onto a Massachusetts map with the understanding that there may be confounding factors or that the outcome may not what is expected. School health data, MassCHIP, and Youth Risk Behavior Survey data might also be looked at. Who will do the analysis was a question yet to be answered. Looking at what other states collect from LPH for data as a possible model, i.e., Ohio requires submission of a set of data points (<http://www.odh.ohio.gov/localhealthdistricts/Futures/Quality%20Indicators.aspx>). The challenge is that the majority of LPH does not have the capacity currently to collect data or conduct surveillance. Without good data it is hard for LPH or the state to track, assess, respond to and plan to address health concerns and trends. It is also hard for the Data Subcommittee to make the case without good data. It was stated that the explanation actually makes a good case for why there needs to be change. By each Subcommittee presenting on 1) Subcommittee Charge, 2) Progress, 3) Preliminary Recommendations (if any), and 4) Next Steps along with the prior presentations, it is hoped that everyone would accept the argument for change. A template will be sent out to subcommittee chairs to prepare. Phoebe Walker mentioned the survey that was being created and Laura Kittross clarified that it focused on understanding the current workforce. The survey would help understand what the current workforce looks like and what would be necessary for instituting Commission standards. Questions other subcommittees may have could be included. Justeen Hyde asked to review the survey and provide feedback.

Review and Discussion of the Roadmap/Timeline

The discussion emphasized the critical need to include stakeholder input and allowing for enough time to integrate stakeholder input, draft recommendations and the report and then going back to stakeholders through public hearings before finalizing the report. The work of the subcommittees has been focusing on findings, i.e., gaps, what other states are doing, and previous work in Massachusetts. These areas address multiple requirements for the final report. The current roadmap does not allow for enough time to adequately engage the diverse stakeholders across the state. Everyone agreed that input and buy-in from stakeholders was critical. Having listening sessions in the spring and then hearings before finalizing the report would provide for that. The required contents for the final report were discussed and it was recommended that in the next 3 months there be a presentation on models for structure. Since in many states there were functional structures, it was easy to overlay a set of standards, which is not the case for Massachusetts and is why it is important the Commission agrees upon the standards. Sequentially, the Commission needs to agree upon standards so that the Structure, Workforce Credentials, and Finance Subcommittees can further their work in coming up with preliminary recommendations. Extending the Commission to December 2018 would allow for good stakeholder input, a comprehensive report that had buy-in, and drafting legislative language, if necessary. Proposing a revised roadmap and the organization of listening session in the spring to the Commission on January 12th was agreed upon. Ron O'Connor agreed to revise the roadmap according to the discussion, review it with the Commissioner, and bring the revised document to the Commission for review.

VOTE: Phoebe Walker moved to revise the roadmap/timeline and to allow DPH to revise it as needed. Steve Ward seconded the motion. The motion passed unanimously.

Next Meeting

It was agreed that there was no need for another Joint meeting of these two subcommittees. Cheryl Sbarra recommended that the Standards Subcommittee meet with the Structure Subcommittee and possibly the Finance Subcommittee. Cheryl Sbarra recommended that Marcia Testa present to the Finance Subcommittee.

Action Steps

- Laura Kittross will finalize the PH slide set (full and shortened version) and send it out for review.
- Ron O'Connor will include the slide set in color among the documents for the Commission meeting.
- Ron O'Connor will revise the roadmap, confer with the Commissioner and will bring it to the Commission.
- Ron O'Connor will send out the article on LPH and the need to focus on chronic diseases.
- The next meeting will be determined by each subcommittee.
- **VOTE:** Cheryl Sbarra moved to adjourn the meeting. Laura Kittross seconded the motion. The motion passed. The meeting adjourned at 11:58 a.m.

Documents and Exhibits Used During the January 3, 2017 Meeting

- The Case for Public Health Presentation
- Special Commission on Local and Regional Public Health Roadmap- October 2017
- Standards Subcommittee minutes of December 8, 2017
- Data Subcommittee minutes of December 11, 2017

Approved by the Data and Standards Subcommittees of the Special Commission on Local and Regional Public Health on April 6, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Agenda

Friday, January 12, 2018

1:00 p.m. to 3:30 p.m.

Massachusetts Division of Fisheries and Wildlife
1 Rabbit Hill Road, Westborough, Massachusetts

- 1:00 Call to Order
Welcome and Introductions
Review Agenda
- 1:05 **VOTE:** Minutes of November 3, 2017 meeting
VOTE: Additions/changes to subcommittee member assignments
- 1:10 **Presentation:** Case for Change in the Massachusetts Local Public Health System
- 1:50 **Presentation:** Commission Progress on Charge Stated in Legislation
- 2:40 **VOTE:** Commission “roadmap” – recommended revisions to Commission meeting plans including spring 2018 listening sessions
- 3:10 Review proposed February-July meeting dates
- 3:20 Plans for next meeting
- 3:30 Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Minutes

Date: Friday, January 12, 2018
Time: 1:00 p.m. to 3:00 p.m.
Location: Massachusetts Division of Fisheries and Wildlife
1 Rabbit Hill Road, Westborough, MA

Members Present: Commissioner Monica Bharel, Chair, Representative Hannah Kane, Sharon Cameron, Justeen Hyde, Laura Kittross, Terri Khoury, Eileen McAnney, David McCready, Kevin Mizikar, Maria Pelletier, Bernard Sullivan, Cheryl Sbarra, Mark Smith, Phoebe Walker, Steven Ward, Sam Wong

Members Absent: Senator Jason Lewis, Senator Richard Ross, Representative Steven Ultrino, Harold Cox, Charlie Kaniecki, Carmela Mancini, Lorraine O'Connor

Quorum: A quorum was present

DPH Staff: Damon Chaplin, Jessica Ferland, Ron O'Connor, Erica Piedade, Eileen Sullivan, Shelly Yarnie

Visitors: Eddy Atallah, Michael Coughlin, Ed Cosgrove, Hayley D'Auteuil, Liz, Doyle, Caroline Kinsella, Glenys Larosa, Melanie O'Malley

Call to Order: Ron O'Connor called the meeting to order at 1:15p.m.

Reminder: Visitors are welcome. However, the Commission cannot take comments or questions from visitors. If you have questions, please follow up with Ron after the meeting.

VOTE: Kevin Mizikar moved to approve the minutes of the two November 3rd, 2017 meeting. Carmela Mancini seconded the motion. The motion passed unanimously.

Commission members were asked if anyone wanted to change, add, or be removed from sub-committees.
Bernie Sullivan wishes to be removed from the Standards Subcommittee
Cheryl Sbarra will join the Finance Subcommittee in addition to other Subcommittee membership

VOTE: Sam Wong moved to approve these changes to the Subcommittee Roster
Phoebe Walker seconded the motion.
The motion passed unanimously.

Making the Case for Local Public Health presentation by Laura Kittross

Discussion

- The issues sound less related to resources and more related to scope of work.
- It seems like chronic health should move out of the Public Health scope.
- Comparison with tobacco control is so important. In the 1990's, DPH changed the social norm of tobacco. This "Social Norm" approach to moving the needle with public health issues on the local level addresses issues proactively instead of reactively.

- Weighing wellness vs. chronic disease is not an equal square.
- We need to find a way to spend more attention and time on prevention. It's a hard sell.
- This is the best time, based on current changes on the horizon.
- We want to get to a place where we've demonstrated that the way we work now (351 municipalities) is not the most effective and propose what we want it to look like and how to pay for it.
- Every year, new regulations come in that make it challenging. Healthcare should be playing a larger role in regard to funding.
- Most hospitals are non-profit based on Community Benefits. A role for DPH to have is to grow relationships with hospital community benefits to combine efforts, money, etc.
- Trainings through LPHI are really good and want that acknowledged
- Improvements should flag variability of services that are underway in some parts of Massachusetts vs. others, i.e. disparities across the state.
- The breadth of what gets done is amazing. There are pockets of places in Massachusetts where things go really well.
- It's hard for people in the medical field. What should be local vs. What falls on hospitals? This needs an invested LPH staff.
- It's a structural issue, there is no way LPH can successfully be doing all of this.
- It's an easier sell when there is a more tangible outcome.
- People need to understand why they are doing it and why it is needed.
- LPH doesn't always see the ROI.
- How do we get all the fish swimming in the same direction? Who is the connector?
- People recognize that there is too much waste in the healthcare system. Someone will always end up getting sick. Healthcare is more motivated to do this work than ever.

Subcommittee Updates

Data

- Looking at indicators on town outcomes, looking for correlations.
 - Look at areas where DPH could be looking at data but doesn't.
 - We have to look at the data available.
- In talking about challenges, is there a municipality that is doing very well that we can look at too? Look at what local municipalities are spending their money on.

Standards

- Looking at the charge law itself. The subcommittee is looking at the meat of that in real life.

Structure

- There is lot of data with all areas of sharing services that can be shared so as not to reinvent the wheel.
- Commission Members from health districts can share their experiences to add to the research related to structure.
- What are the politics around what we want to create? Leave open to a scale large enough for cities to connect within the constructs of the political dynamic
- Look at where efficiencies come from. Cost effectiveness, delivery efficiency should all be held to the same standard.
- There should be education about what Public Health means in Massachusetts.
- In Berkshire County, there are multiple towns with no public health budget at all. They did not know they were supposed to be doing any of this.

Workforce Credentials

- Looking at how would we mandate training and making sure that education expectations are reasonable.
 - Different credential requirements for individual municipalities vs. districts.

Review of Updated Roadmap – Cheryl Sbarra and Phoebe Walker

- Movement of the last two items from today's agenda to February meeting.
- Six listening sessions across the state, which DPH would organize.
 - Do we need a quorum for the listening sessions?
 - What do we hope to gain out of the listening sessions? It seems like a lot of time and resources to invest.

VOTE: David McCreedy moved to accept the roadmap with the change of moving the last two bullets of the January meeting to the February meeting.

Bernie Sullivan seconded the motion.

Steve Ward moved to adjourn the meeting. David McCreedy seconded the motion.

Meeting adjourned at 3:30 p.m.

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Documents and Exhibits Used During the January 12, 2018 Meeting

- Agenda for Special Commission on Local and Regional Public Health Meeting
- Draft minutes from the November 3, 2017 meeting for approval by Commission members
- Draft Revised Roadmap – January, 2018
- Compilation of Meeting Agendas and Minutes of the Commission and its Subcommittees

Slide Presentations at the Meeting

(Distributed to members in their packets at the meeting)

- *Public Health: History & Challenges*, Laura Kittross
- Special Commission on Local and Regional Public Health Subcommittee Progress Reports

Approved by the Special Commission on Local and Regional Public Health on February 16, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Agenda

Friday, February 16, 2018

1:00 p.m. to 3:30 p.m.

Massachusetts Division of Fisheries and Wildlife
1 Rabbit Hill Road, Westborough, Massachusetts

- 1:00 Call to Order
Welcome and Introductions
Review Agenda
- 1:05 **VOTE:** Minutes of January 16, 2018 meeting
VOTE: Additions or changes to subcommittee member assignments
- 1:15 Standards Subcommittee Report
Recommendation for Minimum Package of Local Public Health Services
VOTE: Foundational Public Health Services as the minimum set of services
- 2:15 Plans for Commission Status Report (Review draft staff proposal)
VOTE: Purpose, content, and timing of status report
- 2:45 Discuss Plans for Listening Sessions (Review draft staff proposal)
VOTE: Plan for listening sessions
- 3:15 Plans for next meeting – April 6, 2018
- 3:30 Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Minutes

Date: Friday, February 16, 2018

Time: 1:00 p.m. to 3:30 p.m.

Location: Massachusetts Division of Fisheries and Wildlife
1 Rabbit Hill Road, Westborough, MA

Present: Eileen Sullivan – Appointed Chair, Representative Hannah Kane, Terry Khoury, Eileen McAnneny, David McCready, Kevin Mizikar, Loraine O’Connor, Maria Pelletier, Bernard Sullivan, Cheryl Sbarra, Mark Smith, Phoebe Walker, Steven Ward, Sam Wong

Absent: Commissioner Monica Bharel, Senator Jason Lewis, Senator Richard Ross, Representative Steven Ultrino, Sharon Cameron, Harold Cox, Justeen Hyde, Charlie Kaniecki, Carmela Mancini

Quorum: A quorum was present

MDPH Staff: Michael Coughlin, Jessica Ferland, Ron O’Connor, Erica Piedade, Shelly Yarnie

Visitors: Eddy Atallah, Ed Cosgrove, Hayley D’Auteuil, Caroline Kinsella, David Naparstek, Melanie O’Malley

Call to Order: MDPH Chief Operating Officer, Eileen Sullivan noted that a quorum was present and called the meeting to order at 1:08 p.m.

VOTE: Eileen McAnneny moved to approve the minutes from the January 12, 2018 meeting.
Phoebe Walker seconded this motion. The motion passed unanimously.

Commission members were asked if anyone wanted to change, add, or be removed from sub-committees. No changes were requested.

Cheryl Sbarra presented the Standards Subcommittee Report recommending the Foundational Public Health Services Model.

Discussion

- What does Kansas’s model look like structurally?
 - Kansas uses a county model. However, counties are small so there do exist some multi-county districts.
- Does having the ability mean that LPH can perform the tasks or that they have access to those who can?
 - This is a vision of what LPH should deliver, what the system should look like, not necessarily each individual municipality.
 - Every resident should be able to receive the services, from whom the services are provided is the variant.
 - We need to have the conversation determining what the foundations are and how we get there.
 - The next piece is: What will Kansas look like after? They are ahead of us now, so they look different. It will be interesting to follow them to see where this road leads them.

- Central Massachusetts LPH is doing this successfully now. It would be great to have Karyn Clark come in to present on what they are doing successfully and how.
- It would also be helpful to have representatives from municipalities utilizing different models on a panel to discuss how this would affect them, i.e. small town, large city, district.

VOTE: Phoebe Walker moved to approve the Foundational Public Health Services Model as the standard to be used/ recommended in the final report.

David McCready seconded the motion. The motion was unanimously approved.

