

Commonwealth of Massachusetts

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

STAKEHOLDER COMMENTS ON STATUS REPORT

Summary | September 2018

Prepared by
Massachusetts Department of Public Health
for the
Special Commission on Local and Regional Public Health
Approved September 20, 2018

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

This document is a summary of stakeholder comments received on the May 2018 status report of the Special Commission on Local and Regional Public Health.

To obtain a copy of the status report or for additional comments, please send an e-mail message to LocalRegionalPublicHealth@massmail.state.ma.us

The status report is also available at www.mass.gov/dph/olrh (Special Commission on Local and Regional Public Health).

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Commission Members (As of September 12, 2018)

EXECUTIVE BRANCH MEMBERS

Department of Public Health -----	Commissioner Monica Bharel
Executive Office of Administration and Finance -----	Sean Cronin
Department of Environmental Protection -----	C. Mark Smith
Department of Agricultural Resources -----	Lorraine O'Connor

APPOINTMENTS BY GOVERNOR

Research/Academic Institution -----	Justeen Hyde
Community Health Center -----	Maria Pelletier
Hospital System -----	David McCready
Workforce Development -----	Charles Kaniecki
Municipality >50,000 -----	Sharon Cameron
Municipality 5,000-50,000 -----	Pending
Public Health District (at least one town <5,000) -----	Phoebe Walker
At Large -----	Carmela Mancini

APPOINTMENTS BY LEGISLATIVE LEADERSHIP

Senate President -----	Senator Jason M. Lewis
Senate Minority Leader -----	Senator Richard J. Ross
Speaker of the House -----	Representative Steven Ultrino
House Minority Leader -----	Representative Hannah Kane

NAMED ORGANIZATIONS

Massachusetts Municipal Association -----	Kevin Mizikar
Massachusetts Taxpayers Foundation -----	Eileen McAnneny
Massachusetts Public Health Association -----	Bernard Sullivan
Massachusetts Health Officers Association -----	Sam Wong
Massachusetts Association of Health Boards -----	Cheryl Sbarra
Massachusetts Environmental Health Association -----	Steve Ward
Massachusetts Association of Public Health Nurses -----	Terri Khoury
Western Massachusetts Public Health Association -----	Laura Kittross
Massachusetts Public Health Regionalization Working Group -----	Harold Cox

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Summary of Stakeholder Comments on Status Report September 2018

Background

The Special Commission on Local and Regional Public Health (Commission) was created by legislation enacted in August 2016 to “assess the effectiveness and efficiency of municipal and regional public health systems and to make recommendations to strengthen the delivery of public health services and preventive measures” (Chapter 3 of the Resolves of 2016). Since its first meeting in June 2017, the Commission has reviewed and discussed many dimensions of the local public health system that fall within its charge.

In May 2018, the Commission released a status report to inform local public health stakeholders and to solicit feedback through a series of six listening sessions (Attachment A) and comments submitted by e-mail or letter. The listening sessions were supported by staff from the Massachusetts Department of Public Health. The Commission was represented by at least one member at each of the listening sessions. The Commission received comments from over 50 local public health stakeholders (Attachment B) on workforce credentials, cross-jurisdictional sharing, public health nursing, local public health financing, and other local public health system issues. There was a strong representation from the western part of the state as shown in the geographic distribution of comments in Attachment C.

Individuals providing comments included 18 local public health directors/health agents, 17 public health nurses, and 8 board of health members. Four public health districts (and the many communities that they include) and over 35 individual cities and towns were represented in the comments received.

In addition to reporting general comments on the status report and the work of the Commission, this document summarizes the comments using the following categories that align with the work of the five subcommittees of the Commission:

- 1) National standards (page 5)
- 2) Workforce credentials (page 6)
- 3) Cross-jurisdictional sharing (page 11)
- 4) Data (page 11)
- 5) Finance (page 12)

The following questions were shared with participants to guide their remarks:

- Is the Commission headed in the right direction?
- What are the challenges to implementation?

