

Commonwealth of Massachusetts

**SPECIAL COMMISSION ON
LOCAL AND REGIONAL PUBLIC HEALTH**

STATUS REPORT

May 2018

Prepared by
Massachusetts Department of Public Health
for the
Special Commission on Local and Regional Public Health

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SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Commission Members (As of May 4, 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 McAnney
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

Status Report

Reviewed and Approved on May 4, 2018

“...assess the effectiveness and efficiency of municipal and regional public health systems and ... make recommendations regarding how to strengthen the delivery of public health services and preventive measures.”

Introduction

The Special Commission on Local and Regional Public Health (“the Commission”) was established in August 2016 ([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 provides an opportunity to engage leadership from Massachusetts executive branch agencies, the Massachusetts legislature, trade associations, the health care system, and local public health authorities to address longstanding concerns about inefficiencies and inequities in the delivery of local public health services in Massachusetts. The Commission is chaired by the Commissioner of the Massachusetts Department of Public Health (DPH) and supported by DPH Office of Local and Regional Health and other DPH bureaus and offices that work with local public health authorities in Massachusetts.

Since it was convened in June 2017, the Commission and its subcommittees have been exploring each of the seven elements of its charge as outlined in the legislation (Appendix A). This report summarizes the work and deliberations of the Commission through April 2018. It is intended to provide a foundation for input from the wide range of customers and stakeholders that share an interest in achieving a more robust, high-performing Massachusetts local public health system – one that builds upon the strengths and history of the system and the experience, expertise, and commitment of the local public health workforce. The report conveys to the customers and stakeholders that the work of the Commission is a “work-in-progress” that will benefit now from feedback, comments, and suggestions, after several months of study and discussion, as it moves towards draft recommendations later this year.

The Commission status report summarizes the work of the Commission to date. Additional information about the deliberations of the Commission is available in a compilation of agendas and approved minutes of the Commission and its subcommittees at [Massachusetts Dept of Public Health Office of Local and Regional Health](#).

National Perspective on Public Health

History of Public Health in the U.S. and Massachusetts. Public health has evolved tremendously through history. The following chart illustrates that progression of public health over the course of America's history^{1,2}:



Source: Karen B. DeSalvo, Patrick W. O’Carroll, Denise Koo, John M. Auerbach, Judith A. Monroe, “Public Health 3.0: Time for an Upgrade”, *American Journal of Public Health* 106, no. 4 (April 1, 2016): pp. 621-622. DOI: 10.2105/AJPH.2016.303063²

Earliest public health measures were directed toward isolation of the ill and quarantine of travelers in response to epidemics of smallpox and other communicable diseases. In the mid-1800s, focus on public health expanded to include sanitation in response to increased industrialization and urbanization in European and American cities. Enhancements in availability of clean water, waste management, and other measures to improve living conditions contributed to lower rates of infectious disease.

Massachusetts was a leader in the establishment of governmental public health infrastructure. During the 19th century, Lemuel Shattuck led efforts in the state to establish a sanitation commission and the State Board of Health. By 1900, forty of forty-five states had established

state health departments that were responsible for regulation of sanitation and other public health measures and surveying of living conditions and collection of morbidity and mortality data.

Continued expansion of public health programs in the twentieth century such as vaccination, motor vehicle safety, maternal and child health programs, and recognition of tobacco use as a health hazard contributed to an increase in the average lifespan of 25-30 years over the course of the century. Further expansion of public health has continued over the past twenty years to include focus on addressing the social determinants of health -- the conditions in which people are born, live, work, and age that affect their health. These include socioeconomic status, access to health care, housing conditions, educational access and attainment, and food security³.

The work of the Special Commission is informed by recent and ongoing national efforts to chart a course for the improvement of local public health services. These national efforts are summarized below.

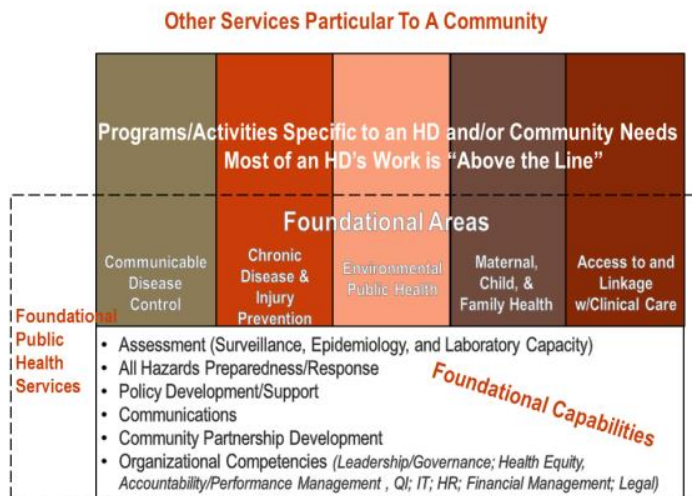
Institute of Medicine Report 2012. In a 2012 report⁴, *For the Public's Health: Investing in a Healthier Future*, the Institute of Medicine (IOM) assessed both the sources and adequacy of current governmental public health funding and identified approaches to building a sustainable and sufficient public health presence going forward, while recognizing the importance of the other stakeholders in the health system.

A series of recommendations called for changing how the nation invests in health funding to support population-based approaches to sustaining health. The report underscored that 1) state and local health departments are qualified when they have the resources to implement population-based prevention approaches, and 2) the state and local public health infrastructure across the nation is not sufficiently funded to carry out this mission. The report developed the concept of a minimum package of public health services, which includes foundational capabilities and an array of basic programs no health department can be without including:

- information systems and resources, including surveillance and epidemiology;
- health planning (including community health improvement planning);
- partnership development and community mobilization;
- policy development, analysis, and decision support;
- communication (including health literacy and cultural competence); and
- public health research, evaluation, and quality improvement.

Foundational Public Health Services 2013. In 2013, the Robert Wood Johnson Foundation funded the Public Health Leadership Forum to develop a set of Foundational Public Health Services (FPHS) -- the minimum package of public health services called for in the IOM report as described above. FPHS is a conceptual framework outlining the capabilities and areas (i.e., programs) that no health department should be without and for which costs can be estimated. The framework also leaves space for additional important programs and activities that are specific to the needs of the community served by the health department.

- Foundational capabilities are cross-cutting skills and capacities needed to support the foundational areas and other programs and activities. They are key to protecting the community’s health and achieving equitable health outcomes.
- Foundational areas are those substantive areas of expertise or program-specific activities in all governmental public health departments that are also essential to protect the community’s health.
- Programs and activities specific to a health department or a community’s needs are those determined to be of additional critical significance to a specific community’s health and are supported by the foundational capabilities and areas⁵.



Source: RESOLVE – Public Health Leadership Forum, *Defining and Constituting Foundational "Capabilities" and "Areas" Version 1 (V-1)*. March 2014⁵

Public Health Accreditation 2011. A parallel process for improvement of state and local public health infrastructure is public health accreditation. The Public Health Accreditation Board (PHAB) developed a series of nationally recognized, practice-focused and evidenced-based Standards and Measures organized in twelve Domains, the first ten of which mirror the Ten Essential Public Health Services developed by the U.S. Centers for Disease Control nearly

twenty-five years ago. The goal of the voluntary national accreditation program is to improve and protect the health of the public by advancing the quality and performance of tribal, state, local, and territorial public health departments.