Ron O'Connor presented the plans for the Commission Status Report

Do we want preliminary recommendations included? A challenge of this is that listening session attendees may feel that we are farther along than we are and that decisions have been made.

- Attendees of the listening sessions need enough information to respond to. If it was just a report used as a check in, that's fine. But to get feedback, it needs more.

VOTE: Lorraine O'Connor moved to adopt the status report outline but not the timeline.

Laura Kittros seconded this motion. The motion was approved unanimously.

Representative Hannah Kane and Kevin Mizikar left at 2:30 p.m. A quorum of 13 members still existed at this time.

Discussion around planning for listening sessions:

- We want to make sure that stakeholders are in attendance to react to key questions, such as ANF, Medical Systems, and others to provide perspective. Also important is to structure the questions to get the information we need.
- The timeline is based on having it finished in December for presentation to the legislature.
- June is a challenging month for LPH to do anything else because it is such a busy time of year. Moving them back may make a difference in attendance.
- We need buy in from LPH so we need their input before they feel like decisions are already made.
- If we don't have preliminary recommendations for the listening sessions, is that a barrier? What we have decided today is not controversial, it's an easy yes. The how is the harder question.
- At the listening sessions, we should offer concepts, not proposals. We need to solicit feedback, not a vote. Think of town meetings – a proposal can cause the meeting to become overwhelmed with people in favor or opposed.
- Why are there 4 sessions instead of 5 or 6?

What do you want to see in the listening sessions?

- Input on whether the audience agrees with the Foundational Public Health Services and which components they feel are necessary.
- Input on the capacity of LPH.
- Make sure that Boards of Health and LPH buy in to what we recommend.
- Get feedback to make sure that we are on the right track.
- Put a time limit on how long people can speak.
- Availability for people to submit written comments in advance, during, and after the sessions.
- In announcing the sessions, provide background information.
- Think of open ended questions to ask.

- Set expectations clearly – what will and will not happen.
- Use questions that can engage different sectors, i.e. Community Benefits of hospitals, etc.
- 4 vs. 6 sessions – making sure the right areas are touched.

What do you want to avoid in the listening sessions?

- Going off topic
- Losing control
- Collecting specific data from groups that members represent

Action Items:

Update the meeting schedule to include a meeting in late May/ early June instead of June 22nd to prepare for the listening sessions.

April 6th meeting will be used for subcommittees to report back related to the status report as well as a planning meeting for the listening sessions.

VOTE: Sam Wong made a motion to adjourn the meeting at 3:10 p.m.

Terri Khoury seconded this motion. The motion was unanimously approved.

The meeting adjourned at 3:10 p.m.

Approved by the Special Commission on Local and Regional Public Health on April 6, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Agenda

February 27, 2018
10:00am to 11:30am

Worcester Senior Center
128 Providence St., Worcester

10:00 Call to Order

VOTE: Approve minutes of January 24, 2018 meeting

10:05 Update on the Municipal and Health District Surveys

10:15 Special Commission Draft Status Report

10:40 Listening Sessions

11:20 Next Steps

VOTE: On Action

11:30 Motion to Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Minutes

February 27, 2018

Worcester Senior Center

128 Providence St., Worcester

Members Present: Sharon Cameron, Charlie Kaniecki, Laura Kittross, Steven Ward

Member Absent: Maria Pelletier

Staff: Erica Piedade

Non-members: None

Call to Order: Laura Kittross, the Chair, noted that a quorum was present and called the meeting to order at 10:10 am.

Vote to Approving Minutes

Charlie Kaniecki moved to approve the minutes of the January 24, 2018 meeting. Sharon Cameron seconded the motion. The motion passed unanimously.

Local Public Health Workforce Survey

Laura Kittross provided an update on the surveys, municipal and health district. The surveys had been sent out by the Office of Local and Regional Health (OLRH) around February 14 and the Office of Preparedness and Emergency Management (OPEM) resent it the following week to ensure that all boards of health received it. Laura Kittross reported that about 200 surveys had already been returned, but she had not yet looked at them to see if they were all completed. Three health districts had submitted surveys. A reminder would be sent by the OLRH at the end of the week. After March 2, the due date, follow up telephone calls will be made to the towns and health districts that have not responded. A suggestion was made to send the surveys to the Mass. Environmental Health Association (MEHA) and the Mass. Health Officers Association (MHOA) and ask them for their support in getting the surveys back.

Status Report Recommendations

Laura Kittross suggested that the Subcommittee start the discussion by focusing on the staffing categories used in the survey and identify training and credentialing recommendations for each of the categories. The categories are:

1. Health Director, Assistant Deputy Health Director – management/administrative only focused responsibilities
2. Health Agent with inspectional and management/administrative responsibilities
3. Inspector, Sanitarian, Code Enforcer – inspectional responsibilities only

4. Public Health Nurse
5. Clerk, Administrative Assistant, Secretary

The following points were made in discussing the recommendations for the report:

- Distinctions between rural or small local boards of health (LBH) and urban or large boards of health were raised. Small LPHs often had staff that were required to have management and inspectional responsibilities.
- Questions about work experience and degrees at hire, ability to substitute work experience for a degree, a very limited workforce pool, especially in rural areas, and grandparenting were raised. It was agreed that a discussion on “grandparenting” would be scheduled for the next meeting.
- Consideration was given regarding the requirement of an educational degree versus trades training versus Certified Health Officer or Registered Sanitarian; it was agreed having a pathway to the profession was critical.
- Setting a bar by setting standards for services and for the workforce would impact the value of the workforce and that impact could also raise salaries or have more competitive salaries. If experience, education and credentials are required, people will invest in them if they believe there will be a return on their investment. Must focus on the local public health system of the future (Public Health 3.0).
- Agreed that the Subcommittee had a major opportunity that would not come again and should provide a workforce standard that brings the LPH workforce throughout the Commonwealth in line with national standards.

Draft Recommendations:

Health Director with management only responsibilities: Master’s degree in related field; Registered Sanitarian (RS)/Certified Health Officer(CHO) at hire; Foundations Course for Local Public Health Practice (“Foundations Course”; Local Public Health Institute) within a year.

Health Agent with inspectional and administrative responsibilities: RS eligible at hire and CHO within 3 years (CHO exam has been revised to eliminate redundancy with RS); Foundations Course. Any relevant certifications for actual inspections performed.

Inspector, Sanitarian, Code Enforcer: Registered Sanitarian “eligible” within 5 years, Foundations Course, and specific licenses as necessary for the community.

Public Health Nurse: BSN with Mass. registered nurse license; completion of MAVEN, ICS100/NIMS700 training and/or Foundations Course within the first year.

Clerk, Administrative Assistant, Secretary: Completion of the Foundations “Like” or “Light” Course (tweaked for clerical staff) to provide public health knowledge and understanding within a year; course needs to include the software and technology necessary for working with LPH; real life case scenarios need to be part of training.

- It was also suggested that an epidemiologist be included because collecting and analyzing real time data is so critical. It was agreed that the Subcommittee might suggest this as part of the final Subcommittee report.

- The importance of requiring the Foundations Course would be to ensure good understanding of public health and local public health in Massachusetts. The current Foundations class would need to be reviewed and possibly tweaked to meet these requirements.
- Will need to increase statewide capacity to support the recommended education, training and credentialing of the workforce: Foundations and Foundations “Like” Courses or post BA certificate program; ensuring access to professional training throughout the state, potentially need to engage community and four-year colleges in developing pathways. Example, Worcester Division of Public Health works with Clark University and Worcester State University to expand their workforce pipeline.
- There will be a time period for implementing the recommendations and that time period will develop the capacity to support the workforce standards along with considering grandparenting for existing staff. Also may want to consider a waiver process similar to the school nurses which requires a BSN and passing the RN exam. There is a waiver process that allows you to take the exam without a nursing degree if you demonstrate that you have met other criteria.
- Develop a system for monitoring that newly hired individuals meet the set workforce standards.
- Developing recommendations on staff/population ratios was suggested similar to the NACCHO Report: *Local Public Health Workforce Benchmarks*, May 2011. Some thought it was the responsibility of the Structure Subcommittee to look at ratios. The group was reminded that there was legislative language on local public health and ratios: *Chapter 4, Section 102B*. It was agreed that benchmarks/ratios would be reviewed at the next meeting agenda.

Action Steps

The Office of Local and Regional Health (OLRH) will send out a survey reminder by the end of the week. Laura Kittross will share with the ORLH staff a list of towns and districts that have completed the survey. OLRH staff will follow up with towns and districts. Charlie Kaniecki will share the legislative language on ratios.

Proposed Meeting Date

Monday, March 19, 2018: 9:30am at the Senior Center, Worcester

Vote to Adjourn

Steve Ward made a motion to adjourn the meeting. Charlie Kaniecki seconded the motion. The motion passed unanimously. The meeting was adjourned at 11:30 am.

Documents and Exhibits Used at the February 27, 2018 Meeting

1. February 27, 2018 Meeting Agenda
2. January 24, 2018 Meeting Minutes

3. Workforce Credentials Subcommittee Progress Report Slides, January 12, 2018
4. Connecticut Documents: *Fact Sheet on District Departments of Health in Connecticut (August 2016)*; *Consolidation of LHD and Districts: Public Health and Financial Benefits (November 2016)*; *Office of Legislative Research: Research Report on Connecticut's Local Health Departments (January 29, 2016)*; *State of Connecticut Local Health Departments and Districts Map (July 2016)*; *Commissioner's Proposed Regulatory Language*; *Literature Review*.
5. NACCHO Report: *Local Public Health Workforce Benchmarks*, May 2011
www.naccho.org/uploads/downloadable-resources/local-public-health-workforce-staffing-benchmarks.pdf

Approved by the Special Commission on Local and Regional Public Health Workforce Credentials Subcommittee, March 19, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Structure Subcommittee

Meeting Agenda

March 9, 2018 | 1:00-2:30 p.m.

Shrewsbury Town Hall, 100 Maple Street, Shrewsbury, Massachusetts

1. Call to Order
2. **VOTE:** Minutes of December 12, 2017 Structure Subcommittee meeting
3. Prepare draft subcommittee progress report for discussion at April 6, 2018 Special Commission meeting
4. Discuss implications of Foundational Public Health Services model for Massachusetts local public health structure
5. Next meeting
6. Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Structure Subcommittee Meeting Minutes

March 9, 2018

Shrewsbury Town Hall

100 Maple Avenue, Shrewsbury, Massachusetts

1:00 p.m. – 2:30 p.m.

Members present: Bernie Sullivan, Chair, Representative Hannah Kane, Kevin Mizikar, Terri Khoury, Lorraine O'Connor, Charlie Kaniecki
Members absent: Harold Cox
MDPH Staff: Shelly Yarnie, Michael Coughlin
Non-members: None

Call to Order: The meeting was called to order at 1:05 p.m. A quorum was present.

VOTE: Terri Khoury moved to accept the minutes of the December 12, 2017 meeting of the Structure Subcommittee. Kevin Mizikar seconded the motion. The motion passed unanimously by voice vote.

Key Issues and Topics Discussed

1) Staff Research Request

Chairperson Sullivan requested that staff or interns be assigned to produce a chart which identifies which state and/or local agencies are responsible for delivering each of the Foundational Public Health Services. As a model he pointed out a chart produced by the state of Kansas in their 2017 Report, "State by State Comparison of Foundational Public Health Services".

2) Review Draft subcommittee Progress Report for discussion at April 6, 2018 Special Commission meeting Members discussed the following Topics:

- District versus "Alliance" models: Several longstanding public health districts were formed in the early 20th century in accordance with Massachusetts General Law Chapter 111, Section 27. These districts, including Tri-Town and Nashoba, have the force of statute behind them and had the benefit at their outset of state funding (no longer provided). More recent cross jurisdictional local health alliances, including the five alliances created by the MDPH Public Health District Incentive Grant Program (2010-2015), are less formal arrangements established through interagency agreements. District models, due to their legal standing, create a more permanent structure where the district is its own legal entity with its own budget and hires its own staff. Alliance arrangements are considered easier to form and more flexible, while relying on one lead community to manage the budget and staff.
- Delivery of Foundational Services: Representative Kane commented that rather than focus on the ideal model the focus of the committee should be on ensuring all communities have access to foundational services. Further, the consensus of the committee is that no one model should be presented to Massachusetts communities as the only way to ensure delivery of foundational public

health services. An equitable holistic approach accounting for differences in population and financial resources across communities should be incorporated into the recommendations of the committee. Rep Kane commented further that the committee's task is to identify a number of ways to procure foundational public health services for all communities in Massachusetts.

- Potential guides for further review include NACCHO staffing models configured according to population base, and the process administered by the Commonwealth Veteran's Services office for the formation of regional Veteran's Services Collaborative Districts.
- Chairperson Sullivan pointed out that efforts could lead to legislation that includes both incentives and legal enforcement tools to move the state toward full provision of the foundational services.

3.) Implications of Foundational Public Health Services model for Massachusetts local public health structure

- Our job is to identify how to get MA to a FPHS model in an efficient, cost-effective manner. We need to show number of ways to meet baseline. There needs to be several models explored.
- A map of the Commonwealth showing who is in a District versus "Alliance" exists and will be important moving forward.
- We do not want to put barriers in joining District versus "Alliance". Some can cherry pick- instead of a one size fits all approach.
- Services should be a requirement- let municipalities decide how they assemble their package of offerings.
- Municipalities do not have to join an "Alliance"- they can create their own. We want to encourage formation of Districts and new ones and provide unique ways of getting there.

Next Steps

1. Review Nashoba Association of Boards of Health to determine services offered and data available.
2. Review Workforce Credential Subcommittee minutes because they have broken down the local public health personnel by titles.
3. Progress report must reflect today's meeting.
4. In reference to the draft progress report in "Next Steps" section: "Evaluate average per capita spending on public health in MA."
5. A question asked "Isn't the Finance Sub-Committee supposed to do this?", "We can take it out?" "Unsure how we get there"? We must inquire what the Finance Subcommittee is doing in this area.
6. We need the ability to say this is what we spend now, providing minimum services would look like.....are we saying here is an efficient/effective way of getting there?
7. We will change to reflect: "Evaluate average services provided in public health in MA"

Documents and Exhibits Used During the March 9, 2017 Meeting

1. Structure Subcommittee March 9, 2018 meeting agenda
2. Structure Subcommittee December 12, 2017 meeting minutes

3. NACCHO State Profiles for OH, TX, CT, WA, CO, NJ and MA
4. Center for Sharing PHS Spectrum of Cross-Jurisdictional Sharing Arrangements
5. Massachusetts Public Health Regionalization Status Report- 09.01.09

VOTE: Charlie Kaniecki moved to adjourn the meeting. Representative Hannah Kane seconded the motion. The motion passed unanimously by voice vote.