General Comments on the Status Report

- Several participants stated that the Commission is headed in the right direction.
- The status report did not address the role of local public health authorities in partnering with community coalitions (including Community Health Networks) to address the social determinants of health
- Municipal leaders need a better understanding of the role of local public health
- Board of health members are often volunteers with many responsibilities and no compensation, support, or recognition
- It is inconceivable that Massachusetts still has health departments that do not meet the national standards; access to good public health services should be equitable across the state
- Need for strong administration and oversight to ensure implementation of recommendations
- Final report needs to make a dramatic, attention-getting case (without singling out communities) for the need to increase support for local health
- A representative of a public health district noted that the Commonwealth needs to be part of partnerships among local public health authorities within districts. Local BOH are the boots on the ground and early warning system for the Commonwealth. They provide cutting edge and innovative approaches to dealing with public health issues.
- DPH regional health offices are needed to provide support to local public health – the DPH regional staff provide critical support (Community Sanitation Program, lead, tuberculosis control, etc.) at the community level in the regions. DPH should be less Boston-centric. Understand the unique needs of communities and regions and provide needed support.
- Massachusetts Department of Environmental Protection (DEP) and Massachusetts Department of Agricultural Resources (MDAR) need to be actively involved in discussion about the future of local public health. Local BOHs work with animal control and nuisances that involve working with and obtaining support from not only DPH but also DEP and MDAR.

Most of the comments received on the status report focused on the workforce standards as set forth in the Workforce Credentials Subcommittee recommendations. Given the relative depth and breadth of the comments, this document provides considerably more comments received on workforce credentials than on other dimensions of the Commission's work.

National Standards

Comments stressed the importance of building capacity to provide the Ten Essential Public Health Services (EPHS). There was an acknowledgement that small communities need to move beyond statutory responsibilities to provide environmental health services and communicable disease surveillance in order to provide community health services. However, boards of health in small communities are particularly challenged in providing EPHS given limited capacity to

meet statutory duties and responsibilities. One person commented that the capacity to deliver EPHS is a “necessity” for larger communities.

Workforce Credentials

Summary

While there was general support for the recommendations, there were narrow differences of opinion on the specificity of some of the recommended experience, training, and credentials. Some the concerns focused the possible impact of instituting the recommendations, such as reducing the workforce pipeline and pool versus disagreement with the actual recommendations.

- There were recommendations that the core staff be better defined.
- There was some disagreement regarding the need for the Registered Sanitarian (RS) credential for the Management/Health Agent and a majority of comments that a MPH/MPHN should be required.
- A majority of comments supported the requirement of RN and BSN/BA credential for public health nurses.
- There was a notable difference in comments between rural and urban communities regarding staff type and credentialing.
 - Rural towns were more apt to support the need for management skills that encompass public health/environmental health (RS) and a need for a trained and credentialed health agent and nurse. However, rural communities also raised concerns about the lack of feasibility for small towns to recruit, retain, and train such staff.
 - Urban communities conveyed less of a need to require management positions to have a RS because these larger health departments may have stratified and combined departments. These communities also tended to indicate that the management position should have full public health skills, including leadership, coalition building, data analysis, human resources, program management and grant writing.
- Comments were strong in emphasizing the need for the affordable, accessible, relevant, and timely training. Concern was expressed that mandating these recommendations without infrastructure, resources, and a phase-in period would cause the local public health workforce pool to shrink - leaving small towns with a heavier burden of not being able to compete for staff. Comments warned that, if infrastructure and resources are not included as part of implementation, requirements would exacerbate the current workforce issues.
- Comments strongly supported having a waiver/“grandfathering” process.
- Consideration with regard to union and existing relevant regulations, such as the credentials of commission staff/commissioner has to be included.
- There was a large number of comments strongly supporting the need for PHNs as core LPH staff for each town or towns covered by shared services. The comments underlined the

critical range of services provided by PHNs, especially disease surveillance and case management, population-based clinical and health education services, coalition building/community engagement, and emergency response services.

A well-resourced infrastructure that ensures affordability and accessibility of timely trainings and has a phased-in process (including a waiver process) is seen as the only feasible way to achieve the recommendations.