PHAB Standards and Measures includes reference to all of the foundational areas and capabilities outlined in FPHS. Accreditation is a tool to improve the performance and quality of individual state, local, and tribal public health departments⁶. Applicants for accreditation are required to submit a Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and a Strategic Plan to PHAB upon submitting their application for public health accreditation. Upon approval from PHAB, they then have one year to compile documentation of conformity of all measures across the twelve domains.

Massachusetts Perspective on Local Public Health

Massachusetts has a decentralized governance structure as defined by the Association of State and Territorial Health Officials⁷. The 351 cities and towns are independently organized for the delivery of local public health services and operate autonomously from the Massachusetts Department of Public Health. Municipalities range in population size from several hundred to more than 600,000 persons. Regardless of population size, all municipalities are expected to provide both state- and locally- mandated public health services.

Massachusetts local boards of health are charged with a complex set of responsibilities including enforcement of state sanitary, environmental, housing, and health codes. These local public health duties and responsibilities are required by state laws and regulations and are outlined in the *Manual of Laws and Regulations Relating to Boards of Health*⁸. Massachusetts does not provide dedicated state funding to support local public health core operations.

Massachusetts is one of the few states without a county or other regional public health system. By home rule charter, each of the state's 351 cities and towns are responsible for the provision of essential public health, public safety, and other governmental services. The decentralized system and dependence on local funding for public health services results in significant disparities in the availability of public health services across the Commonwealth. Inconsistency across communities has led to small towns struggling to meet their local health mandates, variability in the qualifications and credentials of Board of Health members and staff, and limited ability to meet standards of national public health accreditation. Efforts to assist Massachusetts local health departments in their response to these challenges have relied on categorical program support from DPH and from efforts by DPH and other local health

stakeholders to encourage regional approaches to sharing services across local health jurisdictions.

Categorical Program Approach. Since the 1990s, DPH has supported local and regional health efforts by channeling categorical funding for specific public health services to local health through regional collaboratives or directly to local health departments. Several examples include:

- **Tobacco Control:** For over 20 years, DPH’s Tobacco Cessation and Prevention Program has funded local health departments’ enforcement of underage sales, advertising, and public smoking laws and regulations. Additional support is provided to regional education and awareness projects.
- **Emergency Preparedness:** With funding from CDC National Public Health Preparedness grants, DPH created and maintains a statewide network of regional emergency preparedness coalitions that assist local health departments in planning, training, communications, and other aspects of preparing to respond to all hazard emergencies.
- **Healthy Eating/Active Living:** Through the Mass in Motion program, DPH supports local health departments and their municipal partners to enhance recreational opportunities and infrastructure in their communities.
- **Substance Addiction:** With state and federal funding, DPH offers grant opportunities to local health departments and their community partners to combat the opioid epidemic and engage youth in substance addiction prevention efforts.

Support for Shared Services Arrangements. Since the early 2000s, DPH, local health stakeholders, academic partners, and the Massachusetts Legislature have supported efforts in Massachusetts to address the challenges of the local public health system through support for shared services arrangements designed to contribute to improvements in local public health capacity.

- **Massachusetts Public Health Regionalization Working Group:** Based at Boston University School of Public Health, the Regionalization Working Group was formed in the early 2000s to strengthen the Massachusetts public health system by creating a sustainable, regional system for equitable delivery of local public health services across the Commonwealth. The group created a Regionalization Toolkit to assist communities interested in regional local health collaboration, created a workforce credentials committee that developed recommendations for the local public health workforce with particular attention to staff employed in public health districts, and advocated for legislation to create the Special Commission on Local and Regional Public Health⁹.

- Amendments to Massachusetts General Laws: In 2008-2009, in response to recommendations from the Regionalization Advisory Commission (see page 23), the Legislature amended M.G.L. Chapter 27C to streamline the legal process for creating Regional Health Districts.
- Public Health District Incentive Grants (PHDIG): With funding from the U.S. Centers for Disease Control and Prevention through the National Public Health Performance Improvement Initiative, DPH supported planning grants for eleven public health districts and implementation grants for five public health districts. The five districts in the Public Health District Incentive Grant (PHDIG) program encompassed 58 communities and a total population of approximately 808,000.
- Office of Local and Regional Health: DPH established the Office of Local and Regional Health in October 2013. The office includes staff with assignments that support local public health capacity-building including cross-jurisdictional sharing and workforce development. OLRH leads an intra-agency local public health working group that promotes collaboration and communication among all DPH program staff that work with local public health.

Special Commission on Local and Regional Public Health

Chapter 3 of the Resolves of 2016 was signed by Governor Baker in August 2016 (Appendix A). The legislation created a 25-member commission 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.” Members of the Commission are listed at the beginning of this report.

Key Questions. The Commission charge is summarized in the following key questions:

- What is the minimum set of public health services that all Massachusetts residents should expect to receive from their local public health authority and the local public health system?
- What is the most effective and efficient way to design the local public health system to ensure that all Massachusetts residents have access to the minimum set of public health services?
- What professional disciplines, competencies, and credentials are needed to ensure the delivery of the minimum set of public health services?
- What data needs to be collected by local public health departments and reported to DPH to measure local public health system performance?

- What are the resource requirements to meet the minimum set of local public health services?

The following additional questions have emerged in Commission deliberations:

- What is public health? Why is it important?
- Why is it important to build a more efficient and equitable local public health system in Massachusetts?
- How do we make a case for local public health system improvements?

Commission Meetings. The Commission has held seven meetings since June 2017. Following are the dates and the focus of the meeting:

- **June 2017:** an introduction to local public health in Massachusetts, history/background on the legislation, and a review of the Commission charge.
- **September 2017:** information on shared services among local public health authorities in the United States
- **November 2017:** discussion of a minimum set of local public health services that every Massachusetts resident should expect and data that makes the case for improvements in the local public health system
- **January 2018:** making the case for public health, a review of history and challenges in the Massachusetts Public Health system and a review of the roadmap
- **February 2018:** discussion and adoption of the Foundational Public Health Services as the recommended minimum set of local public health services
- **April 2018:** subcommittee progress reports, review of status report outline and content, and discussion and planning for listening sessions
- **May 2018:** review and approval of the status report and discussion of plans for stakeholder listening sessions

Subcommittees. 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 work of the subcommittees is aligned with the seven elements of the Commission charge. Completed and planned meetings of the

Commission and its subcommittees are listed in Appendix B. The subcommittees (including a list of chairpersons and members) are described in Appendix C.

In aligning the work of the subcommittees to the Commission charge, the Commission has also set priorities among the elements of the charge such that standards, capacity assessment, workforce credentials, and service delivery models and approaches have received greater focus in the first several months of discussion.

Progress on Commission Charge

A summary of the progress on each element of the Commission charge follows. The summary includes a description of options, if any, that have been considered.