The meeting adjourned 2:44 p.m.

Approved by the Special Commission on Local and Regional Public Health Structure Subcommittee on June 22, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Agenda

March 19, 2018
9:30am to 11:00am

Worcester Senior Center
128 Providence St., Worcester

9:30 Call to Order

VOTE: Approve minutes of February 27, 2018 meeting

9:35 Update on the Municipal and Health District Surveys

9:50 Special Commission Draft Status Report

- Workforce Standards
- Grandparenting
- Ratios

10:50 Next Steps

VOTE: On Action

11:00 Motion to Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Minutes

March 19, 2018

Worcester Senior Center

128 Providence St., Worcester

Members Present: Sharon Cameron, Charlie Kaniecki, Laura Kittross, Maria Pelletier, Steven Ward
Member Absent: None
Staff: Erica Piedade
Non-members: Rae Dick

Call to Order: Laura Kittross, the Chair, noted that a quorum was present and called the meeting to order at 9:54am.

Vote to Approve the Minutes

A motion was made to approve the Minutes after a discussion to amend the draft minutes by adding “Bachelor’s degree” in the *Draft Recommendation* section for Health Agent. Sharon Cameron moved to approve the minutes of the February 27, 2018 meeting. Charlie Kaniecki seconded the motion. The motion passed unanimously.

Draft Recommendations

Laura Kittross shared the chart she created based on last meeting’s discussion on the draft recommendation for workforce standards. The chart for each core position describes proposed requirements at hire, proposed requirements after hire and other recommendations (attached). The core positions are: Management position - Health Director, Deputy Director, Commissioner; Management/Health Agent; Inspector/Sanitarian; Public Health Nurse; Clerical Staff; and Board of Health. The Subcommittee reviewed the chart and discussed additions or edits.

- For the *Management* position it was clarified that at hire the individual would be required to be a Registered Sanitarian (RS) and have a Master’s degree in a relevant field. The certified health officer (CHO) credential would be required within 3 years of being in the position. It was recommended, but not required, that individuals in this position have a membership in a state health association and should take the LPHI Management Course. Office of Consumer Affairs and Business Regulation, Division of Professional Licensure, oversees the credentialing of RS and CHO.
- The question came up if Health Directors should be certified by the state or if health departments should be certified by the state. In Connecticut, the Health Directors must be approved by the Connecticut Department of Public Health.

- The members discussed if those in the Management position should be allowed to acquire the CHO voluntarily versus being required to do so within 3 years of being in the position. The concern was that if left at voluntary, the state would be in the same place as today which is no standard and lots of inequity across the state.
- Providing oversight or enforcement regarding the recommended requirements was also discussed. It was agreed that the Subcommittee would have to explore the infrastructure to ensure that Commission-recommended workforce standards would be met, such as annual reporting on staffing or a state level of certification. For example, certification might be for 2 years and then there would be a renewal process which would include submitting a record of having acquired certain continuing education credits in relevant areas.
- For the Management/Agent position it was clarified that “RS eligible” meant exam not yet taken but would have to pass within 18 months of being in the position. A recommendation to have individuals in this position also belong to a state health association and to take the LPHI Management Course was added.
- Ensuring that the recommendations are aligned with the Foundational Public Health Services would also ensure that they are aligned with a municipality moving towards being accredited.
- With regard to the Inspector/Sanitarian it was clarified that if an individual was doing any type of inspection (housing, restaurants, septic, pools, lead, etc.) they should be required to have the specific certification for conducting such inspections. It was stated that it was common and critical for most towns to have their inspectional staff be trained to do many types of inspection due to limited staff and staff turnover.
- For the Public Health Nurse position it was also recommended that they belong to a state health association. If a Public Health Nurse was a Health Director, she/he would have to meet the requirements set forth for the Management position.
- For the Clerical position, the requirement that they be competent in Microsoft Office was added.
- Board of Health Members who conduct inspections would have to meet the requirements under the Inspector/Sanitarian position.
- It was agreed that all personnel should have completed at least ICS100/NIMS 700 and those in a leadership role should have completed ICS 200 and above all within a year of hire.
- The recommended standards were seen as a starting point for common workforce standards for communities across the state, but does not prevent communities in setting higher requirements.
- The following suggestions were made for the section of the Chart that listed the types of inspections: Lead Determinator should be under “required”; under Title 5, MAPHIT Waste Water should be included.

Local Public Health Workforce Survey

Laura Kittross provided an update on the submission of surveys and some quick observations. Two hundred municipalities submitted surveys with follow up continuing. Most of the responses came from mid-sized towns; about 94% issue their own permits and the most common range was 100-500. Professionals with RS and CHO

were higher than expected, but that may be related to who responded to date. She would send the preliminary findings to Subcommittee members.

Grandparenting Process: Addressing Professionals Who Have Been In the Field For an Extensive Amount of Years

The process for “grandparenting” to address individuals who have been in the field for a long time and for whom meeting these standards may not be feasible was discussed. This could be done through a waiver process that the municipality can apply for. It was agreed that if doing inspections, professional should have required training and should minimally have gone through the Foundations Course. Since time was running out, the discussion on grandparenting would continue at the next meeting, but some ideas suggested were the following:

- For Inspector position the individual should be in the position for at least 10 years full time prior to the implementation of the new standards before being considered for not having to meet the RS.
- The time period is for working in a state or local health department.
- Board of Health/community would have to sign off on the waiver request.
- The waiver request can be for the RS or the CHO requirements.
- Suggested, but not decided, that if in the position for 20 years (state or local public health department) individual should not have to meet the proposed requirements.

Progress Report

A two-page draft document that highlights the progress and the preliminary recommendations the Workforce Credentials Subcommittee has made was handed out. The draft progress report is for the Commission’s draft status report to be sent out to stakeholders before the Listening Sessions. All Subcommittees are drafting their sections to be reviewed and discussed at the April 6 Commission meeting. The document was quickly reviewed due to the expiration of meeting time and accepted since there were no major concerns raised. Laura Kittross will review the document, update it with regard to the recommendations made at the meeting should it be necessary, and send it out to the members for review. If a meeting prior to the Commission meeting was necessary she would contact members.

Action Steps

Laura Kittross will revise the chart of draft recommendations and Draft Progress Report based on the discussion. Sharon Cameron will review NACCHO’s benchmark document and FDA guidelines and identify relevant information for discussion at the next meeting and Rae Dick offered to assist her.

Laura Kittross, Erica Piedade, Sharon Cameron and Rae Dick offered to reach out to different parts of the state to follow up with towns that have not submitted surveys.

Next Meeting Date

If a meeting is necessary prior to the April 6 Special Commission Meeting, the Chair would call a meeting on that day for noon or 12:30pm. Otherwise the Chair will work with the OLRH staff to schedule the next meeting after April 6.

Vote to Adjourn

Maria Pelletier made a motion to adjourn the meeting. Sharon Cameron seconded the motion. The motion passed unanimously. The meeting was adjourned at 11:30 am.

Documents and Exhibits Used at the March 19, 2018 Meeting

6. March 18, 2018 Meeting Agenda
7. February 27, 2018 Draft Meeting Minutes
8. Chart on Draft Staffing Standards Recommendations
9. Workforce Credentials Subcommittee Notes for Draft Progress Report
10. Email regarding Chapter 41, Section 102B from Charlie Kaniecki

Approved by the Special Commission on Local and Regional Public Health Workforce Credentials Subcommittee on April 30, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Data Subcommittee

Meeting Agenda

March 23, 2018 | 3:00-4:30 p.m.

MDPH West Boylston Site, 180 Beaman St, West Boylston, Massachusetts

1. Call to Order
2. **VOTE:** Minutes of January 3, 2018 Joint Standards/Data Subcommittee meeting at April 6, 2018 Special Commission meeting
3. Prepare draft subcommittee progress report for discussion at April 6, 2018 Special Commission meeting
4. Review and discuss DPH data collected
5. Discuss Data reporting requirements for local public health in other states. What do other states require local public health to collect and report on? (M. Coughlin)
6. Explore LPH capacity survey
7. Next meeting
8. Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Agenda

Friday, April 6, 2018

1:00 p.m. to 3:30 p.m.

1:00 Call to Order
Welcome and Introductions
Review Agenda

1:05 **VOTE:** Minutes of February 16, 2018 meeting
VOTE: Additions or changes to subcommittee member assignments

1:10 Special Commission adjourns to convene a joint meeting of the Standards and Data subcommittees to approve minutes of January 3, 2018 joint meeting

Joint Data and Standards Subcommittee Agenda

- Call to Order
- **VOTE:** Minutes of January 3, 2018 joint meeting of the Standards and Data Subcommittees
- Adjourn Joint Subcommittee

1:15 Special Commission reconvenes

- Call to Order
- Plans for Listening Sessions (Review revised draft staff proposal)
VOTE: Plan for listening sessions

1:45 Commission Status Report/Progress Reports of Subcommittees

VOTE: Approval of Commission status report outline/timeline and progress reports of subcommittees

3:00 Suggestions for information to be gathered from Boston University student visit to Kansas

3:20 Plans for May 4th meeting

3:30 Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Minutes

Date: Friday, April 6, 2018

Time: 1:00 p.m. to 3:30 p.m.

Location: Massachusetts Technology Collaborative, 75 North St., Westborough

Note: The agenda for the April 6, 2018 Special Commission on Local and Regional Public Health meeting began with a brief breakout meeting of the Data and Standards subcommittees for the purpose of approval of the January 3, 2018 joint meeting of the subcommittees.

Joint Data and Standards Subcommittee Meeting

Present: Justeen Hyde (Data Subcommittee Co-Chair), Phoebe Walker (Data Subcommittee Co-Chair), Cheryl Sbarra (Standards Subcommittee Chair), Sharon Cameron, Laura Kittross, Terri Khoury, Carmela Mancini, David McCready, Maria Pelletier, Mark Smith, Steven Ward

MDPH Staff: Jessica Ferland, Ron O'Connor, Erica Piedade, Shelly Yarnie

Call to Order: Phoebe Walker called the joint meeting of the Data and Standards Subcommittees to order at 1:04 pm.

Quorum: A quorum was present for both Subcommittees

VOTE: Justeen Hyde moved to approve the minutes of the January 3, 2018 joint meeting of the Data and Standards subcommittees. Cheryl Sbarra seconded the motion. The motion passed unanimously.

Phoebe Walker moved to adjourn the meeting. Justeen Hyde seconded the motion. The motion was unanimously approved. The meeting adjourned at 1:06 p.m.

Special Commission on Local and Regional Public Health Meeting

Present: Commissioner Monica Bharel (Chair), Senator Jason Lewis, Representative Hannah Kane, Sharon Cameron, Harold Cox, Justeen Hyde, Charles Kaniecki, Terri Khoury, Laura Kittross, Carmela Mancini, David McCready, Kevin Mizikar, Lorraine O'Connor, Bernard Sullivan, Cheryl Sbarra, Mark Smith, Phoebe Walker, Steven Ward, Sam Wong

Absent: Senator Richard Ross, Representative Steven Ultrino, Eileen McAnneny, Maria Pelletier

Visitors: Eddy Atallah, Ed Cosgrove, Hayley D'Auteuil, Melanie O'Malley

MDPH Staff: Michael Coughlin, Jessica Ferland, Ron O'Connor, Erica Piedade, Eileen Sullivan, Shelly Yarnie

Quorum: A quorum was present.

Commissioner Monica Bharel, Commission Chair, noted that a quorum was present and called the meeting to order at 1:15p.m.

VOTE: Charles Kaniecki moved to approve the minutes from the February 16, 2018 meeting. Carmela Mancini seconded the motion. Sharon Cameron abstained from voting. The minutes were approved by affirmative vote by all other members present.

Commission members were asked if anyone wanted to change, be added to, or be removed from subcommittees. No changes were requested.

Stakeholder Listening Sessions

Ron O'Connor reviewed the proposed plan for the stakeholder listening sessions:

- The Commission recommended five regional sessions in five different locations (two in western Massachusetts)
- Locations were discussed including two recommended locations for western Massachusetts – Greenfield and Westfield.
- Commission members will be able to sign up for sessions that they can attend; dates will be confirmed based on Commission member availability.

Discussion of the proposed listening sessions included

- The need to be clear about expectations for comments from participants at the listening sessions.
- Comments are requested on the status report that will be posted in advance.
- Comments may be submitted in writing in addition to oral comments at listening sessions
- The introduction at the listening sessions should provide clear direction to attendees that plan to comment. Although Commission members plan to provide the welcome and introduction to the listening sessions, remarks need to be scripted to ensure consistency across locations.
- Introduction should highlight progress to date with an invitation for feedback. Since adoption of Foundational Public Health Services (FPHS) as the minimum package of public health services is the primary recommendation of the Commission, it will be important to have feedback on FPHS.
- Create a one-page fact sheet as a supplement to the status report.
- A document including “Key Questions and Findings” for explanation would help.
- Concerns about presenting preliminary recommendations in a way that ensures that stakeholders understand that the Commission welcomes feedback.

Action items:

- Consider using Cheryl Sbarra’s presentation that she has developed about the Commission for Boards of Health orientation as a baseline for developing an educational component
- DPH staff will develop a script which will include informing the participants of the guidelines for the listening session (i.e., the Commissioners and staff will listen and not engage in a discussion).
- Consider the option of recording an introduction/summary of Commission charge to show at all sessions for consistency.

Further discussion of stakeholder listening sessions was tabled until after subcommittee progress reports.

Subcommittee Progress Reports

The meeting packet included written subcommittee progress reports on which Commission members provided comments and questions.