General Comments on Staffing & Credentialing

- Several strong statements were made in support of the need for well-trained and credentialed staff as recommended in the status report.
- Recommendations are long overdue; standards/credentials exist for other positions such as soil evaluators.
- Municipalities need to be held accountable for ensuring adequately trained staff.
- Having a local public health (LPH) workforce pipeline is critical - internships to support pipeline are needed and LPH needs to work with academia.
- Need competitive salaries for recruitment and retention.
- Requirements are a burden on/not realistic for small towns – limited budgets make it difficult to compete with larger or more resourced towns/cities for hiring staff and providing training benefits.
- Should mandate standards/credentials – provides support to pushing towns/unions to incorporate in job descriptions.
- Need to look at broader roles of LPH – often in large towns, health directors have dual roles, such as director of development and inspectional services and some towns have high level managers that oversee public health and non-public health services.
- If town budgets are limited, prioritize the hiring of public health nurses (PHN) and health agents (HA).
- Many towns, especially small and rural towns, need staffing with a comprehensive set of skills or be more innovative in using allied services.
- Caution raised about unfunded mandates; towns have been promised support in the past from state and that did not come through.
- Caution raised about recommendations as a barrier that results in a shrinkage in the pool of available workers and pipeline, especially for people of color wanting to enter the field.
- Regionalization seen as ability to provide more opportunity to have comprehensive public health services and services provided by adequately trained and credentialed staff.
- Standards are overly ambitious and have financial implications – credentialing should be by choice; towns should be able to decide on specific requirements.
- No instantaneous mandates; requirements should be phased in.
- Positions do not always lend themselves to being able to access training (work outside of 9-5 hours); may not have ability to attend trainings/educational classes, or have the money to pay for professional development due to low pay or no money from BOH.
- Rural communities have unique needs; may need the core staff with the core skills and credentials defined by the recommendations, but at the same time, these rural

representatives expressed heightened concern about being overly burdened by costs; sharing services seen by some as an option.

- Workforce definitions need more detail to avoid confusion.
- Support the division of local public health into two roles: BOH and LHD. LHD by definition provides all public health services/inspections, even if the same people who serve as the BOH. All LHD must meet workforce standards and work towards meeting national and state standards
- A recommendation was made to bring back the DPH district health officers program.

Management/Health Director

- Categories of Management and Management/Health Agent were confusing without definitions for duties; the use of “*commissioner*” should only be as defined in statute.
- Consider legislation to allow local health directors/health agents to have a three-year contract. This measure would be consistent with contracts for other positions in town government (e.g., town manager, accountants, auditors) and foster employment security for senior health department staff.
- Allow MPH (nursing) as well as MPH as a credential for Management/Director position.
- Define Management/Director as someone who supervises at least 1 full or part-time public health person and does not do inspections.
- Don’t require Management/Directors to have RS; position needs experience and training in public/population health/management/leadership versus environmental health.
- Allow at least 5 years for a person to meet requirements.
- Allow Districts to meet this standard for participating towns as long as the LHD staff participates regularly in the District.
- This position does not need a master’s degree; not a good return on investment (ROI).
- Recommendations are not sufficient compared with the town planner requirements, which needs a college degree. LPH should have college training, especially since LPH is responsible for safety of the community.
- Less stringent RS requirements because of concerns about pipeline and pool; having the RS credential means having a BA.

Management/Health Agent/Sanitarian

- Define Management/Agent as LHD Managers who do inspections. BOH who do any inspections would also need to meet the requirements under Management/Agents.
- Require management/agents to have an MPH/MPHN or to participate in regional collaboratives that have an MPH/MPHN and are working towards national standards to ensure equal access for public health planning for all towns.
- Should have a BA.
- Not realistic to require a BA within 6 years of hire but good benchmark for future workforce.
- Less stringent RS requirements because may negatively impact pipeline and pool.
- Should have Associates Degree and get on the job training.

- Create a new category “Inspector” who must work under the supervision of a RS; RS providing oversight will have to have all the relevant training certifications and obtains annual CEUS as required for RS.
- Recommend RS for all Inspectors.
- Meeting requirements under these position categories provides no return on investment for the individual due to generally low pay of field.