- 1. Examine the capacity of local and regional public health authorities in comparison to national public health standards and recommendations from the Centers for Disease Control and Prevention, the Public Health Accreditation Board, the National Association of County and City Health Officials, the National Association of Local Boards of Health, the Association of State and Territorial Health Officials and other relevant organizations**

National standards for local public health departments have generally been stated in terms of a minimum set of public health services to which every resident can expect to have access in their community. The minimum set of services has evolved from the Core Public Health Functions (Institute of Medicine, 1988)¹⁰, Ten Essential Public Health Services (U.S. Centers for Disease Control and Prevention, 1994)¹¹, Operational Definition of a Functional Local Public Health Department (National Association of County and City Health Officials, 2005)¹², voluntary accreditation standards of the Public Health Accreditation Board (2012)¹³, and the Foundational Public Health Services (2013)¹⁴. The PHAB standards employ the Ten Essential Public Health Services and two additional standards associated with administration and governance. The Foundational Public Health Services has recently been adopted by some state and local public health departments as a framework aligned with the PHAB standards. It defines 1) Foundational Capabilities (essential cross-cutting skills) and 2) Foundational Areas (subject matter expertise). Some states have referred to their public health system improvements as “public health modernization.”

Unlike some other states, Massachusetts has not adopted national standards. The minimum set of local public health services that every Massachusetts resident can expect from their local public health department is defined as those duties and responsibilities of local boards of

health embodied in statute and regulations. The set of services required by statute and regulations is far less than the Ten Essential Public Health Services; many communities (particularly small towns) lack the capacity to provide this minimum set of services (based upon surveys conducted within the past 15 years).

The Standards Subcommittee has reviewed the experience of other states in adopting national standards for local public health departments. For example, Ohio requires that each of its local public health departments achieve PHAB accreditation as a condition of state funding. Other states (Washington, Oregon, Colorado, North Carolina, Texas, North Dakota, and Kentucky) have adopted the Foundational Public Health Services framework for their state and local public health departments.

The subcommittee has reviewed the Foundational Public Health Services (FPHS) framework as a possible approach in Massachusetts (see page 7 for more information about FPHS). The Commission accepted the proposal of the Standards Subcommittee that the Commission recommend Foundational Public Health Services as the minimum set of local public health services.

The Standards Subcommittee is pursuing the following strategies in support of that recommendation:

- 1) Create a cross-walk between Foundational Public Health Services and existing statutes and regulations to identify areas where changes in statute or regulation are required;
- 2) Determine which of the services are provided by agencies or organizations other than local government; and
- 3) Explore the availability of private foundation funding to facilitate implementation of the Foundational Public Health Services in Massachusetts.

2. Assess the capacity of local public health authorities to carry out their statutory powers and duties

In Massachusetts, there are differences among communities in terms of local public health staffing and resources. This section of the status report addresses functional capacity to carry out statutory powers and duties. Capacity in terms of workforce qualifications is addressed in charge #4 on page 17. These differences affect the capacity of local public health authorities to offer complete protections to all residents. Many of these differences are documented in the 2003 study¹⁵ for the Massachusetts Coalition for Local Public Health, *A Case for Improving the*

Massachusetts Local Public Health Infrastructure which outlined the following areas that were in need of improvement: Organizational Capacity, Workforce Standards and Competency, Information, Communication and Data Systems, and Resources. The 2006 report¹⁶, *Strengthening Local Public Health in Massachusetts: A Call to Action* found differences in the local public health infrastructure across the Commonwealth. The most striking differences were between smaller and larger communities. Capacity to enforce environmental laws and perform communicable disease surveillance tends to be higher in larger communities. The Data Subcommittee is charged with collecting and analyzing current data relevant to documenting these disparities.

Data reporting from local public health to DPH is limited to reporting required by statute or regulation. In some cases, capacity is limited within DPH to monitor, audit, and verify the data that is reported. Other states (for example, Ohio and New Jersey) have more robust data reporting requirements for local public health.

The Data Subcommittee reviewed DPH and Department of Environmental Protection (DEP) data that documents local health capacity and performance in terms of mandated responsibilities. The data gathered and reviewed included:

- Massachusetts Virtual Epidemiological Network (MAVEN) participation;
- Health and Homeland Alert Network (HHAN) drill response rates and Emergency Dispensing Site Plans;
- retail food inspection reports to DPH;
- lead determinators;
- beach water testing;
- drinking water testing; and
- capacity to provide Essential Public Health Services.

Each of these data elements were selected because a) they may be proxy measures of the overall capacity of the local public health system and b) have data available through an established reporting/record-keeping process.

The Data Subcommittee identified the following areas in which local public health system reporting in Massachusetts is either lacking or limited:

- Housing code enforcement data;
- Septic (Title 5) code enforcement data;
- Title 5 Inspector or Soil Evaluator certification data;

- listing of towns that meet requirement to have a lead determinator;
- private well water protection data;
- food inspection data;
- data on compliance with food inspector qualification standards;
- statewide data on food safety violation trends;
- MAVEN case management quality data;
- data on compliance with requirement for a lead determination at each housing inspection involving a child under 6 years of age; and
- data on percentage of local health departments meeting frequency requirement for beach water sampling.

The Data Subcommittee presented their findings on the data analysis to the Commission at the April 6, 2018 Commission meeting. Commission members acknowledged that it is important to use real-life examples to highlight the impact of inconsistent data, especially data that is required. It was emphasized that even though there may be a system for collecting data, local public health staff capacity to report data is limited. The data collection expectation and requirements should focus on, and make transparent, the need for such data and the consequences for not providing the data.

The Data Subcommittee's analysis also found that data collection is more robust when federal or state resources support the program in question. Health districts that have a high level of compliance provide important lessons in data collection and reporting.

The limitations in the ability of data analyzed by the Data Subcommittee to capture local public health capacity highlights the need for a more systematic approach to the collection of data that measures local public health system performance. While many other states have a mandatory local health "report card" that can be reviewed by state and local administration, the state Legislature, and consumers, there is currently no system in place in Massachusetts to either collect data on important functions or analyze it. In addition to considering changes to the public health structure for the state to ensure efficient, effective local public health to all of its residents, it is important that Massachusetts create a standard data reporting requirement for local public health to measure capacity.

The need to fully assess the capacity of local public health authorities to carry out their statutory powers and duties has been raised. The Data Subcommittee recognizes the importance of exploring capacity along several dimensions (structure, workforce, and funding). A robust capacity assessment to determine the capacity of the Massachusetts local public health system to deliver the FPHS services model will illustrate that there are variations in the

ability to implement the FPHS components. Such a capacity assessment, similar to that conducted in other states, will be an important next step.

The Data Subcommittee plans to

- Explore with the Commission the development of a robust capacity assessment (structure, workforce, and funding) to determine the capacity of the Massachusetts local public health system to deliver the FPHS services model will illustrate that there are variations in the ability to implement the FPHS components. Such a capacity assessment, similar to that conducted in other states, will be an important next step.
- Review and evaluate data reporting requirements for local public health in other states such as Ohio, New Jersey, and Connecticut and will make recommendations on how to strengthen the local public health reporting system in Massachusetts.
- Explore new data reporting collection efforts.
- Review and incorporate feedback from the listening sessions regarding capacity at multiple levels (structure, workforce, funding) to ensure local public health authorities are able to carry out their statutory powers and duties.