Workforce Credentials Subcommittee

The Workforce Credentials Subcommittee provided an overview of draft recommendations for the local public health workforce credentials.

Questions and Responses

Has the subcommittee discussed the availability of a waiver of the recommended requirements for a new hire?

- Further discussion needs to take place. The recommendation of the subcommittee includes a period after hire for new hires to meet the standard.
- Given small town challenges in meeting any credentials requirements, the subcommittee has been guided by the importance of reasonable standards.

How do the subcommittee recommendations differ from the current state of workforce credentials?

- The gap is not as large as one would think. Even though it is preliminary, the workforce survey conducted by the subcommittee shows that there are many credentialed local public health staff.
- In larger communities, having a credential is not the issue. There is a concern about adequate numbers of staff to meet the need for services. The National Association of County and City Health Officials (NACCHO) offers guidance/benchmarks regarding staff to population ratios. The subcommittee is exploring that guidance.
- Looking at the population size is not enough to determine staffing, for example, some communities have a large tourist influx so seasonal demands for inspections increases during that time period and can stress the existing staff.

What is meant by the term “core local public health staff”? Are these positions considered a priority? What about national standards?

- Core public health staff represent the range (and the most common) of local public health staff necessary to provide essential public health services. Education or training requirements do not currently exist for these positions.
- The focus is to ensure that the workforce is prepared for the future landscape of public health which would also ensure that they are capable of providing the currently mandated services.
- National standards do not exist for each position. Some states have standards for some of the positions (mostly health director).

Why was Certified Health Officer (CHO) chosen as a recommended credential given that it is a Massachusetts credential rather than a national one?

- The CHO regulations and exam have been reviewed and areas of redundancy/ questions with the Registered Sanitarian requirements have been removed. Additional management and community/population health knowledge and expertise are now included.
- The revision would utilize the existing infrastructure for certifying health officers in Massachusetts and would ensure that those in management positions have the administrative management and comprehensive public health competencies necessary to ensure the provision of Foundational Public Health Services.

Recommendations from Commission members

- Explore offering a waiver for a specific period with an end date. Allow the waiver to follow the individual versus providing it to the municipality.
- Develop a pathway for local public health professionals and identify incentives for supporting such a pathway.
- Assess the credentialing requirements from a health equity perspective. Credentials may have a built-in bias towards individuals with resources to allow them to advance to health director positions (i.e., white professionals) which could possibly create a barrier for the advancement of professionals of color. Subcommittee should explore a combination of experience and education.
- Attention needs to be paid to the use of a waiver of requirements. If a waiver is given to a municipality it could keep an individual from moving to another municipality.
- Ensure that an infrastructure is in place to support the recommended requirements. Trainings are not always held in all parts of the state, sometimes are only provided annually, and have limited enrollment, (e.g., Massachusetts Public Health Inspector Training (MAPHIT) Housing, MAPHIT Food.

Comments from Commission members

- The desire for waivers makes sense. However, there is a concern about a system with discretionary decision-making. Also, people could “job hop” every 5 years to avoid the credentialing requirements.
- The existing system is completely inefficient. The core issue that the Commission needs to raise is inefficiency of the system and how the recommendations will make it more efficient.
- The Commission charge does not state that “money will be asked for” and, therefore, it should not be stated in the status report or at stakeholder listening sessions.
- Framing the draft recommendations for the listening sessions will be very important. There needs to be education about workforce credentialing issues.
- The subcommittee recommendation for requirements for hire for the inspector/sanitarian position needs more information. It should include high school diploma as a minimum educational requirement.
- If we are using the FPHS to define the minimum package of public health services, we should include other public health professionals, such as epidemiologists.
- The de Beaumont Foundation has done a lot of research on the public health workforce and is a good resource for the subcommittee. The Connecticut Department of Public Health may be a good resource as well.

Data Subcommittee

Comments

- The use of real life examples as stories to highlight the impact of not having consistent data, especially data that is required, is important.
- It was emphasized that even though there may be a system for collecting data, there is limited staff capacity at the local level for reporting the data.
- Data collection expectation and requirements should focus and make transparent the need for data and the consequences for not having data.
- The subcommittee analysis finds that data collection is more robust when federal or state resources support the program in question.
- Learning from Health Districts that have a high level of compliance will be important.
- If local public health structure changes, data collection systems will need to change with it.
- Next steps include further analysis of other state data collection systems.

Structure Subcommittee

Comments

- Models recommended by the Commission that will ensure consistent delivery of foundational public health services must rely on both incentives and new mandates.
- A suggestion was made that a Data Subcommittee meeting in western Massachusetts will give the subcommittee access to many health districts to learn from their successes (Berkshire Public Health Alliance, Tri-Town Health Department, Franklin Regional Council of Governments, Foothills Health District, and Quabbin Health District).
- There are statutory reporting requirements but there are no penalties for not complying with these requirements.
- May need to create incentives for reporting.

Standards Subcommittee

There were no questions or comments on the Standards Subcommittee progress report.

Research on Kansas Local Public Health System Improvements

Eddy Atallah, Boston University School of Public Health Activist Fellow, will travel to Kansas in the spring to learn about their work with Foundational Public Health Services and cross-jurisdictional sharing as part of his fellowship. Commission members were asked to provide questions that will inform the work of the Commission.

- How have they been able to organize themselves regionally to be efficient with resources and time?
- Focus on questions the subcommittees have – what is the structure, standards for services and for the workforce, what are data requirements, how have they supported the process and the changes?
- How did they manage and fund key informant interviews?
- How were services rolled out?
- Understand where they were when they started compared to where they are now.
- How did they handle the perceived and real impact of loss of control/ power that may come with cross-jurisdictional sharing?

Stakeholder Listening Sessions

The Commission briefly returned to the Stakeholder Listening Sessions agenda item that was tabled until the subcommittee progress reports were discussed. The Commission will review the timing of the listening sessions at the May 4th meeting.

Next Steps

- DPH staff will incorporate information and insights from this meeting into the draft status report.
- The status report will be reviewed internally before being shared with Commission members prior to the May 4th meeting.
- A vote on the status report will be postponed until the May 4th meeting.
- The Commission will consider at the May 4 if it is ready for listening sessions to be held in May/June.
- The Commission timeline will be reviewed pending a decision on the timing of listening sessions.
- Subcommittee chairs will submit to DPH desired outcomes from the listening sessions for each subcommittee.
- Cheryl Sbarra will forward her presentation to DPH staff.
- Eddy Atallah will plan to report on the trip to Kansas at the June Commission meeting.
- Subcommittee chairs will provide additional questions to DPH staff to guide Eddy Atallah's visit to Kansas.

Senator Lewis moved to adjourn the meeting. Phoebe Walker seconded the motion. Motion approved unanimously.

Meeting adjourned at 3:15pm

Approved by the Special Commission on Local and Regional Public Health on May 4, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Agenda

April 30, 2018
9:30am to 11:00am

Worcester Senior Center, 1st Floor
128 Providence St., Worcester

9:30 Call to Order

VOTE: Approve minutes of March 19, 2018 meeting

9:35 Certified Health Officers (CHO) Credential

- Revised regulations and exam
- The significance of the CHO credential to LPH of the future

9:55 Preliminary Findings from the Municipal and Health District Surveys

10:25 Listening Session

- Questions the Subcommittee wants answered?
- Specific areas the Subcommittee wants feedback on

10:35 Draft Standards

- Ratios
- Grandparenting

10:50 Next Steps

VOTE: On Action

11:00 Motion to Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Minutes

April 30, 2018

Worcester Senior Center
128 Providence St., Worcester

Members Present: Sharon Cameron, Charlie Kaniecki, Laura Kittross, Maria Pelletier, Steven Ward
Member Absent: None
Staff: Erica Piedade
Non-members: Rae Dick

Call to Order: Laura Kittross, the Chair, noted that a quorum was present and called the meeting to order at 9:36 am.

Vote to Approve the Minutes

Charlie Kaniecki made a motion to approve the minutes of the March 19, 2018 meeting. Steve Ward seconded the motion. The motion passed unanimously.

Certified Health Officer Credentials

Steve Ward provided an overview of the proposed changes to the Certified Health Officer (CHO) regulations and exam. The purpose of the changes was to 1) make the CHO credential relevant to the field by creating a professional pathway for local public health professionals seeking management positions (from Registered Sanitarian/Registered Environmental Health Specialist to CHO); 2) assess areas and questions that maybe redundant with the Registered Sanitarian exam and credential; and 3) ensuring it is in sync with the Public Health Accreditation Board (PHAB). The Division of Professional Licensure has oversight of the certification process and the working group has been meeting with them to institute the changes. The CHO incorporates the 10 Essential Services and 3 core functions as well as addresses administration, management and leadership competencies. The CHO is a credential with an infrastructure that already exists in Mass. (exam offered 3 times a year/self-study guide) and is an opportunity to ensure management level public health professionals have the competencies necessary to manage and lead, especially if the Foundational Public Health Services (FPHS) will be the standard that will be expected across health departments.

Preliminary Findings from the Municipal and Health Surveys

The Members reviewed the handouts on the preliminary findings from the workforce survey. There were 299 cities and towns that submitted a survey with 252 surveys deemed as complete. Highlights were discussed: the majority of submissions came from towns less than 25,000 residents which represents the majority of cities and towns in Massachusetts; most of the respondents stated that they issued 100-500 permits annually; Title 5 inspections were generally less numerous as the towns became larger which was not surprising; about half of the respondents conducted less than 25 housing inspections but that may be a reflection of the split between the health department and inspectional services department. Separating housing inspections from the health

departments raises concern regarding missed opportunities to address public health issues (air quality and childhood asthma, hoarding and mental health, exposure to contaminants, etc.). The data on staffing and credentials did not show a trend of larger cities or towns necessarily having more credentialed staff. What the data did show is the results of a lack of standards. Another significant observation was that the extremely high number of respondents reporting the retirement of a very large portion of their staff within 5-10 years, which is consistent with national studies on the local public health workforce. The aging out of an experienced public health workforce with a limited pipeline and hiring pool will have significant results on Boards of Health being able to meet the public health needs of their communities. With regard to staff training, about half of the respondents reported they had a training budget of about \$1,000. The Members agreed that it would be useful for the Data Subcommittee to further analyze the survey data which they have agreed to do.

Workforce Standards for Education, Training and Credentialing Chart: Draft Recommendations

The Subcommittee discussed the feedback provided by the Commission members at the April 6 meeting. The following revisions were agreed upon:

- For the *Management* position: define management position as someone who does not conduct inspections but supervises the inspectors/sanitarians; under “Required” add *Master’s in relevant field or BA with 5 years of experience and 16 graduate credit in relevant field*; under “Required after hire” add *complete Master’s within 2 years*; under “Recommended” add *3 years of experience in local or state public health and MAVEN training within a year*.
- Under *Management/Agent* and “Required at hire” change to *Foundations Class w/in 18 months* and for the certifications add *within a year*; under “Recommended” add *CHO w/in 3 years of hire*.
- Under *Inspector/Sanitarian*: add *high school degree* under “Required at hire”; under “Required after hire” add *Foundations Class w/in 18 months* and certifications *w/in a year*; under “Recommended” add *associates degree*.
- Under *Inspection Type* add *Tanning/Body Art* and for that require MA PHIT which will need to be developed; for Housing Inspections require *housing court training* which would need to be developed; in the column “Recommended” include *relevant LPHI modules* for each inspectional type.

The chart will be revised and will be shared with the Commission members at the May 4 meeting in preparation for the Status Report.

Ratios/Benchmarks

In researching national trends for local public health staffing ratios, only the NACCHO document on benchmarks was found which was discussed at the last meeting. The document is out of date but provides some insights into how the Subcommittee might think what is the optimal number for an adequate local public health staff. There seems to be a lack of national consensus on the taxonomy of public health positions. Instead of fixed ratios (position: population size), the idea of ranges was discussed as a more feasible alternative. The Subcommittee agreed to continue discussing this topic at the next meeting.

Listening Sessions

The Subcommittee is eager to receive feedback from stakeholders on the draft workforce standards chart. Along with comments on the educational, training and credentials included in the chart, comments on what infrastructure would be necessary to get their staff to that level would also be useful.

Action Steps

Everyone will review the draft Status Report for the Listening Sessions to ensure the Subcommittee's work is reflected accurately.

Next Meeting Date

Monday, May 21, 2018 from 9:30-11:30am at the Worcester Senior Center (Classroom A), 128 Providence St., Worcester.

Vote to Adjourn

Maria Pelletier made a motion to adjourn the meeting. Steve Ward seconded the motion.

The motion passed unanimously.

The meeting was adjourned at 11:30 am.

Documents and Exhibits Used at the April 30, 2018 Meeting

11. April 30, 2018 Meeting Agenda
12. March 19, 2018 Draft Meeting Minutes
13. Workforce Survey Preliminary Results
14. Revised Chart on Draft Staffing Standards Recommendations
15. Draft Chart on Ratios/Benchmarks
16. Certified Health Officer (CHO) handouts on proposed exam (April 2016 – Matrix), slides of proposed changes, and regulations
17. *Building Skills for a More Strategic Public Health Workforce: A Call to Action*, de Beaumont Foundation (2105), <http://www.debeaumont.org/consortiumreport/>
18. H.R.1909 Environmental Health Workforce Act of 2017, www.congress.gov/bill/115th-congress/house-bill/1909/
19. *Public Health Workforce Taxonomy Guidelines for Use, August 2016*, Center of Excellence in Public Health Workforce Studies, University of Michigan School of Public Health, file:///C:/Users/empiedade/Downloads/Taxonomy_User_Manual.pdf

Approved by the Workforce Credentials subcommittee of the Special Commission on Local and Regional Public Health on May 21, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Agenda

Friday, May 4, 2018
1:00 p.m. to 3:30 p.m.