Public Health Nurses (PHN)

- Strongly recommend having a RN and BSN, especially for Massachusetts Virtual Epidemiological Network MAVEN and follow up case management for communicable diseases.
- Multiple comments on how essential PHNs are and all towns should have PHN; it is an efficient public health model and provides critical public health/clinical services.
- PHN is critical for TB case management; MAVEN – communicable disease surveillance and follow-up; provides support to school nurses; rural towns not close to hospitals. The PHN provides needed services and is essential in an emergency when community is cut off.
- Even though having a PHN raises concern about the pipeline and pool, still feel that a PHN for each town is necessary boots on the ground, especially in responding to emerging diseases or other emergencies.
- PHN should only serve one town rather than several towns.
- A few comments stated that BA/BN should not be required, especially since the compensation is not commensurate with investment in degree; easier to hire diplomas in nursing (RN) or AA – recommend allowing time to acquire BA or grandparent current staff.

Clerical Staff

- Each BOH needs clerical staff.
- Require LHD clerical staff to take online course of study/test and complete annual CEU requirements.

Members of Boards of Health (BOH)

- Need training and support.
- Consider further requirements, even though for elected BOH this may be challenging to enforce.
- Many BOH members do not understand their responsibilities; ill-prepared – especially for such activities as emergency preparedness; do not know about or understand the 10 Essential Public Health Services model.
- High turnover – need continuous training/orientation.
- Requirements may reduce volunteer pool.
- Massachusetts Association of Health Boards orientation is only training needed.
- BOH members should not be doing inspections; it is a conflict of interest. They should provide oversight and not do the inspectional work. They should be trained to provide policy and procedural oversight.

- Conflict when BOH works as agent or thinks knows better than the agent. How is oversight done when there is an appeal or hearing of issues the BOH member is involved with when acting in dual role?

Training

- State needs to provide and fund training.
- Provide support to the following: Local Public Health Institute, Massachusetts Health Officers Association, Massachusetts Environmental Health Association, MAHB, Massachusetts Association of Public Health Nurses and support on-going, affordable, accessible training, especially for Western Massachusetts and rural communities, to keep up with innovations and train new-to-the-field LPH staff.
- More opportunities and support are needed; especially with regulations or codes changes.
- Need infrastructure; academia needs to be involved; currently Foundations of Local Public Health Practice course or Massachusetts Public Health Inspector Training programs are not offered enough to meet the requirements of recommendations; some courses do not currently exist; can have a Foundations of Local Public Health Practice by LPHI or equivalent.
- Field training is needed and is critical; the 2010 Competency Report (by LPHI) recommended the need for field training but little movement has happened since.
- Need training on data collection.
- Towns need budget or adequate for training.
- Need to coordinate with DEP to increase relevant training (Title 5/waste water).
- Use school nurses training and credentialing model to garner support from state; school nurse training model includes training institute funding, consultants, evaluators, funds district schools, supports recruitment and retention.
- Need more classroom type of training versus on-line.
- Ask public colleges/universities to set reduced fees for LHD staff who are working towards meeting LHD workforce standards or consider a series of science exams that would meet the science requirements.

Waivers

- Allow waivers for staff with 5+ years of public health experience.
- Require annual educational plan and CEUs reports for all waivers.
- All waivers should expire after 3 years, subject to 3 year-renewal for good cause.
- Give to town and not transferrable – unless DPH for whatever reason approves.
- Have consequences for when town does not meet standards and can't apply for a waiver.

“Grandfathering”

- Support a process for allowing exceptions to meeting the standards.
- Allow for existing management, inspectors, and PHNs without limitation to be waived, unless there is a break in service of more than 5 years.

Trade Association Membership

- Rationale needs to be clear.

- Associations only have individual not department memberships. If the individual leaves, the membership goes with the person, so there is not an incentive for the town to pay or contribute. Recommend these organizations have department memberships.
- BOH has no money to cover individual's or town's membership.

Structure: Cross-jurisdictional Sharing/Regionalization

Comments regarding regionalization and cross-jurisdictional sharing (CJS) were relatively modest in number, especially in comparison to workforce credentials. Those comments submitted were generally supportive of regionalization as means of efficiently providing local health services in areas that are currently not meeting existing standards. One theme from comments submitted is the idea that regionalization is most beneficial to smaller towns and of less direct benefit to larger towns that have more resources, but that was not a universal view.