3. Evaluate existing municipal and state resources for local health and assess per capita funding levels within municipalities for local health

Unlike most other states, Massachusetts uses municipal funding (as well as discretionary and variable use of general local aid) as the mechanism for funding core public health services at the municipal level. There is considerable variation in local public health funding because it is primarily supported at the local level. Local public health is also supported by other resources and funding sources (including categorical state funding and DPH staff) as described in this report on page 9 and page 21 . In its deliberations, the Commission has noted that “more funding” is not the sole solution to “more effective and efficient municipal and regional public health systems.”

The Finance Subcommittee has held one meeting during which it discussed challenges in collecting a uniform set of information about local public health funding in each Massachusetts communities. Among the challenges are variations in the services provided by communities (for example, animal control is more often a public safety than public health responsibility). Other financing issues will depend upon recommendations of the Commission and its subcommittees.

4. Evaluate the workforce credentials of the current and future public health workforce as to educational standards, credentialing and training

The Massachusetts local public health workforce includes the hundreds of public health professionals and elected or appointed members of local boards of health who work every day to protect and improve the health of their communities.

Massachusetts does not have standards for experience, training, or credentials for the local public health workforce. This results in a lack of consistency in the ability of boards of health (BOH) to adequately provide public health services to residents across the Commonwealth. Those who provide local public health services across the state range from trained and experienced staff to contractors, volunteers, or board members. The pool of trained local public health workers and the pipeline for public health workers is minimal and is further exacerbated by the large number of experienced local public health workers who are expected to retire in the next few years. The lack of a standard for experience, training, credentialing, and staffing for local public health - board of health members and staff - creates inequity in local public health capacity across the state. “Where you live” determines not only the depth and breadth of public health services that are available but also the qualifications of the individuals providing the services.

The Workforce Credentials Subcommittee reviewed existing studies and recommendations (including required competencies) on the Massachusetts local public health workforce. The subcommittee has reviewed existing voluntary credentials in Massachusetts in comparison to requirements of selected other states (New Jersey, Connecticut, Illinois, Colorado and Ohio). Requirements for similar types of municipal workforces, such as building inspector and animal control officer, were also reviewed.

Voluntary training is available and provided by multiple organizations. The Massachusetts Department of Public Health funds the Local Public Health Initiative (LPHI) at the Boston University School of Public Health which provides on-line, web-based and classroom blended training specifically for increasing the skill and knowledge competencies of the local public health workforce. The Coalition for Local Public Health (CLPH), comprised of the public health trade organizations that represent the majority of the local public health professionals, provides orientation to the local public health workforce and serves as an advisory group on workforce development to LPHI. The CLPH member organizations each provide training and education for the public health workforce. For example, the Massachusetts Association of Health Boards offers orientation and training to local public health board members annually. The Massachusetts Health Officers Association, Massachusetts Environmental Health

Association, and the Massachusetts Association of Public Health Nurses each provide annual conferences and other educational opportunities that meet continuing education requirements for their members. Other regionally based organizations also offer training to local public health. Since training is voluntary and there are no required standards, the boards of health and health departments with resources or strong commitment benefit the most from these initiatives, increasing already an unequitable situation.

The subcommittee has explored critical experience, training, and credentials for core staff, including board of health members. The subcommittee focused on the most common positions in local health departments and positions which often do not have experience, training, or credentialing requirements but are essential for providing essential public health services. These positions have been classified as:

- 1) management (director, assistant or deputy director or commissioner);
- 2) management and health agent (duties include both administrative and health agent);
- 3) inspector or sanitarian (code enforcement);
- 4) public health nurse;
- 5) clerical staff; and
- 6) board of health member.

To acquire a better sense of the current workforce, a survey focusing on local public health staffing size, staff positions, and qualifications of staffing has been conducted. Over 275 local boards of health have responded to the survey. The data is being analyzed and will help inform the amount of effort, time, and resources that will be needed to bring staffing to a recommended standard.

The subcommittee presented and the Commission discussed preliminary recommendations for local public health workforce credentials at its April 6, 2018 meeting. It was emphasized that the draft recommendations focused on the local public health workforce of the future – one that is skilled to carry out the Foundational Public Health Services - as opposed to just ensuring that it could meet current mandates. Based on that discussion, the subcommittee revised its recommendations as presented in the table in Appendix E.

While there is general agreement on the need to establish workforce qualifications, there are varying points of view on the details. For example, the Commission has discussed whether a Master's degree (or Bachelor's with graduate credits) should be required at hire or within 5 years after hire for management positions (see table in Appendix E). The Commission welcomes input from stakeholders before it makes final recommendations.

Recognizing that there is a limited workforce and that there are some geographical limitations with recruitment and retention, developing a “grandparenting” and waiver process is being reviewed. A “grandparenting” process is intended to ensure that seasoned public health professionals who may retire within 10 years are fairly impacted by the draft regulations - if they were to be implemented. In addition, the option of having a waiver with well-defined criteria, would help towns, especially small towns, recruit and retain committed professionals who were working towards meeting the requirements. This approach would also support a pathway for the local public health profession. Questions remain regarding when a waiver could be submitted and would the waiver be issued to the town or to the individual. The subcommittee was asked to consider the draft recommendations from an equity lens due to concerns that educational and credentialing requirements might limit access to career advancement for local public health professionals of color who might already be under-represented in the profession.

Some national organizations have established staff to population ratios for some public health positions. The subcommittee is exploring these ratios as a benchmark for local public health staffing. The subcommittee will also align its preliminary recommendations with the FPHS minimum set of services recommended by the Commission. The Commission encouraged the subcommittee to continue researching other states to compare their draft recommendations, to explore staff to population ratios, and to ensure that the recommendations are aligned with the Foundational Public Health Services.

The Workforce Credentials Subcommittee plans to:

- Analyze the local public health workforce survey data to assess the current local public health (LPH) workforce landscape and to estimate the gaps in capacity to provide the Commission-recommended minimum set of LPH services;
- Define required versus recommended workforce standards and core versus expanded staffing;
- Identify the necessary structures and supports for ensuring the capacity to provide training across the state that supports a LPH workforce that meets the Commission’s minimum set of LPH services;
- Further develop the concepts of “grandparenting” and waivers;
- Explore national benchmarks and staffing guidelines (ratios);
- Compare draft recommendations to standards set by other similar states and/or with national standards/benchmarks; and

- Review and incorporate feedback from the listening sessions regarding minimum educational, training, and credentialing standards for essential local public health professionals to meet the FPHS standard.

5. Assess the current capacity of the Office of Local and Regional Health (OLRH) within the Department of Public Health

Created in 2013, the Office of Local and Regional Health (OLRH) provides leadership in collaboration with internal and external public health stakeholders to strengthen the capacity of Massachusetts local Boards of Health (BOH) to meet their legal responsibilities to protect the health of their communities. In addition to the Office of Local and Regional Health, DPH provides staff support in the form of training, technical assistance, and other guidance to local public health authorities on a wide range of public health issues. Communicable disease control, emergency preparedness, state sanitary code, tobacco control, food protection, and substance addiction are among the public health issues for which DPH works with local public health officials. For some programs, DPH funds regional coalitions and collaborative activities that support an efficient and effective use of resources.