Massachusetts Emergency Management Agency
400 Worcester Road, Framingham

- 1:00 Call to Order
Welcome and Introductions
Review Agenda
- 1:05 **VOTE:** Minutes of April 6, 2018 meeting
VOTE: Additions or changes to subcommittee member assignments
- 1:10 Commission Status Report
VOTE: Approval of Commission status report
- 2:00 Discussion of stakeholder listening sessions/scripted presentation
- 2:45 Proposed plan for local public health capacity survey
- 3:15 Plans for June 22nd meeting
- 3:30 Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Minutes

Date: Friday, May 4, 2018

Time: 1:00 p.m. to 3:30 p.m.

Location: Massachusetts Emergency Management Agency, 400 Worcester Rd., Framingham

Present: Eileen Sullivan (Chair), Representative Hannah Kane, Harold Cox, Terri Khoury, Laura Kittross, Carmela Mancini, Eileen McAnneny, David McCready, Kevin Mizikar, Lorraine O'Connor, Maria Pelletier, Cheryl Sbarra, Steven Ward, Sam Wong

Absent: Senator Jason Lewis, Senator Richard Ross, Representative Steven Ultrino, Sharon Cameron, Justeen Hyde, Charles Kaniecki, Mark Smith, Bernard Sullivan, Phoebe Walker

Visitors: Melanie O'Malley, Maddie Ribble, Kim Waller

MDPH Staff: Michael Coughlin, Jessica Ferland, Ron O'Connor, Erica Piedade, Shelly Yarnie

Quorum: A quorum was present.

Eileen Sullivan indicated that Commissioner Bharel was unavailable to chair the meeting. She designated her as chair for this meeting.

Eileen Sullivan noted that a quorum was present and called the meeting to order at 1:20 p.m.

MOTION: Maria Pelletier moved to approve the minutes of the April 6, 2018 meeting. Cheryl Sbarra seconded the motion.

DISCUSSION: Steve Ward requested that the first bullet on page 4 of the draft minutes be re-written with the following "... areas of redundancy and questions with the Registered Sanitarian exam may be removed...".

VOTE: Eileen McAnneny abstained from voting. The motion was approved with the proposed change by affirmative vote by all other members present.

Eileen Sullivan announced that Sean Cronin has been assigned as the designee of the Secretary of the Executive Office of Administration and Finance. He will join the Commission at the next meeting.

Commission members were asked if anyone wanted to change, be added to, or be removed from subcommittees. No changes were requested.

VOTE: Sam Wong moved to add Sean Cronin to the Finance Subcommittee. Eileen McAnneny seconded the motion. The motion was unanimously approved by voice vote.

Status Report

MOTION: David McCready moved to approve the status report. Carmela Mancini seconded the motion.

DISCUSSION:

Each section of the report was reviewed. The majority of the discussion focused on the Workforce Credentials Subcommittee's preliminary recommendations.

- An update on the status of the appointment to the Commission of a representative of municipalities with a population of 5,000-50,000 was requested. The appointment is still pending.
- It was recommended that, in the "Capacity" section (page 3), a statement be added that preliminary recommendations on the workforce will follow later in the report.
- The Workforce Credentials Subcommittee requested that the chart of recommendations be included in the report for eliciting feedback from stakeholders.
- Language on page 17 regarding the municipal funding needs to be corrected. The fact that the majority of funding is from local tax revenue rather than state local aid is one of the main reasons there is such variation in types of health departments and services provided. It was further recommended that 1) information about MDPH funding and support from different bureaus or programs be made clear and 2) language regarding "more funding is not the solution" be changed to "more funding is not the sole solution".
- In reviewing the section on Workforce Credentials, caution was raised regarding overly defining positions and requirements since there are already challenges with the workforce pool. In response to the question if the Workforce Credentials Subcommittee compared the recommendations in the chart with what currently exists, it was stated that the workforce survey (299 responses) from municipalities has provided that information. In response to the comment regarding understanding the possible financial costs to a municipality in having to hire individuals with recommended experience, training, and credentials, it was stated that the survey is showing that many municipalities already have individuals with credentials and pooling municipal resources might be a feasible option to ensure well-trained staff. The Subcommittee had also discussed the pool and academic pipeline and plan to discuss recommendations for ensuring an infrastructure that can support the training and credentialing recommendations. There is also a financial implication to municipalities because they will likely have to pay more to candidates who meet these criteria.
- For the position of Management (someone who does not do inspections but supervises those who do), a recommendation was made to eliminate the requirement of 16 graduate credits as part of the requirement of having a Bachelor's Degree + 5 years of experience. There was agreement to include Registered Environmental Health Specialist (REHS) in addition to Registered Sanitarian (RS). There was much discussion regarding the skills, experience, and competencies necessary for the Management position which would include director or commissioner of a department of health. The feedback will be reviewed by the Subcommittee.
- For the Public Health Nurses position, it was recommended that a Bachelor's of Science in Nursing (BSN) be removed as a requirement. This change was not supported by the majority of Commission members. This position often is required to work independently and the National American Nursing Association has set a BSN as a standard.
- It was agreed that the waiver process would include all positions but would not include the certifications or training required for those providing the different types of inspections.

- Additional language was recommended to indicate that the Commission agreed that there is a need for workforce standards but the Commission was still exploring the level of specificity that might be informed by feedback at the listening sessions.
- For recommendations regarding structure, the term “comprehensive/cafeteria style model” could create more complexity. Berkshire Health Alliance’s experience was that towns which had a cafeteria model asked for more comprehensive services over time. It was accepted that the cafeteria-style cross-jurisdictional model might be a good starting point for municipalities considering and ambivalent about shared services. The Structure Subcommittee is still exploring what the models entail, which ones might be considered the most effective.
- The status report should include MDPH’s capacity to support local public health, especially the use of categorical funding, in light of the Commission’s recommendations. In the past, DPH had regional staff (public health nurse, epidemiologist, health officer) that provided training and technical assistance to local public health. Those resources have been either eliminated or centralized. The status report should also mention that municipalities receive state and federal funding, including federal funding through DPH.

VOTE: The motion was unanimously approved by voice vote with the following changes to the status report:

- Add a statement in the “Capacity” section (page 3) that preliminary recommendations on the workforce will follow later in the report.
- Include the Workforce Credentials Subcommittee chart of recommendations in the report.
- Modify language on page 17 regarding the municipal funding as noted above.
- Eliminate the requirement of 16 graduate credits as a requirement for the Management position.
- Include reference to Registered Environmental Health Specialist (REHS) in addition to Registered Sanitarian (RS).
- Include a statement that the Commission agrees that there is a need for workforce standards but the Commission was still exploring the level of specificity that might be informed by feedback at the listening sessions.
- Include reference to DPH support for local public health through categorical funding.
- Add that municipalities receive state and federal funding, including federal funding through DPH.

Listening Sessions

Discussion:

- Members reviewed a list of guiding questions provided by Commission members and staff.
- The following questions will frame feedback from stakeholders at the listening sessions: 1) Are you in philosophical agreement with the recommendations of the Commission (is the Commission headed in the right direction?) and 2) are there any implementation issues?
- These questions can be sent out with the report so stakeholders can consider them in their review of the status report.
- The information about the listening sessions needs to be very clear about the kind of feedback that the Commission expects including time limit for speaking (3 minutes each) so that people can prioritize their comments. The listening sessions will be scheduled for two hours.
- The introductory slide presentation should provide a brief overview of the report and guidelines for the listening sessions. The overview should be an executive summary of the status report. The assumption is that people will have read the report and will have prepared their responses in advance.
- Copies of the report will be available at each listening session.
- Commission members agreed that staff should present introductory slides from a script to ensure consistency.

- Commission members signed up to represent the Commission for the six listening sessions dates. The schedule would be sent out to the Commission members so they could save the dates.

Additional Discussion:

- A recommendation was made to ask for an extension to the deadline for the Special Commission to complete its work.
- After the listening sessions, the Commission will review and incorporate the feedback. There will be a final report and public hearings before it is submitted as required by legislation that established the Commission.
- A capacity survey similar to the Kansas Health Institute survey that assessed resource gaps for implementation of the Foundational Public Health Services in Kansas was discussed. NACCHO does a survey (National Profile of Local Health Departments) but Massachusetts has had a very low response from municipalities.
- The Boston University School of Public Health Activist Fellow (Eddy Atallah) is going to Kansas with support from BUSPH Activist Lab for fact-finding. He will ask questions that each subcommittee has been exploring with regard to Kansas' experience in implementing the Foundational Public Health Services. A report of his findings will be shared with Commission members.

Next Steps

- The status report will be updated per discussion at the meeting and then sent to Commission members for review to ensure that requested changes were made.
- The revised, approved status report will be posted on the Special Commission page of the Office of Local and Regional Health webpage. It will be sent with a listening sessions schedule flyer to local public health authorities and other stakeholders.
- DPH staff will plan to present the status report overview slides at each listening session.
- The listening sessions flyer will include a deadline and email address for written feedback or comments.
- DPH staff will reach out to members absent from this meeting to request availability for listening sessions.
- The next Commission meeting is scheduled for July 27th in the morning. Since the Commission will not meet as planned on June 22nd, subcommittees were encouraged to meet on that date.

Sam Wong moved to adjourn the meeting. Eileen McAnneny seconded the motion. The motion was approved unanimously by voice vote.

The meeting adjourned at 3:00 p.m.

Documents and Exhibits Used During the May 4, 2018 Meeting

- Agenda for Special Commission on Local and Regional Public Health May 4, 2018 Meeting
- Draft minutes of the April 6, 2018 meeting for approval by Commission members
- Draft Commission Status Report
- Draft Listening Session PowerPoint presentation
- Draft Listening Session script

Approved by the Special Commission on Local and Regional Public Health on September 20, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Agenda

May 21, 2018
9:30am to 11:30am

Worcester Senior Center, Classroom A
128 Providence St., Worcester

9:30 Call to Order

VOTE: Approve minutes of April 30, 2018 meeting

9:35 Preliminary Recommendations

- Commission Member Comments from May 4 Meeting
- Waiver Process
- Benchmarks/Ratios

10:35 Municipal and Health District Surveys

- Data Subcommittee Review
- Presentation July 27

11:05 Listening Session

11:20 Next Steps

VOTE: On Action

Next Meeting Date: June 22, 2018 Westborough

11:30 Motion to Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Minutes

May 21, 2018

Worcester Senior Center

128 Providence St., Worcester

Members Present: Sharon Cameron, Charlie Kaniecki, Laura Kittross (Chair), Maria Pelletier, Steven Ward

Member Absent: None

Staff: Erica Piedade

Non-members: None

Call to Order: Laura Kittross, the Chair, noted that a quorum was present and called the meeting to order at 9:51 am.

Vote to Approve the Minutes

Sharon Cameron made a motion to approve the minutes of the April 30, 2018 meeting. Charlie Kaniecki seconded the motion. Steve Ward asked that there be a correction made to the minutes regarding the CHO exam. The correction was accepted and amended minutes will be sent out. The motion to approve the minutes with the correction was unanimously passed.

Review of Commission Member Feedback and Recommendations for Workforce Standards

Laura Kittross strongly recommended to the Commission members that the grid of recommendations for workforce standards be included in the Status Report in order to receive feedback from Listening Sessions participants and other stakeholders.

Management Position: It was stated at the Commission meeting that large health departments that had multiple layers of oversight should or would expect their health director to be a Registered Sanitarian and put forth to the Workforce Credentials Subcommittee to reconsider that requirement.

The Subcommittee members discussed this and it was noted that there were only a few large health departments, having someone with the R.S. credential is important if they are supervising health agents/inspectors, and MEHA supports the recommendation. It was also state if it works for 98% of the health departments then why lower the requirements for a few. The question if Health Commissions have different statutory hiring requirements than municipal health departments was raised and needed to be looked into. It was also pointed out that they are standards that will be phased along with the Commission's other recommendations and not standards that are required immediately.

A discussion ensued if the R.S. should be required within 6 months or in 1 year of hire. Charlie Kaniecki made a motion to vote on changing the recommended requirement for the management position to have a R.S. after 1 year of hire. Some Subcommittee members argued against changing the recommendation. There was also a concern raised regarding the requiring at hire a Master's degree or BA/BS with 16 graduate credits for the management position/health director and why not require a MA after a period post being hired. The

Subcommittee members that wanted it to stay the same argued that it is important to have management and administrative competencies for the position. The Subcommittee members who attended the Special Commission meeting were surprised at the resistance of having a MA or the BA/BS with 16 graduate credits be a requirement at hire. It was stated that this was in sync with many other states. Some of the Special Commission Members stated that they were concerned of the impact on the hiring pool that these requirements would have.

Laura Kittross stated that the survey results actually demonstrate that there are more Registered Sanitarians in these top positions than not and affirmed that the waiver process was created for exceptional cases. The standards being set by the Subcommittee is for the future workforce – the best workforce necessary to fulfill the Foundational Public Health Services.

Vote to Make Changes to the Recommendation for the Management Position:

Charlie Kaniecki modified motion to require for the management position to be R.S. eligible or equivalent at hire. Sharon Cameron seconded the motion. The motion was approved unanimously. Laura Kittross will make changes to the grid.

Public Health Nurse (PHN): At the Commission meeting there was a discussion if the PHN should be required to have a BSN and Subcommittee members argued that they should. Subcommittee members agreed that the responsibilities of PHN, especially, in rural areas requires many to work independently and be responsible for a very large range of health promotion and disease prevention activities and that the recommendation should stay. What needed to be clarified is that if there was an exceptional case that the municipality could submit a waiver regarding that case which was not clear in the grid. A Subcommittee member stated that the Subcommittee cannot go too deep into the weeds. Should all the recommendations be approved by the legislature, general statutes are created to ensure the implementation of the recommendations which would include the development of policies and procedures for the specifics of a waiver process.

Waiver Process: The waiver process would come from municipalities for individuals who have had 10 years of experience and do not meet the grid requirements. If they move to a new municipality, the new municipality would have to submit for the waiver. The process would be liberal and not blind, for example. The specifics of how it will work can be decided later. It was recommended that the Subcommittee later could develop a 1 page policy recommendation.