Funding was tied to regionalization in several comments. Regionalization in and of itself does not lead to enhanced services without additional financial resources to fund those services. Salient comment (paraphrased here) – “State initiatives come and go. Very difficult on the community level when they buy into the initiative and then they “go”, i.e., funding and support dry up”.

Most of the comments regarding structure were submitted from jurisdictions that actively participate in regional public health district or alliance collaboration. These comments were mostly very positive. Specific comments included access to more services, increased access to better trained staff, and increased learning opportunities that are a result of cross-jurisdictional sharing and collaboration. These observations might suggest that the experience of regionalization in Massachusetts is positive and those who question its efficacy are largely those who have not had direct experience working in a regional setting that delivers CJS. One challenge that was cited regarding existing regional collaborations is it can be difficult for towns of differing size to find a way to collaborate “fairly”, so that one municipality is not in the position of having to subsidize another.

Data

Comments related to data were limited to feedback and concerns on the importance of small town data, timely data collection, coordinated dissemination efforts, and ways to strengthen data collection efforts in Massachusetts. The comments reflected many jurisdictions across the Commonwealth and are noted below in key themes – small towns, timely and coordinated data, lack of resources/unfunded mandates, and general ideas/suggestions.

Small towns

- All cities and towns, regardless of size, need community-specific data for planning and grant writing.
- Concern expressed that DPH small town data is not always accurate or useful.
- Small towns need staff capacity to collect data and use it to plan and write grants. Most small health departments have a single person staff person who does not have time for data collection and analysis..

Timely and coordinated

- Data collection and dissemination needs to be more timely and shared across/among communities. Older data (e.g., 2015 is most recent in some cases) is difficult to use at local level because of rapidly shifting demographics in some communities.
- Suggestion that DPH and DEP cooperate on data collection for recreational camps so that LHDs aren't required to submit similar data sets to both agencies but in different formats.
- Current data compiled is "reactionary". Need more proactive information about public health: contribute to a culture of health in communities.
- The drive for more data must be weighed against local administrative capacity and resources. Just asking for more data, will not always result in what is needed. Past DPH practice was to include in a requirement in regulations that the BOH forward data instead of requiring permit holders to send to DPH. The BOHs were in essence "the clerks for DPH". A more effective tool is, for example, to require beach testing results to be sent to BOH and DPH simultaneously. DPH beach testing staff have established an email address to receive these reports. The result is data in real time instead of at the end of beach season. Easy to fill-in data sheets should accompany reporting requirements (for example, the DPH food inspections annual report.)

Lack of resources/unfunded mandates

- Local health departments don't have resources to meet all current demands on data reporting; undercounting is likely (e.g., when DPH reports the number of local health departments that submit food inspection reports).
- When statute or regulations requires BOH to inspect housing upon request, food establishments a minimum of two times a year, recreational camps or pools, or to have a lead determinator, consider the burden of the unfunded mandate.
- As state cut back DPH and DEP staff and resources, capacity at the local level was decreased. Re-energize DPH regional offices and mandates. Bring back the DPH district health officer program.

General ideas/suggestions

- The state auditor report on food inspections might be useful to make the case for increased local health resources and support. Report should be shared with the Commission.
- Continue a strong State Lab, Epidemiologists, Arbovirus support, and Food Protection Program, etc. to provide the technical assistance and guidance.

- Assess in statute, requirements for funding from state resources such reimbursement for capital expenses for health district, for half moving costs when LBOH condemn a dwelling, and TB-DOT reimbursement cost etc.
- Why aren't camps used as a data set as it is a required report
- "Data on compliance with food inspector qualifications"- the question not explained is to what qualifications is the report referring?