Work related to this element of the charge will depend on preliminary recommendations of the Commission.

6. Evaluate existing regional collaboration and various models of service delivery across the commonwealth, including stand-alone, shared service and fully comprehensive regional districts

While most states have a relatively uniform, efficient structure for the delivery of local public health services through a county system, Massachusetts has a “patchwork” of public health districts, other shared services arrangements among communities, and many standalone local health departments. Massachusetts has the most local public health departments (351) in the United States.

The Commission hosted a presentation from the National Center for Sharing Public Health Services on September 15, 2017¹⁷. Cross-jurisdictional Sharing (CJS) of services is a term used to refer to the wide variety of means by which jurisdictions can collaborate around the provision of public health services. CJS is a tool that may assist the Commonwealth in reaching the goal of providing Foundational Public Health Services in every community.

Consideration of CJS could be helpful in identifying structure(s) that would serve as models for communities that are not able to currently provide foundational services to do so in collaboration

with other communities in their region. As discussed at the September 2017 Commission meeting, elements of CJS that could be favorable to increased cross jurisdictional collaboration include:

- 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.
- To avoid pushback when the mandate comes from above the Center reports that the formation of new models is most successful when formed voluntarily. 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.
- CJS should not be seen as a means of cutting service costs. It is a means of maximizing money spent and may be a useful tool to build on the return of the investment.
- Recognize the unique challenge in Massachusetts presented by its having the largest number of public health jurisdictions of any state in the country and seeing CJS as a tool to help respond to that challenge.
- The Center reported that change management is difficult and will be a potential pitfall to success in Massachusetts in reaching the goal of enhancing the availability of public health services through CJS.

A detailed list of existing local public health districts in Massachusetts and a list of local public health structures in other states have been provided to Structure Subcommittee members for evaluation and further discussion. In addition, members also discussed funding mechanisms (M.G.L. Chapter 111 Section 27C) and the Public Health District Incentive Grant program designed to support the formation of local public health districts and various shared service arrangements in Massachusetts

The subcommittee has reviewed and discussed the local public health structures in six states: Colorado, New Jersey, Texas, Washington, Ohio, and Connecticut.

A flexible and comprehensive approach to local public health governance (i.e., public health districts) has been discussed as an effective option for providing a more efficient and equitable local public health system in Massachusetts. An incremental approach to shared services that recognizes the complexity of the local public health environment and incorporates knowledge of models that work will be important.

A comprehensive/cafeteria style model with a baseline set of minimum services in which municipalities can also receive additional niche services (i.e., Title V inspection), if needed, is probably a good starting point for local public health infrastructure redesign and planning.

Structural redesign should be based on the Foundational Public Health Services. Deeper evaluation of public health districts is needed and may support these findings (e.g., Nashoba Associated Boards of Health, Berkshire Public Health Alliance, Montachusett Public Health Network, Central Massachusetts Regional Public Health Alliance, and Franklin Regional Council of Governments).

The Structure Subcommittee plans to

- Evaluate a representative sample of public health districts and regional public health alliances in its review of models/approaches that work to improve local public health capacity
- Contrast statutory districts with regional alliances formed through interagency agreements (e.g., PHDIG collaboratives)
- Consider Regional Veteran’s Services Collaborative Districts as a model
- Evaluate the Commission’s ability to get buy-in from municipal officials.
- Evaluate average services provided in public health in Massachusetts (document the state/local agencies responsible for delivering each of the foundational public health services).
- Evaluate ways in which municipal officials can retain their local board of health powers during transition.

7. Determine the commonwealth’s progress towards achieving recommendations made by the Massachusetts regionalization advisory commission pursuant to chapter 60 of the acts of 2009

Massachusetts Regionalization Advisory Commission. Chapter 60 of the Massachusetts General Laws of 2009 created a Regionalization Advisory Commission chaired by then Lieutenant Governor Timothy Murray. The Commission reviewed possible opportunities, benefits, and challenges of regionalizing services within the Commonwealth by focusing on a number of specific local services areas including public health. The Regionalization Advisory Commission Report included examples of successful collaborations as well as an analysis of the status of regionalization in Massachusetts and how other states are addressing regionalization. The report also includes a set of recommendations that, individually or collectively, will help municipalities move closer to sharing services with neighboring communities. The Commission report¹⁸, issued in 2010, included several recommendations intended to facilitate regionalization of public health services. Those recommendations and progress to date in implementing them are provided here:

Further amend M.G.L. c.111 s.27B to remove the requirement that a town meeting must vote to approve formation of a public health district. (This will streamline district formation and

retain appropriate roles for municipal leaders and Boards of Health currently included in statute.)

M.G.L. c.111 s.27B was amended effective November 7, 2016 to remove the town meeting approval requirement for district formation (see 2016, 218, Sec. 213) and appointments to a regional board of health (see 2016, 218, Sec. 214).

Begin state funding to promote formation of public health districts by providing pilot funding for six districts, in accordance with the provisions of M.G.L. c.111 s.27A-C.

With funding from the U.S. Centers for Disease Control and Prevention through the National Public Health Performance Improvement Initiative, DPH supported planning grants for eleven and implementation grants for five public health districts. The five districts in the Public Health District Incentive Grant (PHDIG) program encompassed 58 communities and a total population of approximately 808,000.

Implement lessons from the pilot program in order to take a regional public health system “to scale” in Massachusetts by providing sustained state funding for district start-ups and operations.

The final report on the PHDIG program (including an analysis of the lessons learned) will be an important part of discussions by the Structure Subcommittee and Commission. Sustained state funding for district start-ups and operations will depend on recommendations of the Commission.

Seek opportunities to use state contracts and other revenue sources to promote increased regionalization of local public health.

DPH provides funding to municipalities for emergency preparedness, tobacco control, wellness, and substance misuse prevention. In many cases, these programs employ a regional model that includes local public health and other community partners.

Community Compact Cabinet. Governor Baker launched an initiative to support regionalization at the start of his administration. The Community Compact Cabinet promotes enhanced partnership between state government and municipalities and allows the Governor’s Office to work more closely with leaders from all

municipalities. The Community Compact Cabinet supports specific regional initiatives through the Efficiency & Regionalization grant program. The purpose of this competitive grant program is to provide financial support for governmental entities interested in implementing regionalization and other efficiency initiatives that allow for long-term sustainability. These grants provide funds for one-time or transition costs for municipalities, regional school districts, school districts considering forming a regional school district or regionalizing services, regional planning agencies and councils of governments interested in such projects.

Public health initiatives funded through the program since its inception include a shared services agreement among Chelsea, Winthrop, and Revere; a mosquito control district in western Massachusetts for eleven towns; and a shared public health nurse among Avon, Holbrook, and Randolph.

Establish an Office of Local Health within the Department of Public Health, with adequate staffing to provide technical assistance to promote and support public health regionalization.

DPH established the Office of Local and Regional Health in October 2013. The office includes staff with assignments that support local public health capacity building including cross-jurisdictional sharing and workforce development.