Workforce Benchmarks/Ratios: Staffing standards or ranges (and often the setting of fees) are hard to figure out. The time a person needs to complete an inspection, travel time, the paperwork all need to be included and then multiplied for the number of inspections to help figure out the adequate number of staff needed. Looking at the FPHS and all the tasks and figuring out person time might be helpful. But the question of standard for an inspection is also at issue; defining what needs to be done and the quality of the inspection is another factor. With regard to the ratio grid, the only document that was relevant to its creation was NACCHOs which is dated. It sets the floor and can be a benchmark for Mass.; a rationale for why having such a benchmark is critical will have to be included for this grid as well. In breaking down what the positions in the workforce standards grid need to do to implement the FPHS, the benchmark recommendations can show why the number of staff are needed. For example, a 2-3 clerks may be needed for a population of 100,000, but every BOH needs at least 1/3

FTE for a clerk minimally to accomplish all the administrative tasks. Every town needs is required by regulation to be on MAVEN so 2-3 PHNs per 100,000 population is critical. For food inspectors adopt the FDA recommendations. Managers 3 per 100,000. The members agreed that without data to back up their recommendations they might be challenged. Without staffing benchmarks, local public health professionals will continue to be overloaded without much recourse for BOH or health directors to fight for adequate staffing/support. Subcommittee members agreed that more time was needed to flesh the recommendation out and that it will be on the next meeting's agenda.

General Comments Regarding Commission Member Feedback:

Some Subcommittee members were surprised at the questions and comments of Commission Members. From the Commission members' responses to the recommendations, it was agreed that the Subcommittee needed to present the background and the rationale for how they have come up with these recommendations at the July 27 Commission meeting similar to how the Standards Subcommittee did for the FPHS. The presentation should chart out what they have learned from other states and the PHAB and stress that the high standard that is being set is critical to the skills and standards needed to implement FPHS or to respond to the public health landscape of the future. This can be done in about 5 slides and maybe providing a 2-3 page document for Commission members to read beforehand might be useful (here is what FPHS requires, here is what other states are doing, and here is what the survey shows). The Chair stated that she would start putting the presentation together. It was emphasized that being aware of the impact on Boards of Health and having mechanism for oversight and enforcement was critical, otherwise nothing will change. Addressing the concerns about regionalization was also important, though as one Subcommittee pointed out, there were lots of towns benefiting from regionalization/health districts. Sometimes it is so seamless that the towns do not even recognize the benefit, such as those in Barnstable which augments many of their services. The model proposed is to set the standard and if municipalities meet it, fine, if not they are given a choice of models to help to move to a model that meets the standards.

Listening Sessions

Subcommittee members voiced that it would be important to stress that the workforce standards need to be viewed as part of the whole Commission recommendations and not separately.

Action Steps

Erica Piedade will amend the April 30, 2018 draft minutes and redistribute them.

Laura Kittross will revise the workforce standards grid.

Laura Kittross will begin preparing the presentation for July 27, 2018 Commission Meeting.

Sharon Cameron will revise the benchmark grid to discuss at the next meeting.

Next Meeting Date

Friday, June 22, 2018 from 11:00am at the Fisheries and Wildlife Headquarters, 1 Rabbit Hill Road, Westborough.

Vote to Adjourn

Charlie Kaniecki made a motion to adjourn the meeting. Sharon Cameron seconded the motion.

The motion passed unanimously.

The meeting was adjourned at 11:43 am.

Documents and Exhibits Used at the May 21, 2018 Meeting

1. May 21, 2018 Meeting Agenda
2. April 30, 2018 Draft Meeting Minutes
3. Revised Chart on Draft Staffing Standards Recommendations
4. Draft Chart on Ratios/Benchmarks

Approved by the Workforce Credentials subcommittee of the Special Commission on Local and Regional Public Health on June 22, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Stakeholder Listening Session

Monday, June 4, 2018
2:00 p.m. to 4:00 p.m.

John Olver Transit Center, Greenfield, Massachusetts

Agenda

2:00 Listening Session Opens

- Welcome and introductions
- Overview of the Status Report of the Special Commission on Local and Regional Public Health
- Listening session process

2:20 Comments and questions*

4:00 Listening Session Closes

*Please note: The listening session will be facilitated by staff from the Massachusetts Department of Public Health. Staff will take notes but will not respond to questions or comments. While members of the Special Commission on Local and Regional Public Health might be present at this session, they are not permitted to provide feedback on comments or respond to questions. The Commission will review comments and questions from all listening sessions at its next meeting.

Written comments may be submitted until 5:00 p.m. on June 20, 2018 to:

localregionalpublichealth@massmail.state.ma.us

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Tuesday, June 5, 2018
10:00 p.m. to 12:00 p.m.
Massachusetts Division of Fisheries and Wildlife, Westborough, MA

Agenda

10:00 Listening Session Opens

- Welcome and introductions
- Overview of the Status Report of the Special Commission on Local and Regional Public Health
- Listening session process

10:20 Comments and questions*

12:00 Listening Session Closes

*Please note: The listening session will be facilitated by staff from the Massachusetts Department of Public Health. Staff will take notes but will not respond to questions or comments. While members of the Special Commission on Local and Regional Public Health might be present at this session, they are not permitted to provide feedback on comments or respond to questions. The Commission will review comments and questions from all listening sessions at its next meeting.

Written comments may be submitted until 5:00 p.m. on June 20, 2018 to:

localregionalpublichealth@massmail.state.ma.us

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Friday, June 8, 2018
10:00 p.m. to 12:00 p.m.
Waltham Public Library, Waltham, Massachusetts

Agenda

10:00 Listening Session Opens

- Welcome and introductions
- Overview of the Status Report of the Special Commission on Local and Regional Public Health
- Listening session process

10:20 Comments and questions*

12:00 Listening Session Closes

*Please note: The listening session will be facilitated by staff from the Massachusetts Department of Public Health. Staff will take notes but will not respond to questions or comments. While members of the Special Commission on Local and Regional Public Health might be present at this session, they are not permitted to provide feedback on comments or respond to questions. The Commission will review comments and questions from all listening sessions at its next meeting.

Written comments may be submitted until 5:00 p.m. on June 20, 2018 to:

localregionalpublichealth@massmail.state.ma.us

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Stakeholder Listening Session

Monday, June 11, 2018
2:00 p.m. to 4:00 p.m.

Peabody Municipal Light Plant, Peabody, Massachusetts

Agenda

2:00 Listening Session Opens

- Welcome and introductions
- Overview of the Status Report of the Special Commission on Local and Regional Public Health
- Listening session process

2:20 Comments and questions*

4:00 Listening Session Closes

*Please note: The listening session will be facilitated by staff from the Massachusetts Department of Public Health. Staff will take notes but will not respond to questions or comments. While members of the Special Commission on Local and Regional Public Health might be present at this session, they are not permitted to provide feedback on comments or respond to questions. The Commission will review comments and questions from all listening sessions at its next meeting.

Written comments may be submitted until 5:00 p.m. on June 20, 2018 to:

localregionalpublichealth@massmail.state.ma.us

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Stakeholder Listening Session

Wednesday, June 13, 2018
2:00 p.m. to 4:00 p.m.

Lakeville Public Library, Lakeville, Massachusetts

Agenda

2:00 Listening Session Opens

- Welcome and introductions
- Overview of the Status Report of the Special Commission on Local and Regional Public Health
- Listening session process

2:20 Comments and questions*

4:00 Listening Session Closes

*Please note: The listening session will be facilitated by staff from the Massachusetts Department of Public Health. Staff will take notes but will not respond to questions or comments. While members of the Special Commission on Local and Regional Public Health might be present at this session, they are not permitted to provide feedback on comments or respond to questions. The Commission will review comments and questions from all listening sessions at its next meeting.

Written comments may be submitted until 5:00 p.m. on June 20, 2018 to:

localregionalpublichealth@massmail.state.ma.us

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Friday, June 15, 2018
10:00 p.m. to 12:00 p.m.
Western Massachusetts Hospital, Westfield, Massachusetts

Agenda

10:00 Listening Session Opens

- Welcome and introductions
- Overview of the Status Report of the Special Commission on Local and Regional Public Health
- Listening session process

10:20 Comments and questions*

12:00 Listening Session Closes

*Please note: The listening session will be facilitated by staff from the Massachusetts Department of Public Health. Staff will take notes but will not respond to questions or comments. While members of the Special Commission on Local and Regional Public Health might be present at this session, they are not permitted to provide feedback on comments or respond to questions. The Commission will review comments and questions from all listening sessions at its next meeting.

Written comments may be submitted until 5:00 p.m. on June 20, 2018 to:

localregionalpublichealth@massmail.state.ma.us

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Agenda

June 22, 2018
11:00am to 12:30pm

Massachusetts Technology Collaborative
75 North Street, Westboro, Massachusetts

11:00 Call to Order

VOTE: Approve minutes of May 22, 2018 meeting

11:10 Review and Discussion of the Summary of Feedback from Listening Session

11:50 Presentation for July 27

- Response to Listening Session Feedback
- Rationale for Workforce Recommendations (Standards & Ranges)
- Workforce Survey Data

12:20 Next Steps

VOTE: On Action

Next Meeting Date

12:30 Motion to Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Minutes

June 22, 2018

Massachusetts Technology Collaborative, Weiss Building
75 North St., Westborough

Members Present: Sharon Cameron, Charlie Kaniecki, Laura Kittross (Chair), Maria Pelletier, Steven Ward
Member Absent: None
Staff: Erica Piedade
Non-members: None

Call to Order: Laura Kittross, the Chair, noted that a quorum was present and called the meeting to order at 11 am.

Vote to Approve the Minutes

Charlie Kaniecki made a motion to approve the minutes of the May 21, 2018 meeting. Steve Ward seconded the motion. An amendment was proposed to the minutes regarding the Management position (page 2) and the inclusion of Registered Environmental Health Specialist (REHS) along with the Registered Sanitarian (RS) being required at hire. The language will be changed to *R.S. eligible or equivalent at hire*. The motion to approve the minutes with the amendment was passed unanimously.

Listening Session Feedback

Erica Piedade provided a general overview of the key themes that arose in the feedback provided by those who spoke at the Listening Sessions or provided written feedback:

- Support and see the need for having a well-trained and credentialed staff;
- Concerned about the resources to support hiring well-trained staff or supporting the training of staff;
- Concern about the availability of a training infrastructure to operationalize the recommendations, especially geographical access; and
- Concerned that recommendations will be a barrier to hiring due to lack of Board of Health (BOH) funds, limited pool, and lack of return on investment for individual to acquire training and credentials.

The Subcommittee members who attended a Listening Session commented on the low numbers of attendees and wondered if it suggested that LPH was generally on board with the recommendations or they were waiting for the final recommendations and hearings to invest their time into. Members speculated that those in the field a long time and will retire might not think this will impact them; those who are contracted or short term might not be paying attention; and those who have seen such efforts in the past and have felt they have not gone far might not think it is worth the effort.

The concern about degrees was less about the appropriateness of recommendation versus concern about being able to find staff with the degrees. The Workforce Credentials Subcommittee survey data actually shows there

are actually a large number of credentialed staff working in LPH across the state. Subcommittee members agreed that a response to the concerns should stress that the recommendations focus on the experience, training and credentials needed to run a health department. They also agreed that there needs to be a strong, geographically-based, accessible infrastructure for supporting the training recommendations.

The survey data on the training budgets for local health departments showed that it was less than \$1,000 on average and more than 1/3 spent less than \$500. It was stated that community health centers generally budgeted \$2500 per staff recognizing that it supports staff in maintaining their licenses or credentials. Access to training, a budget to support training, and adequate staffing to cover when others go to training was identified as critical. One subcommittee member stated that having a budget to contract for services frees up staff to go to training.

Members thought that many did not read the report in full and wondered if the report was too long and overly complicated. They commented that these were lessons for drafting the final report.

Workforce Standards

Concern was raised by the use of the terminology “eligible” as in R.S. eligible, a Master’s in Public Health would be considered “eligible”, but without a clear definition it may cause confusion. The waiver process was raised if there was a compelling rationale for supporting a hire that did not meet the requirements.

Vote: Charlie Kaniecki made a motion to strike the requirement of 16 credits along with a BS/BA and 5 years of relevant experience under the Management position. Maria Pelletier seconded the motion. The motion was passed unanimously.

One member stated that she was challenged by her decision to support the motion because she was not certain that the removal was due because the requirement was not deemed necessary or because the Subcommittee was concerned about the impact on the workforce pool. A statement strongly encouraging all towns, including small towns, to hire for LPH management position a well-trained and credentialed staff should be made, but the recommendations would still allow for a person with a BA/BS and 5 years of experience to be hired. It was suggested that reviewing the regulations specifying the credentials and experience for hiring the head of a Public Health Commission might be helpful (M.G.L. 111, S.26B <http://www.mahb.org/massachusetts-laws/mgl-ch-111-sec-26-32/>). The recommendations may include a statement that these are the requirements unless otherwise required by statute. It was agreed that the work of the Subcommittee is not to develop recommendations with minute specificity, since, if recommendations are passed that will be the work of the designated state body.

With regard to the training infrastructure needed for developing the skills and competencies for these positions, it was suggested that the Local Public Health Institute (LPHI) could design an apprenticeship program with vetted trainers and that is built on mentoring new inspectors/staff. Even peer review or mentoring helps to increase perspective, skills, and standards.

Workforce Benchmarks

The Chair thanked Sharon Cameron for all the work she put into developing the benchmark document. It was recognized that because most health departments cover less than 100,000 residents, setting benchmarks as a starting point was useful. The chart was useful in that it cited benchmarks from sources available and then it gave the Subcommittee's recommendation for each as well. In reviewing the chart, it was noted that the Food Inspector and Environmental Health Specialist were separated out and did not include each other's functions. Having staff that met these benchmarks did not mean they could not be cross-trained or augment each other. The benchmarks included considerations when making decisions about adequate numbers of staff such as geography, population dynamics, increases in temporary or permanent food establishments, food inspector not doing housing inspections, etc. It was suggested that under the Public Health Nurses notes to add population dynamics (children/elders) and that this position does not include school nursing responsibilities. The members thought it might be useful to have a statement about how to approach the use of the benchmarks, i.e., a disclaimer. Sharon Cameron volunteered to draft the language. Another suggestion was to include a statement about the importance of interns as a way to expose them to LPH and bring them into the pipeline.