Finance

General support

- Communities need financial support to have adequate and well trained staff that meet a wide range of requirements.
- Disagree with the statement that 'funding is not the sole answer' – where you spend money is where the focus goes
- State budget should have dedicated source of revenue for local public health.
- Need funding to support the adequate staffing, training of staff, staff to plan, attend coalitions, collect data, provide public health promotion and disease prevention
- Just a little bit of money for each community would go a long way.
- Categorical grant programs would be more efficient if distributed according to uniform catchment areas.
- Need adequate and sustainable funding for towns such as revolving fund accounts and fee structures.
- A Massachusetts Association of Public Health Nurses survey indicated that "lack of funding" for public health nurses is the largest barrier to addressing social determinants of health, second to "not having enough time."
 - The legislature's "subject to appropriation" clause creates insurmountable, irrecoverable, and cumulative funding gaps that significantly impact community services
 - Despite statement in status report regarding funding alone not the solution, need to point out that state support for categorical services has been stagnant. For example, the tobacco grants have not increased in 6-8 years and local BOHs are not able to deliver the same level of services today as they could in the past. A mechanism to increase funding to meet changing needs and demand (e.g.; e-cigarettes/vaping) is needed. Other demands continue to press on LHDs (opioids) and would benefit from increased financial support

Cross-jurisdictional sharing support

- Encourage the use of DPH funding to promote cross-jurisdictional sharing in an equitable way.
- Consider the role that clearly delineated and adequately funded regional health districts could play in generating greater economy of scale to allow for consistent full-time public

health staff that could help augment regional preparedness efforts, and assume greater leadership in leading municipal public health response.

- The following districts are not mentioned in the status report: Eastern Franklin County Health District, Foothills Health District, Quabbin Public Health District, and Tri-Town Health Department. Consider these smaller, leaner but scalable models for future funding in the state's efforts to promote shared public health services.
- Shared nursing services have not worked out because often the nurse cannot get to all the communities to do the work.

Cities versus small towns

- Gateway cities seem to get funding to respond to their problems but small towns are overlooked. Small towns have “big city problems” (major lead paint problem in old homes, homelessness, opioid overdoses, etc.) and other challenges (lack of lead screening, lack of transportation, lack of service providers, etc.). Small towns often cannot compete with large cities for grant funding.
- Small towns with only one staff person do not have time to write grants, attend coalition meetings, etc.
- Grant funding requirements and short deadlines eliminate many rural communities’ access to funding opportunities
- We need to strengthen what exists, especially regarding reimbursement.
 - For example, for the tuberculosis fund reimbursement, the Commonwealth is required to provide payment for some of the local public health activities but often that does not happen.
 - Can funding associated with Accountable Care Organizations be leveraged to support local public health nurses?
- property taxes are the main source of revenue for small rural communities

Unfunded Mandates

- Unfunded mandates (perhaps disproportionately) impact rural small communities
- Local public health is part of the business sector. If you have unfunded mandates we cannot do the work. There needs to be a business-like provision when local public health is required to implement regulatory requirements. Massachusetts has a lot of mandates but it does not provide funding to meet the mandates. For example, the sharps collection program requires a lot of resources, including staff time but there are no resources provided to compensate local health departments.
- Massachusetts should provide funding for all the mandates they place on local communities, also for regional PHEP requirements, including consultant salaries.
- Mandated training should be paid for by the state because municipalities do not have the funds to pay for additional training.

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

ATTACHMENT A Schedule of Listening Sessions June 2018

The Massachusetts Special Commission on Local and Regional Public Health seeks input from a wide range of stakeholders on its progress as described in its Status Report. The report is located at www.mass.gov/dph/olrh.

If you are deaf, hard of hearing, or a person with a disability that requires accommodation, please contact jessica.ferland@state.ma.us, 781-774-6749, or TTY (MassRelay): 800-720-3480 as soon as possible.