Establish minimum workforce qualifications for the local health workforce through legislation and regulation, including appropriate “grandfathering” provisions. (Municipalities are more likely to form districts in order to share the costs of better qualified staff.)

The Workforce Credentials Subcommittee of the Massachusetts Public Health Regionalization Working Group developed recommendations for the local public health workforce with particular attention to staff employed in public health districts. Those recommendations are informing the work of the Workforce Credentials Subcommittee of the Commission in addressing the issues associated with this recommendation.

Establish minimum performance standards for Boards of Health, linked to state funding for operating capacity required to meet statutory and regulatory responsibilities.

This recommendation has not been addressed.

Plans for Stakeholder Engagement and Public Input

The Commission will provide two opportunities for stakeholder engagement and public input: 1) listening sessions in response to this Commission status report and 2) public hearings in response to draft recommendations as outlined in the reporting requirements of the legislation that created the Commission (see “Commission Final Report” below).

- **Listening sessions.** The Commission has planned stakeholder listening sessions to obtain feedback, comments, and suggestions in response to the Commission Status Report and other matters of concern to local public health stakeholders and customers. The listening sessions will be held in each region of the state. They are intended to communicate transparency and inclusiveness in the work of the Commission and to ensure that Commission members are aware of local readiness for and barriers to local public health system change.

The schedule of listening sessions is provided in Appendix D. In addition to comments received at the listening sessions, written comments will also be accepted.

- **Public hearings.** Informed by input from the stakeholder listening sessions and additional deliberations among its members, the Commission will prepare draft recommendations for public comment. Details about the public hearing process will be available when draft recommendations are approved by the Commission for public comment.

Commission Final Report

The Commission is charged with preparing and submitting a report to the Governor, the Joint Committee on Public Health and the House and Senate Committees on Ways and Means. That report is expected to include the following elements:

- Review of local public health organization and financing in other states, and
- Review of the strengths and weaknesses of the local public health system as it currently exists in the Commonwealth, with particular emphasis on capacity, functionality, and efficiency.

Recommendations

- Organizational and fiscal models that would work to ensure capacity across municipalities.
- Sharing of resources across municipalities, including regionalization.

- Strengthen public health data reporting, gathering, and analysis, including any recommendations on mandatory reporting of local health authorities to the department.
- Resources needed to effectively meet statutory responsibilities at the state and local level.
- Strengthen the local public health workforce and ensure training of the next generation of local public health professionals, including leveraging academic partnerships.

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Appendices

- A. Chapter 3 of the Resolves of 2016
- B. Special Commission on Local and Regional Public Health (SCLRPH) Meetings List
- C. SCLRPH Subcommittee Members List and Descriptions
- D. Stakeholder Listening Sessions Schedule and Locations Details
- E. Workforce Credentials Subcommittee: Draft Education, Training, and Credentialing Recommendations (April 23, 2018)
- F. Glossary of terms
- G. Acronyms

Appendix A

RESOLVE ESTABLISHING THE SPECIAL COMMISSION ON LOCAL AND REGIONAL PUBLIC HEALTH

Resolved, that there shall be a special commission on local and regional public health 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 commission shall consist of the following persons, or their designees: the secretary of administration and finance; the commissioner of public health, who shall serve as chair; the commissioner of environmental protection; the commissioner of agricultural resources; 2 members of the house of representatives, 1 of whom shall be appointed by the speaker of the house and 1 of whom shall be appointed by the house minority leader; 2 members of senate, 1 of whom shall be appointed by the senate president and 1 of whom shall be appointed by the senate minority leader; a representative of the Massachusetts Municipal Association; a representative of the Massachusetts Taxpayers Foundation; a representative of the Massachusetts Public Health Association; a representative of the Massachusetts Health Officers Association; a representative of the Massachusetts Association of Health Boards; a representative of the Massachusetts Environmental Health Association; a representative of the Massachusetts Association of Public Health Nurses; a representative of the Western Massachusetts Public Health Association; a representative of the Massachusetts Public Health Regionalization Project working group at Boston University School of Public Health; and 8 persons to be appointed by the governor, 1 of whom shall be a representative of a research or academic institution with experience in public health data collection and analysis; 1 of whom shall be a representative of a community health center; 1 of whom shall be a representative of a hospital system; 1 of whom shall have expertise in public health workforce development; 1 of whom shall be a public health representative of a municipality with a population greater than 50,000; 1 of whom shall be a public health representative of a municipality with a population between 5,000 and 50,000; and 1 of whom shall be a public health representative of a regional service model that includes at least 1 town with a population of less than 5,000.

The commission shall: (i) examine the capacity of local and regional public health authorities in comparison to national public health standards and recommendations from the Centers for Disease Control and Prevention, the Public Health Accreditation Board, the National Association of County and City Health Officials, the National Association of Local Boards of Health, the Association of State and Territorial Health Officials and other relevant organizations; (ii) assess the capacity of local public health authorities to carry out their statutory powers and duties; (iii) evaluate existing municipal and state resources for local health and assess per capita funding levels within municipalities for local health; (iv) evaluate the workforce credentials of the current and future public health workforce as to educational standards, credentialing and training; (v) assess the current capacity of the office of local and regional health within the department of public health; (vi) evaluate existing regional collaboration and various models of service delivery across the commonwealth, including stand-alone, shared service and fully comprehensive regional districts; and (vii) determine the commonwealth's progress towards

achieving recommendations made by the Massachusetts regionalization advisory commission pursuant to chapter 60 of the acts of 2009.

The commission may solicit public input through public hearings and testimony.

The commission shall prepare and submit to the governor, the joint committee on public health and the house and senate committee on ways and means a report that includes: (i) a summary of the commission's findings; (ii) a review of local public health organization and financing in other states; (iii) a review of the strengths and weaknesses of the local public health system as it currently exists in the commonwealth, with particular emphasis on capacity, functionality and efficiency; (iv) recommendations on organizational and fiscal models that would work to ensure capacity across municipalities; (v) recommendations on the sharing of resources across municipalities, including regionalization; (vi) recommendations to strengthen public health data reporting, gathering and analysis, including any recommendations on mandatory reporting of local health authorities to the department; (vii) recommendations on resources needed to effectively meet statutory responsibilities at the state and local level; and (viii) recommendations to strengthen the local public health workforce and ensure training of the next generation of local public health professionals, including leveraging academic partnerships. The commission shall submit its final report by July 31, 2017.

Approved August 12, 2016.