Workforce Survey Results

Laura Kittross handed out copies of the workforce survey results based on 299 respondents from municipalities of which 252 were complete; 299 from 351 municipalities was an excellent response rate. The numbers and analysis did not include the results from the health districts. Highlights were presented with confidence that they survey showed a good representative sampling.

- Most municipalities issue their own permits regardless if they are part of a health district or not
- Most municipalities issue between 101-500 permits annually
- For the ranges provided for the number of Title 5 permits issued, i.e., 0-5 to 101-500, it generally was the same for all ranges which was not unexpected since more public sewer and water systems are in big towns and urban centers than small towns
- 60% of respondents indicated that they issue 25 fewer than 25 housing permits annually – a factor can be the separation of inspectional services from LPH in some communities
- More than half of the municipalities reported that they have a R.S. on staff; 48% of responding towns that have less than 5,000 population reported having a R.S. on staff and not as part of a health district
- Of the 168 respondents (with 131 skipping the question), 69.64% stated that they had a nurse with RN and 33.93% with BSN
- Within the next 10 years about 400 staff may retire, this category included the following positions: management, management/inspectional, health inspectors, clerical, and public health nurses
- Less municipalities contract out for inspectional services versus contracting out for nursing services; for contracting for nursing services was almost the same for doing so or not
- The majority of respondents stated that they had \$1,000 or less for their training budget
- Salaries show less variation but need further analysis; need to also consider benefits and impact of unions

The survey results suggest that municipalities may have less problems meeting the recommended credentials with the possible exception of public health nurses. A suggestion was to require a BSN for new hires and waiver anyone with 10 or more years of experience. If the position is part-time, which is often the case, it is hard to hire a nurse with a BSN even in a public health district. The training budget was considered shockingly low and

with such low budgets training up will not happen. It was not clear how many staff were included under that budget so no per capita figure was available. One member mentioned that even if a budget was available, often staff did not have time off for “educational days” or keeping up their credentials or licenses let alone paying for the renewal of licenses/certification. BOH with few staff had no coverage while away at trainings. It was agreed that a training budget must cover the cost critical staff training and must include coverage for when the staff is away at training, travel and lodging. Subcommittee members agreed that if they had further comments about the slides they would send them to the chair for discussion at the next subcommittee meeting.

Presentation at Commission Meeting July 27

The DPH staff informed the group that the presentation materials would need to be ready for review by July 13 at the latest. Due to the vacation season, members agreed that it would be difficult to schedule a meeting to finalize the presentation. Laura Kittross stated that she would put the presentation together and send it out for comment. Members understood that there could not be any deliberation and would send comments to the chair. The chair asked that the DPH staff share the charts of recommendations for workforce credentials and for the benchmarks and the slides for review. The presentation will be based on the documents and will focus on:

- The rationale for the workforce standards and the benchmark recommendations
- Research and sources
- Survey results that support the recommendations

Members agreed to attend the Commission meeting to support the chair in presenting the above and agreed that 30 minutes would be needed and to allow for 15 minutes for questions and comments.

Action Steps

Erica Piedade will amend the May 21, 2018 draft minutes and redistribute them.

Laura Kittross will begin preparing the presentation for July 27, 2018 Commission Meeting.

Sharon Cameron will draft language regarding the benchmarks.

Vote to Adjourn

Charlie Kaniecki made a motion to adjourn the meeting. Maria Pelletier seconded the motion.

The motion passed unanimously.

The meeting was adjourned at 12:40pm.

Documents and Exhibits Used at the June 22, 2018 Meeting

20. June 22, 2018 Meeting Agenda
21. May 21, 2018 Draft Meeting Minutes
22. April 30, 2018 Final Meeting Minutes
23. Revised Chart on Draft Staffing Standards Recommendations
24. Draft Chart on Benchmarks
25. Draft Local Public Health Workforce Survey Results

Approved by the Workforce Credentials subcommittee of the Special Commission on Local and Regional Public Health on September 10, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Structure Subcommittee

June 22, 2018

Massachusetts Technology Collaborative
75 North Street, Westboro, Massachusetts
1:00 p.m. – 3:00 p.m.

AGENDA

7. Call to Order
8. **VOTE:** Minutes of March 9, 2018 Structure Subcommittee meeting
9. Presentation and Discussion about Regional Approaches to Cross-jurisdictional services and the Foundational Public Health Services in MA -- Presenters:
 - a. Bernie Sullivan, Montachusett Public Health Network
 - b. Laura Kittross, Berkshire Public Health Alliance
 - c. Phoebe Walker, FRCOG Cooperative Public Health Service
 - d. Damon Chaplin, City of New Bedford Health Department
10. Discussion of Comments from Listening Sessions pertaining to Structure Subcommittee

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Structure Subcommittee DRAFT Meeting Minutes

June 22, 2018

Massachusetts Department of Fisheries and Wildlife

1 Rabbit Hill Rd., Westborough, Massachusetts

1:00pm – 3:00pm

Members present: Bernie Sullivan, Chair, Representative Hannah Kane, Harold Cox (by telephone), Charlie Kaniecki, Terri Khoury, Kevin Mizikar, Lorraine O'Connor

Members absent: none

MDPH Staff: Mike Coughlin, Jessica Ferland, Erica Piedade, Shelly Yarnie

Guests: Melanie O'Malley, Steve Ward

Speakers: Damon Chaplin, Laura Kittross, Phoebe Walker

Call to Order: The meeting was called to order at 1:00pm. A quorum was present.

VOTE: Kevin Mizikar moved to accept the minutes of the March 9, 2018 meeting of the Structure Subcommittee. Terri Khoury seconded the motion. The motion passed unanimously.

Presentations on Examples of Cross-Jurisdictional Models:

Montachusett Public Health Network (MPHN): Bernie Sullivan

- Fitchburg Board of Health is the lead agency
- Cafeteria model funded by the Public Health District Incentive Grant Program (PHDIG) administered from 2010-2015.
- 11 towns signed Intermunicipal Agreements (IMAs)
- The towns are billed for the services they use, i.e., invoice system
- Assessment for each town is provided, services include access to a Public Health Nurse, Health Agent and health promotion, disease prevention activities
- Service budge is approximately \$60,000 with no administrative budget, Fitchburg Health Director provides administrative support in kind
- In response to how the Health District is able to provide Foundational Public Health Services:
 - Concerned about capacity to collect data
 - No lab services; beach testing is contracted out
 - Has strong emergency preparedness capacity; participates in Public Health Emergency Preparedness PHEP Region 2
 - Concern about capacity to manage communications across all 7 towns
 - Community partnership is strong
 - Leveraged partnership to secure other funds, including substance abuse grant from DPH
 - No experience with Maternal and Child Health
- Success for the shared service model has come from a history of working together and a development of trust
- The model retains home rule and power remains with the cities/towns
- Challenges: staffing capacity is limited and nursing services cost a lot; no money for prevention and to cover administrative costs no data to sell why funding such activities is important

Discussion: A discussion about the funding of the model followed. Is the cafeteria model, especially regarding the system of invoicing for services rendered, reactive as opposed to proactive? Was it better to require a set payment, i.e., \$10,000 for beach water testing, versus billing for when beach testing was needed? Maybe a blended process for budgeting might work better, i.e., if opt in the town would have to pay a set fee for the services. The health district needs the capacity to be proactive and when PHDIG funding was available it helped the health district to be proactive.

Berkshire Public Health Alliance: Laura Kittross

- Formed with PHDIG money, planning had been in the works in advance of the funding; even with that could not have gotten started without the PHDIG
- 21 towns had signed on and 3 towns since have joined, including Pittsfield
- No cost to towns to belong; must come to quarterly meeting
- Cafeteria model with a comprehensive buy in model
 - 10 towns pay for services from the Public Health Nurse, ranging from small town of Windsor to large town of North Adams
 - 5 towns pay for comprehensive inspectional services
 - Can contract for camp inspections, Title 5, housing inspection services
- A major benefit is being able to apply for grants as a group wherein the individual towns would not be able to
 - 5 year FDA Standards grant – provides for on-line permitting, inspector training, resulting in increase in standards, substance abuse grant from DPH Bureau of Substance Abuse Services
- Shared services have allowed for standardization of policies and procedures fees, forms, regulations, and training
- Have centralized administrative function which allows them to be proactive though underfunded; they can think about things within a regional perspective – participate in coalitions or statewide advocacy
 - Can address cross cutting issues – they have permission to view MAVEN information for 24 towns and can recognize trends such as the explosion of Hepatitis C cases and Lyme disease and other areas that they provide cross-cutting support
 - Emergency preparedness/HMCC/MRC
 - Policy development and support
 - Community partnerships
 - Health equity/SDOH
 - Able to sit on committees and provide regional perspective
- With regard to FPHS
 - Have credentialed trained environmental health staff
 - Have chronic disease and injury prevention grants
 - Provide communicable disease surveillance and control
 - Provide flu vaccination clinics at schools
 - Provide MCH through Prevention and Wellness Trust Funds
 - Have linkages with clinical care through public health nurse program; preventing falls program; have 2 part time nurses
- Pros and cons
 - Slow to build up and slow to break even
 - Use grants to subsidize activities/services
 - PHDIG grant ended and money dried up
 - Would love to have a governing board that was invested and would take the lead in marketing, outreach, administrative structure and apply for grants

- Lack of funding to pay for administrative functions which takes time and resources
- There was an advantage to allow towns to come in at a low cost to them
- They really trust the Alliance and will listen to the Alliance
- Discussion: A question was asked about the Executive Committee which is made up of a mix of BOH members and health agents. The health district uniquely allows municipalities to be part of the executive committee without contracting for services. The discussion focused on why a town would participate in a health district if the town was not interested in contracting for services. The responses included being part of a safety net and when a major concern arose, they were assured they could get the help. Laura Kittross stated that it took a year visiting BOHs to get them to sign on and they get the benefit of the services provided by the grants the Alliance is able to acquire. The PHDIG funding was the seed money that allowed for the development of the administrative infrastructure to form the health district (identify how much services cost, call meetings). It paid for a full-time salaried staff with benefits to help form and oversee the health district.

City of New Bedford: Damon Chaplin

- Large municipality
 - 1 out of 26 gateway communities
 - 1 of 14 largest cities
 - A diverse population
 - New Bedford has unique challenges in the areas of education, unemployment, and poverty and shares the universal challenge posed by the opioid crisis.
 - Vertical organization with strong Mayor, elected city council and school committee, and other boards and committees appointed by the Mayor
- Inspectional services split from the Board of Health (BoH)
- 3 member BOH, BOH appointed Health Director, 1 FTE Public Health Nurse, 1 FTE Dental Hygienist, about 7 FTE Code enforcement/inspection, recently hired someone to do a CHA and CHIP
- Challenges when considering implementing the FPHS or shared services
 - Assessment – accessing data, don't have an epidemiologist
 - Maternal and Child Health
 - No one to work on website
 - Lack of staff to focus on community engagement
 - Sharing data between communities
 - Performance Management/Quality Improvement (PMQI)
 - Municipal budget always level funded; expansion of services will require outside funding sources
 - Limited staffing capacity
 - Competing priorities among leadership
- Pros for being stand alone
 - Independent – get things done quickly
 - Simplicity of developing policies and processes
 - Environmental health services strong
 - Strong emergency preparedness
 - Have nursing services
 - Supported by solicitor and municipal administrative functions
 - Good communications – have a communications officer
 - Community partnerships but would have more engagement if had staff to focus on that

- If were to adopt the FPHS would have to make organizational changes to be effective, i.e., health and human services model, since not all relevant departments are in the same unit; would need to appointment a commissioner

Discussion: The conversation evolved around data and data collection. A member was struck by the amount of data the city did have. A recommendation that the state should create a data system wherein towns could have access to and to create HEAT (data) maps with current real time data was made. The Chair suggested that for the next meeting, the Subcommittee should focus on identifying what the state could provide and what the towns could provide, such as the state assign epidemiologists to work with towns. It was also suggested that in looking at the FPHS the Subcommittee should look at what FPHS services are relevant for the state as some other states have done. A comment was made that even though New Bedford stands alone, it collaborates regionally on such areas as emergency preparedness and tobacco control, and why should a local health department be expected to have the capacity to provide all services.

Franklin Regional Council of Governments (FRCOG) Cooperative Public Health Services: Phoebe Walker

- Used state funding to get started
- Budget of \$185,000 and another \$70,000 in grants annually
- Covers 11 towns
- Have four programs (Public Nurse and wellness, Title 5 and private wells, food safety, and community sanitation); if utilize all 4 then considered comprehensive
- 8 towns are provided comprehensive services; 3 towns are only provided Public Health Nurses services
- Have the ability to leave the model, but must provide one year's notice
- Each town has a 3 year contract with the FRCOG which must be signed by the BOH and Select Board
- Shared fee schedule – collected regionally to offset budget
- Governance consists of representatives from each BOH (organized under MGL 40, Section 4A), meets monthly, participate in the hiring of staff, weighted vote on fiscal issues, policy and grant decisions
- Access to many activities along with those stated above: vaccination and free clinics, epidemiology, home visits, inspection services, CHNA/CHIP, food safety training, on-line permitting, lyme disease prevention – providing for economies of scale for the towns covered
- Pros
 - Flexible legal structure is attractive
 - Incremental membership
 - Comprehensive services for small towns
 - Local BOH stays intact
 - Financial formula incentivizes good public health practices
 - Able to create and disseminate best practices
 - Enhances collaboration
 - Have trained and credentialed staff
- Cons
 - Flexible legal structure means towns can get out relatively easily
 - Towns can leave in a year's notice
 - Not being a district decreases stability for planning and for budgets; no guaranteed assessment revenue
 - Not being a health district, towns can choose not to use qualified staff, continuing disparities
 - In considering FPHS
 - Not comprehensive MCH approach but the public health nurse provides connections to clinical care

- Work with Mass in Motion
 - Would struggle with administrative supports to meet Foundational Capacities
 - Currently able to be part of committees and boards
 - Rely on state data to provide for an epidemiological analysis
- Taking model to scale
 - Use of planning grants allowed for the time it took to negotiate with towns
 - Need 3 years of seed funding
 - PHDIG money covered costs but now gone; helped professionalize BOH and services

Shared Services Discussion

Since Mass. is considered one of the healthiest states in the nation, how do we sell this – how do we demonstrate that these models may be more efficient and effective? The response was that the Boards of Health sold it by talking about their experiences in trying to manage the provision of services, especially prior to being part of the Cooperative. They described being part of the Cooperative as being insured – for a small amount of money they receive a lot in return (PHN provides MAVEN required services, works with school nurses. Telling the story of how towns will be “on the hook if a bunch of people get sick or have a screwed up septic system” which responding to that will be much more expensive. Many BOHs do not understand what they are required to provide by statute and when they find out, many realize that they do not have the capacity to do it. An example for the Cooperative in saving the town money with a well trained inspector was when a school had a well with bad water. Drilling another well would have been very expensive. Had not the inspector informed them that they could use a pre-treatment system they would have had to spend a lot of money they did not have.