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

Franklin Regional Council of Governments
John W. Olver Transit Center, 12 Olive Street #2, Greenfield

Tuesday, June 5, 2018 | 10:00 a.m. to Noon

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

Friday, June 8, 2018 | 10:00 a.m. to Noon

Waltham Public Library, Lecture Hall, 735 Main Street, Waltham

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

Peabody Municipal Light Plant, 201 Warren Street Extension, Peabody

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

Lakeville Public Library, Community Meeting Room, 4 Precinct Street, Lakeville

Friday, June 15, 2018 | 10:00 a.m. to Noon

Western Massachusetts Hospital, Conference Center, 91 East Mountain Road, Westfield

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

LocalRegionalPublicHealth@massmail.state.ma.us

[Please see listening sessions locations details on the next page.](#)

LISTENING SESSIONS LOCATIONS DETAILS

GREENFIELD (JUNE 4). There is no on-site parking (other than accessible spaces) at the John W. Olver Transit Center. Parking is available at one of the pay-and-display lots in Greenfield or at metered spots on Bank Row. Please plan to arrive ten minutes early to park and walk to the transit center.

WESTBOROUGH (JUNE 5). 1 Rabbit Hill Road is off North Drive. There is a parking lot on site. Visitors are asked to carpool, if possible, because parking may be limited. Visitors can meet up at the park-and-ride at the corner of Oak and Milk Streets (right on Route 135) and ride up the hill in one car from there (2 minutes away). Please report to the reception desk upon arrival.

WALTHAM (JUNE 8). There is a metered parking lot behind the library and metered on-street parking. A metered municipal lot is located one block from the library off of Lexington Street between Main Street and School Street.

PEABODY (JUNE 11). There is parking lot at the Peabody Municipal Light Plant (PMLP). PMLP staff will direct you to the meeting room.

LAKEVILLE (JUNE 13). Please park in the Old Town Hall parking lot (at the bottom of the driveway of the library) or church parking lot across the street. The event will be held in the Community Meeting Room—on your left after entering the library.

WESTFIELD (JUNE 15). On-campus parking with ADA accessible entrances is available in the front, rear, and northern section of the main building. The event will be held in the Conference Center.

Public Transit: Onsite, public transportation pick-up is serviced by the Pioneer Valley Transit Authority (PVRTA), route R10. Drop off, while not onsite, is proximate to the facility, approximately 200 yards away. The event will be held in the Conference Center.

SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

ATTACHMENT B Participants in Stakeholder Listening Sessions – June 2018

Greenfield – Persons Providing Comments		
Bell-Perkins, Elizabeth	Goshen Board of Health	Board of Health Member
Benson, Kathie	Leyden Board of Health	Board of Health Member
Federman, Julie	Amherst Health Department	Health Director
Hirschhorn, Beverly	Longmeadow Board of Health	Health Director
Kovacs, Betsy	Heath Board of Health	Board of Health Member
Stoler, Rachel	Franklin Regional Council of Governments	Community Health Program Manager
Telling, Doug	Charlemont Board of Health	Board of Health Member
Vondal, Deborah	Athol Board of Health	Health Agent

Lakeville – Persons Providing Comments		
Cardarelli, Maureen	Community VNA	Public Health Nurse
Chaplin, Damon	New Bedford Health Department	Health Director
Donovan Palmer, Amy	Mansfield Board of Health	Health Agent
Downey, Kathy	Marion Board of Health	Public Health Nurse
McVarish, Kathleen	Boston University School of Public Health	Academic Institution
Michaud, Chris	Dartmouth Board of Health	Health Director

Peabody – Persons Providing Comments		
Carbone, Thomas	Andover Health Department	Health Director
Carroll, Karin	Gloucester Health Department	Health Director
Cosgrove, Edward	Needham Board of Health	Board of Health Member
McKenzie, Mary	Saugus Health Department	Public Health Nurse
Stone, Jeff	North Suffolk Public Health Collaborative	Director

Waltham – Persons Providing Comments		
Eckhouse, Seth	Local Public Health Institute	Academic Institution
Kinsella, Caroline	Massachusetts Association of Public Health Nurses	Public Health Nurse
Kress, Doug	Somerville Health and Human Services	Health Director

Westborough – Person Providing Comments		
Leger, Philip	Worcester Division of Public Health, Royalston BOH	Health Agent

Westfield – Persons Providing Comments		
Bozigian-Merrick, Stephanie	Pioneer Valley Planning Commission	Regional Planning Agency
Meyer, Jenny	Northampton Board of Health	Public Health Nurse
Petrucci, Sherry	Agawam Health Department	Public Health Nurse
Proctor, Alison	Springfield Health Department	Program Director