Appendix B

Special Commission on Local and Regional Public Health
Year-to-Date and Planned Meetings
Updated – May 15, 2018

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)

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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 (Framingham)
Workforce Credentials Subcommittee	May 21, 2018 (Worcester)
Commission (to be confirmed)	July 27, 2018 (to be determined)

Meetings of the Special Commission on Local and Regional Public Health and its subcommittees are posted on the Massachusetts Department of Public Health Open Meeting Notices page

[Special Commission for Local and Regional Public Health Open Meeting Notices](#)

A compilation of agendas and approved minutes of the Special Commission on Local and Regional Public Health and its subcommittees is available

[Compilation of Agendas and Approved Minutes of the Special Commission on Local and Regional Public Health and its Subcommittees](#)

Appendix C

Special Commission on Local and Regional Public Health Subcommittee Membership and Descriptions (As of May 4, 2018)

Member	Data	Standards	Structure	Credentials	Finance	Total
Cameron, Sharon		X		X		2
Cox, Harold			X			1
Sean Cronin					X	1
Hyde, Justeen	X					1
Kane, Rep. Hannah			X			1
Kaniecki, Charlie			X	X		2
Khoury, Terri		X	X			2
Kittross, Laura		X		X		2
Lewis, Sen. Jason					X	1
Mancini, Carmela	X					1
McAnneny, Eileen					X	1
McCready, David	X					1
Mizikar, Kevin			X			1
O'Connor, Lorraine			X			1
Pelletier, Maria		X		X		2
Ross, Sen. Richard	Subcommittee membership to be determined					
Sbarra, Cheryl	X	X			X	3
Smith, Mark	X					1
Sullivan, Bernie			X			2
Ultrino, Rep. Steven					X	1
Walker, Phoebe	X	X				2
Ward, Steven		X		X		2
Wong, Sam					X	1
Municipality 5,000-50,000	Pending					
Total (quorum)	6 (4)	7 (4)	7 (4)	5 (3)	6 (4)	

X – Subcommittee chair/co-chair

Descriptions of Subcommittees

Data Subcommittee

Members: Justeen Hyde (Co-chair), Phoebe Walker (Co-chair), Cheryl Sbarra, Mark Smith, Carmela Mancini, David McCready

OLRH Staff: Shelly Yarnie

Relevant language from Commission charge

Entire Commission Charge

Tasks

- Review information about resources, staffing, credentials, and capacity to meet standards listed in the charge.
- Explore DPH and DEP data
- Consider a new data collection effort

Finance Subcommittee

Members: Sen. Jason Lewis, Rep. Steven Ultrino, Sean Cronin , Eileen McAnney, Cheryl Sbarra, Sam Wong [*Chair to be determined*]

OLRH Staff: Ron O'Connor

Relevant language from Commission charge

Evaluate existing municipal and state resources for local health and assess per capita funding levels within municipalities for local health.

Tasks

- Examine variation in current per capita spending across the state
- Explore funding models from other states without county taxation structure (CT, NJ?)
- Later: Evaluate costs of Commission's recommendations and explore sources of funding to meet them.

Structure Subcommittee

Members: Bernie Sullivan (Chair), Rep. Hannah Kane, Harold Cox, Kevin Mizikar, Charlie Kaniecki, Terri Khoury, Lorraine O'Connor
OLRH Staff: Michael Coughlin, Ron O'Connor

Relevant language from Commission charge

Evaluate existing regional collaboration and various models of service delivery across the commonwealth, including stand-alone, shared service and fully comprehensive regional districts.

Tasks

Compile a list of regional public health structures in Massachusetts and other states, including their governance systems, any evaluation data, and any details on funding systems and requirements.

Workforce Credentials Subcommittee

Members: Laura Kittross (Chair), Sharon Cameron, Charlie Kaniecki, Maria Pelletier, Steven Ward
OLRH Staff: Erica Piedade

Relevant language from Commission charge

Evaluate the workforce credentials of the current and future public health workforce as to educational standards, credentialing, and training.

Subcommittee Tasks

- Review existing credential requirements in Massachusetts and compare to requirements of other states
- Identify the systems in place in states with mandated credentials to manage their requirements
- Review data on current credentials of the local public health workforce (once it becomes available)
- Research process of changing mandated credentials in Massachusetts (Veterans Agent, Animal Control Officer, Building Commissioner, etc.)
- Prepare draft credential requirements for review by full Commission

Standards Subcommittee

Members: Cheryl Sbarra (Chair), Sharon Cameron, Terri Khoury, Laura Kittross, Maria Pelletier, Phoebe Walker, Steven Ward
OLRH Staff: Ron O'Connor

Relevant language from Commission charge

- Assess the capacity of local public health authorities to carry out their statutory powers and duties.
- Examine the capacity of local and regional public health authorities in comparison to national public health standards and recommendations.

Subcommittee Tasks

- 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 including U.S. Centers for Disease Control, National Association of County and City Health Officials, Public Health Accreditation Board, National Association of Local Boards of Health, Association of State and Territorial Health Officials, and American Public Health Association

Appendix D

**Special Commission on Local and Regional Public Health
Schedule of Listening Sessions
(Revised June 1, 2018)**

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

Franklin Regional Council of Governments
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
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
4 Precinct Street, Lakeville

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

Western Massachusetts Hospital
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 (PVTA), 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.

**Appendix E – Status Report – Special Commission on Local and Regional Public Health
Workforce Credentials Subcommittee
Draft Education, Training, and Credentialing Recommendations (April 23, 2018)**

POSITION	REQUIRED AT HIRE	REQUIRED AFTER HIRE	RECOMMENDED
MANAGEMENT – e.g., Director, Assistant Director, Deputy Director*	<ul style="list-style-type: none"> Registered Sanitarian (RS) Master’s degree in relevant field OR BA/BS degree with 5 years of experience and with 16 graduate credits in relevant field 	<ul style="list-style-type: none"> Foundations for Local Public Health Practice (“Foundations”) course within one year of hire Certified Health Officer (CHO) within 3 years of hire; Complete master’s degree within 2 years 	<ul style="list-style-type: none"> Health association membership Local Public Health Institute (LPHI) Managing Effectively in Today’s Public Health Environment (“Management”) course Three years of experience in local or state public health Massachusetts Virtual Epidemiologic Network (MAVEN) training within 1 year
MANAGEMENT/AGENT	<ul style="list-style-type: none"> Registered Sanitarian or Registered Sanitarian eligible 	<ul style="list-style-type: none"> Foundations course within 18 months RS within 18 months of hire Specific certifications for inspections performed, such as soil evaluator, system inspector, food inspector training, housing inspection training, certified pool operator/certified pool inspector, lead determinator within one year of hire 	<ul style="list-style-type: none"> Health association membership LPHI Management Course CHO within 3 years of hire
INSPECTOR/SANITARIAN	<ul style="list-style-type: none"> High School Diploma 	<ul style="list-style-type: none"> RS within 6 years of hire Foundations course within 18 months Specific certifications for inspections performed, such as soil evaluator, system inspector, food inspector training, housing inspection training, certified pool operator/certified pool inspector, lead determinator within 1 year of hire 	<ul style="list-style-type: none"> Health association membership Associate’s degree in science or public health at hire.