Using such examples for case studies to sell such models will be critical and should be at the beginning of the final report. Also focusing on how much we are currently spending on health care and how much could be saved (reduction of ED visits, reduction of CMS costs, opioid overdose epidemic, responding to hoarding) is important. Emphasizing access to comprehensive services, FPHS, especially for small towns will be important. Having figures that show for every \$1 invested for LPH (prevention of communicable (TB/pertussis), chronic diseases, reducing potential disasters) saves the town/state money would be helpful. An outbreak of TB could break the town’s budget – these examples are compelling. Experience has been that many towns joined a shared service model because of trust that was built up gradually or came about organically. History must also be taken into account - some of the existing shared models (Quabbin, Foothills, Eastern Franklin are well established. The story has to be about why a town should change, why it is better, and how being part of shared services will give you access to more qualified staff, broader range of critical services, critical service that will be there when you most need them, even though healthiest state not healthy for everyone throughout the state and what does healthy mean for each individual and each town.

Listening Session Feedback

Mike shared highlights and key trends from the feedback collected during the Listening Sessions. The OLRH Staff will be compiling all the comments to present at the Special Commission Meeting on July 27.

Vote to Adjourn

Kevin Mizikar made a motion to adjourn the meeting. Terri Khoury seconded this motion. The motion was passed unanimously.

Meeting was adjourned at 3:00pm.

Approved by the Structure Subcommittee of the Special Commission on Local and Regional Public Health on September 20, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Finance Subcommittee

Meeting Agenda

June 22, 2018 | 2:00 p.m. to 3:30 p.m.

Massachusetts Department of Public Health | Lobby Conference Room 2
250 Washington Street, Boston

- 2:00 pm Call to order
- Member introductions
- VOTE:** Selection of subcommittee chair (or co-chairs)
- VOTE:** Minutes of September 15, 2017 meeting
- Review of subcommittee charge
- Role of non-members in subcommittee meetings
- Local public health financing in Massachusetts
- Local public health financing in other states
- Next steps
- Next meeting date
- 3:30 pm Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Finance Subcommittee

Meeting Minutes

June 22, 2018

Massachusetts Department of Public Health, 250 Washington Street, Boston

Members present: Senator Jason Lewis, Sean Cronin, Eileen McAnneny, Cheryl Sbarra, Sam Wong
Members absent: Representative Steven Ultrino
MDPH staff: Ron O'Connor
Non-members: Maddie Ribble, Eddy Atallah

Call to order: Because the subcommittee had not selected a chair, the meeting was called to order by Ron O'Connor at 2:05 p.m. A quorum was present.

VOTE: Jason Lewis moved to appoint Sam Wong as chair of the Finance Subcommittee. Cheryl Sbarra seconded the motion. The motion passed unanimously by voice vote. [Cheryl Sbarra agreed to serve as “backup” chair.]

VOTE: Eileen McAnneny moved to accept the minutes of the September 15, 2017 Finance Subcommittee meeting. Jason Lewis seconded the motion. The motion passed with two members in favor (Eileen McAnneny and Sam Wong); three members abstained (Cheryl Sbarra, Jason Lewis, and Sean Cronin) because they did not attend the September 15th meeting.

Review of Subcommittee Charge

The subcommittee charge was discussed. The statement - “Evaluate existing municipal and state resources for local health and assess per capita funding levels within municipalities for local health” – was amended to include reference to federal resources as follows:

“Evaluate existing municipal, state, and *federal* resources for local health and assess per capita funding levels within municipalities for local health.”

Role of non-members in subcommittee meetings

Members discussed participation of non-members in subcommittee meetings. Comments and questions from non-members should be directed through the chair. The extent to which non-members may participate will depend on the number of non-members present.

Local public health financing in Massachusetts

DPH staff provided an overview of a draft document (“Local Public Health Funding Data”) obtained from the Division of Local Services, Executive Office of Administration and Finance. The document included per capita spending on public health and public health spending as a percent of all spending. Sean Cronin explained that the data was derived from annual, required expenditure reports (“Schedule A”) provided by every city and town.

He also discussed the limitations of the information (includes property tax revenue and state local aid expenditures; does not include grants, revolving accounts, trusts, enterprise funds). The document included estimated per capita spending for each year from 2006 through 2017. Using the estimated per capita cost of providing Foundational Public Health Services (\$54 at “current attainment levels”¹), the approximate amount spent per capita (\$11) is relatively small. However, Massachusetts might spend more at the state level for services (e.g., immunization) that are not counted in local expenditure reports. According the National Association of County and City Health Officials 2016 National Profile of Local Health Departments, overall public health expenditures per capita in Massachusetts are in the range of \$50 to \$69.99.

Additional comments and suggestions for further analysis

- Trends associated with population size or region of the state. Office of Local and Regional health Staff indicated that a preliminary analysis by population size indicated considerable variability within towns grouped by population size.
- Review whether there is an association between per capita spending and health status
- Review whether there is an association between per capita spending and median household income
- Spending that is voluntary vs. involuntary. Does the data help with this analysis? Expenditure reports do not provide spending information in that way.
- Is the definition of “public health spending” uniform from community to community? There is variability (for example, opioid-related spending is “public health” in some communities and “public safety” in other communities. One recommendation of the subcommittee might be to create a uniform approach to reporting public health spending. Can an incentive be provided to achieve uniform approach? There is no state public health funding common to all municipalities such that DPH can require every community to uniformly provide annual expenditure information.
- Discuss with Justeen Hyde (researcher; Commission member) – did she look at local expenditure data in her studies of local public health? Look at her food inspection spending data. Invite her to next subcommittee meeting.
- Local public health spending survey might be helpful. Can the Center for Health Information and Analysis help with a survey?
- Public libraries were cited as an example of a local entity that receives state funding subject to certification requirements (hours of operation, staffing, budget, book expenses).
- Explore school spending as an example (i.e., “net school spending”). Massachusetts does not approach local public health services in the same way that it approaches local education. A regional basis for public health services is more important than it is for schools. “Foundation budget” for schools might not be efficient – even when a school district is meeting its target?
- Are there communities that are “over capacity”? For example, have more public health FTEs than are needed for level of service?
- Discussion about Accountable Care Organizations and their role in addressing social determinants of health. Are there public health functions that the health care system can provide as health care system moves towards a “well care system”?
- Explore short-term gains – what services do we expect in the short run? Ensure that every community has capacity to meet current statutory requirements? Commission should consider two- tiers (meeting statutory requirements – short term; Foundational Public Health Services – long term)

¹ Mamaril, CBC, Mays, GP, Brunham, DK, Behemeier, B, Marlowe, J, and Timsina, L: Estimating the Cost of Providing Foundational Public Health Services. [Health Serv Res.](#) 2017 Dec 28. doi: 10.1111/1475-6773.12816

- Foundational Public Health Services is a good approach; the Commission (Standards Subcommittee) needs to take a closer look to determine more precisely the implications for public health services delivery in Massachusetts.
- Equity was raised as a concern – currently, the level of local public health services is based on where you live.

Local public health financing in other states

- Need to look at Connecticut and other similar states. Massachusetts is an “outlier” compared with other states.
- Is there a state that is similar to Massachusetts? Many states are decentralized with deeply rooted local autonomy but no other states have as many local public health jurisdictions.

General Comments

Rather than moving towards recommendations that require funding, the Commission can work towards telling as complete a story as possible about the local public health system. How are we similar to or different from other states? What does it mean if we are different? Evaluate the cost of implementing recommendations. Identify ways that the system can take incremental steps towards improvement. Consider not only what we might aspire to but also what we can realistically achieve.

Next steps

- Take a deeper look at expenditure data – relationship to health status; median income; city/town size; other
- Look at surrounding states for examples
- Invite Justeen Hyde to next meeting

Proposed next meeting date: July 27, 2018, 9:00 a.m. to 10:00 a.m.
Massachusetts Division of Fisheries and Wildlife, 1 Rabbit Hill Road, Westborough.

Adjournment

VOTE: Cheryl Sbarra moved to adjourn the meeting at 3:35 p.m. Eileen McAnneny seconded the motion. The motion passed unanimously by voice vote.

Approved by the Finance Subcommittee of the Special Commission on Local and Regional Public Health on September 11, 2018.

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Data Subcommittee

Meeting Agenda

June 22, 2018 | 3:00-4:00 p.m.

Massachusetts Technology Collaborative
75 North Street, Westboro, Massachusetts

1. Call to Order
2. **VOTE:** Minutes of March 23, 2018 Data Subcommittee meeting
3. Health District presentation discussion
4. Review and Discussion of the Summary of Feedback from Listening Session
5. Recommendations to strengthen public health data reporting, gathering and analysis, including any recommendations on mandatory reporting of local health authorities to the department.
(*Chapter 3 of the Resolves of 2016- final reporting requirements*)
6. Next meeting
7. Adjourn

* This meeting was cancelled due to lack of Quorum

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Data Subcommittee

Meeting Agenda

August 13, 2018 | 2:30-4:30 p.m.

Massachusetts Department of Public Health
Lobby Conference Room 2,
250 Washington Street, Boston, Massachusetts

1. Call to Order
2. **VOTE:** Minutes of March 23, 2018 Data Subcommittee meeting
3. Review and Discussion of the Summary of Feedback from Commission Status Report Stakeholder Listening Sessions
4. Workforce Credentials Committee Data
 - a. Brief overview of analyses completed to-date
 - b. Any additional analyses we want to do?
5. Have we accomplished this?
Recommendations to strengthen public health data reporting, gathering and analysis, including any recommendations on mandatory reporting of local health authorities to the department. (Chapter 3 of the Resolves of 2016- final reporting requirements)
 - a. Discuss data reporting requirements for local public health in Connecticut (CT). What does CT require local public health to collect and report on? (S. Yarnie)
 - b. Review data reporting requirements in other states (Colorado, Oregon, Ohio, and New Jersey)
 - c. What are the incentives needed for annual reporting to the state?
6. Plans for subcommittee update on September 20, 2018 Commission meeting
7. Possible subcommittee tasks for Boston University School of Public Health Activist Fellow
8. Next meeting
9. Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Workforce Credentials Subcommittee Meeting Agenda

Monday, September 10, 2018
9:30am to 11:30am

Senior Center
128 Providence St., Worcester

9:30 Call to Order

VOTE: Approve minutes of June 22, 2018 meeting

9:35 Status of CHO Board & CHO Exam

9:40 Listening Sessions Feedback on Subcommittee Recommendations

- Revised Workforce Standards Chart
- Revised Benchmarks Chart

10:10 Special Commission Presentation (September 20)

- Rationale for Workforce Recommendations
 - National trends & other states
 - Alignment to Regionalization Working Group Recommendations
 - Alignment to FPHS
- Workforce Standards Chart
- Benchmark Chart
- Survey Data that Supports Recommendations
- Tasks
- Presenters

11:10 Status of Charge

11:20 Next Steps & Meeting Date

11:30 Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Standards Subcommittee

Meeting Agenda

September 10, 2018 | 11:45 a.m. to 1:15 p.m.

Worcester Senior Center
128 Providence Street, Worcester

1. Call to Order
2. Findings of visit to Kansas by Eddy Atallah, Boston University School of Public Health student
3. Review of Foundational Public Health Services (FPHS) as Massachusetts standard
4. Discussion of pilot Massachusetts FPHS initiative including funding sources
5. Plans for subcommittee update at September 20, 2018 Commission meeting
6. Next meeting date
7. Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Finance Subcommittee

Meeting Agenda

September 11, 2018 | 10:00 a.m. to 11:30 a.m.

Massachusetts Department of Public Health | Lobby Conference Room 2
250 Washington Street, Boston

10:00 a.m. Call to order

VOTE: Minutes of June 22, 2018 meeting

Update on local public health financing in Massachusetts

Local public health financing in other states

Plans for subcommittee update at September 20, 2018 Commission meeting

Next meeting date

11:30 a.m. Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Structure Subcommittee

Meeting Agenda

Thursday, September 20, 2018

11:30 AM – 12:45 PM

Massachusetts Division of Fisheries and Wildlife

1 Rabbit Hill Road, Westborough, Massachusetts

- 11:30 Call to Order
 - Welcome and Introductions
 - Review Agenda
- 11:35 **VOTE:** Minutes of June 22, 2018 meeting
- 11:40 Presentation and discussion of comments received on status report related to structure
- 12:00 Preliminary Discussion of recommendations related to structural issues for final Commission report
- 12:30 outline of report to full Commission (later that day)
- 12:45 Adjourn

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Meeting Agenda

Thursday, September 20, 2018
1:30 p.m. to 4:00 p.m.

Massachusetts Division of Fisheries and Wildlife
1 Rabbit Hill Road, Westborough, Massachusetts

- 1:30 Call to Order
Welcome and Introductions
Review Agenda
- 1:35 **VOTE:** Minutes of May 4, 2018 meeting
VOTE: Additions or changes to subcommittee member assignments
- 1:40 Presentation and discussion of comments received on status report
- 2:00 Updates from Subcommittees
- Standards
 - Finance
 - Data
 - Structure
 - Workforce Credentials
- 3:30 Review and discussion of proposed Commission plans to complete final report and recommendations
- VOTE:** Commission roadmap
- 4:00 Adjourn