Comments Submitted by E-mail		
Clay, Ruth	Towns of Wakefield and Melrose	Health Director
Collins, Bethany	Dighton Board of Health	Public Health Nurse
Conlon, Jaime	Rehoboth Board of Health	Public Health Nurse
Crochier, Randy	Gill Board of Health	Board of Health Member, Selectboard Member
DeCampo, Karen	Woburn Board of Health	Public Health Nurse
DePalo, Alexandra	Framingham Board of Health	Deputy Health Director
Donovan Palmer, Amy	Mansfield Board of Health	Health Agent
Drummey, Peg	Stoneham Board of Health	Public Health Nurse
Dukes, Cheryl	UMass Amherst School of Nursing	Academic Institution
Fortino, Fran	Whately Board of Health, Foothills Health District	Board of Health Member
Guarino, Terri	Bourne Board of Health	Health Agent
Keppard, Barry	Metropolitan Area Planning Council	Regional Planning Agency
Kinsella, Caroline	Milton Health Department	Health Director

Comments Submitted by E-mail		
Lebrun, Evelyn	Brockton Board of Health	Public Health Nurse
Leger, Philip	Worcester Division of Public Health, Royalston BOH	Health Agent
Litchfield, Sheila	Rowe Board of Health	Public Health Nurse
Maloni, Mark	Franklin Regional Council of Governments	Public Health Planner
Martin, Sandra	Berkshire Regional Planning Commission	Regional Planning Agency
Michaud, Chris	Dartmouth Board of Health	Health Director
Mori, Ruth	Wayland Board of Health	Public Health Nurse
Perlman, Bill	Franklin Regional Council of Governments	Executive Committee Chair
Poirier, Susan	Milton Health Department	Public Health Nurse
Sarni, Susan	Town of Hingham	Health Director
Sullivan, Joyce	Hull Board of Health	Health Director
Taverna,, Joan	Hull Board of Health	Public Health Nurse
Telling, Doug	Charlemont Board of Health	Board of Health Member
Tracy, Jessica	Dedham Health Department	Public Health Nurse
White, Lisa	Franklin Regional Council of Governments	Public Health Nurse
Zajdel, Pauline	Town of Foxboro	Health Director

Attended Listening Session but Did Not Comment			
Pierce, Kathern	Montague Board of Health	Health Inspector	Greenfield
Puleo, Elaine	Shutesbury Select Board	Board of Selectmen Member	Greenfield
Solomon, Josh	The Recorder (Greenfield)	Reporter	Greenfield
Volpe, Cheryl	Greenfield Board of Health	Public Health Nurse	Greenfield
Desmarais, Lori	Freetown/Lakeville	Public Health Nurse	Lakeville
Hall, Stacey	Marion Board of Health	Unkown	Lakeville
Lebrun, Evelyn	Brockton Board of Health	Public Health Nurse	Lakeville
Desmarais, Michelle	Lynn Health Department	Health Director	Peabody
Greenbaum, Dave	Saugus Health Department	Health Director	Peabody

Attended Listening Session but Did Not Comment			
Kaufman, Barbara	Melrose-Wakefield Healthcare	Health Care	Peabody
Mello, Traci	Wilmington/ Middleton BOH	Public Health Nurse	Peabody
Waller, Kim	Salem	Academic Institution	Peabody
Younger, Tom	Stoneham	Town Administrator	Peabody
Murphy, Jennifer	Winchester Health Dept.	Health Director	Waltham
Anglin, Najheen	Longmeadow Board of Health	Student	Westborough
Baccari, Steven	Westboro Board of Health	Health Director	Westborough
Auer, Kathleen	Agawam Health Department	Health Agent	Westfield
Lavery, Cassandra	Westfield Health Department	Public Health Nurse	Westfield

ATTACHMENT C

Geographic Distribution of Comments on Status Report			
Region	Listening Session Comments	Written Comments	Total
West	12	9	21
Central	1	1	2
Northeast	3	2	5
MetroWest	2	11	13
Greater Boston	1	0	1
Southeast	5	6	11
Statewide	3	0	3
	27	29	56