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POSITION	REQUIRED AT HIRE	REQUIRED AFTER HIRE	RECOMMENDED
CLERICAL STAFF	<ul style="list-style-type: none"> • Microsoft Office (or similar) applications 	<ul style="list-style-type: none"> • Modified Foundations course (Foundations course for Clerical Workers) within one year of hire 	<ul style="list-style-type: none"> • On-line permitting
PUBLIC HEALTH NURSE	<ul style="list-style-type: none"> • Bachelor of Science in Nursing degree (BSN) • Registered Nurse (RN), current MA license 	<ul style="list-style-type: none"> • MAVEN trained within 6 months • Foundations course within one year of hire 	<ul style="list-style-type: none"> • MAPHN Membership
BOH MEMBER (NOTE: IF DOING INSPECTIONS MUST MEET REQUIREMENTS ABOVE)			<ul style="list-style-type: none"> • Orientation to Public Health within 3 months • Foundations course within one year

INSPECTION TYPE	REQUIRED	RECOMMENDED
FOOD PROTECTION	<ul style="list-style-type: none"> • ServeSafe or similar • Massachusetts Public Health Inspector Training (MA PHIT) Food Inspection Class 	<ul style="list-style-type: none"> • Food and Drug Administration • Oak Ridge Associated Universities
HOUSING	<ul style="list-style-type: none"> • MA PHIT Housing Class • Housing Court training (TBD) • Lead Determinator 	<ul style="list-style-type: none"> • Relevant LPHI Modules
TITLE 5	<ul style="list-style-type: none"> • Soil Evaluator • System Inspector • MA PHIT Wastewater 	<ul style="list-style-type: none"> • Relevant LPHI Modules
POOLS	<ul style="list-style-type: none"> • Certified Pool Operator or Certified Pool Inspector 	<ul style="list-style-type: none"> • Relevant LPHI Modules
CAMPS	<ul style="list-style-type: none"> • MA PHIT Camps (TBD) 	<ul style="list-style-type: none"> • Relevant LPHI Modules
TANNING/BODY ART	<ul style="list-style-type: none"> • MA PHIT (TBD) 	<ul style="list-style-type: none"> • Relevant LPHI Modules

- All personnel should have at least Incident Command System (ICS) 100/National Incident Management System (NIMS)700 within one year of hire. Those who might have a leadership role should have ICS 200 and above.
- Municipalities may have stricter requirements, but must meet these requirements.
- Municipalities with current staff who have worked for local or state public health for at least 10 years, but who do not meet these requirements, may request a waiver of the Registered Sanitarian or Certified Health Officer requirement.

*Management position is defined as someone who does not do inspections but supervises those who do.

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Appendix F

Status Report Glossary

Board of Health. “A board of health is a legally designated governing entity whose members are appointed or elected to provide advisory functions and/or governing oversight of public health activities, including assessment, assurance, and policy development, for the protection and promotion of health in their community.”

Source: *National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms, CDC, 2007.* [US Centers for Disease Control Glossary and Reference Terms](#)

Centralized/Decentralized Governance Structure. “A centralized health department is defined, for the purposes of PHAB accreditation, as a state public health organizational structure that operates all or most of the local health departments. Centralized health departments have a central office that provides administrative, policy, managerial direction, and support. The local health departments in centralized states are organizationally a part of the state health department. Employees are state employees, except for those in independent local public health departments, usually in one or more major city or county in the state. Where the state or territorial health department operates local and/or regional health department(s), a single local or regional applicant or a number of individual applicants may choose to apply together. Compliance with local-level standards must be demonstrated for each local and/or regional unit.”

Source: *Public Health Accreditation Board. Guide to National Public Health Department Accreditation Version 1.0. Alexandria, VA, May 2011*

In a decentralized governance structure, “local health units are primarily led by employees of local governments and the local governments retain authority over most fiscal decisions.”

Source: <http://www.astho.org/Research/Data-and-Analysis/State-and-Local-Governance-Classification-Tree/>

Cross-Jurisdictional Sharing. “Cross-jurisdictional sharing is ‘the deliberate exercise of public authority to enable collaboration across jurisdictional boundaries to deliver essential public health services’ (Center for Sharing Public Health Services, 2013). Cross-jurisdictional sharing can range from supporting informal arrangements to more formal changes in structure. In public health, cross-jurisdictional sharing often occurs between health departments or agencies serving two or more jurisdictions. Collaboration allows communities to solve issues or problems that cannot be easily solved by a single organization or jurisdiction.

Examples of cross-jurisdictional sharing include

- Regionalization of health departments, such as through the consolidation of two or more health departments
- Sharing staff between two or more health departments, such as an epidemiologist or sanitarian that supports multiple health department jurisdictions
- Sharing defined services, such as laboratory testing services or inspection services

- Collaborative assessment and planning processes that include two or more health departments and leads to shared priorities; examples might include regional preparedness plans, cross-border plans, or community health improvement plans”

Source: *Center for Sharing Public Health Services, 2013 and <https://www.cdc.gov/stltpublichealth/cjs/index.html>*

Essential Public Health Services. “The Essential Public Health Services are the ten services identified in Public Health in America developed by representatives from federal agencies and national organizations to describe what public health seeks to accomplish and how it will carry out its basic responsibilities. The list of ten services defines the practice of public health:

1. Monitor health status to identify and solve community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships and action to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure competent public and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

Sources: [Office of Disease Prevention and Health Promotion](#) and [CDC National Health Performance Standards](#).

Foundational Public Health Services. Foundational Public Health Services (FPHS) is a “conceptual framework describing the capacities and programs that state and local health departments should be able to provide to all communities and for which costs can be estimated. Additionally, health departments should have the capacity for additional important programs and activities specific to the needs of their individual communities. As such, the FPHS model-consists of the following components:

- **Foundational Capabilities:** cross-cutting skills needed in state/local health departments to support all activities (e.g., human resources, communications)
- **Foundational Areas:** substantive areas of expertise or program-specific activities in all state/local health departments necessary to protect the community’s health (e.g., communicable disease control.”

Source: *Public Health National Center for Innovations. Foundational Public Health Services. 2016; [Foundational Public Health Services](#)*

Inter-municipal Agreement. “An agreement with another governmental unit to perform jointly or for that unit's services, activities or undertakings which any of the contracting units is authorized by law to perform.”

Source: *M.G.L. c.40, S.4A*

Mandated Public Health Services. “Mandated public health services are required by statute, rule/regulation, ordinance or other similar legally binding process.”

Source: *(Public Health Accreditation Board. Standards and Measures Version 1.0. Alexandria, VA. May 2011)*

National Association of County and City Health Officials. “The National Association of County and City Health Officials (NACCHO) was founded in the 1960's. Since its inception, NACCHO has sought to improve the public's health while adhering to a set of core values: equity, excellence, participation, respect, integrity, leadership, science & innovation. Today, NACCHO comprises nearly 3,000 local health departments across the United States. Together, they form an organization focused on being a leader, partner, catalyst, and voice for change for local health departments around the nation.”

Source: <https://www.naccho.org/about>

Public Health Accreditation. “Accreditation for public health departments is defined as:

1. The development and acceptance of a set of national public health department accreditation standards;
2. The development and acceptance of a standardized process to measure health department performance against those standards;
3. The periodic issuance of recognition for health departments that meet a specified set of national accreditation standards; and
4. The periodic review, refining, and updating of the national public health department accreditation standards and the process for measuring and awarding accreditation recognition.

Source: *Public Health Accreditation Board. Guide to National Public Health Department Accreditation Version 1.0. Alexandria, VA. May 2011)*

Public Health Accreditation Board. “The Public Health Accreditation Board (PHAB) is the national accrediting organization for public health departments. A nonprofit organization, PHAB is dedicated to advancing the continuous quality improvement of Tribal, state, local, and territorial public health departments. PHAB is working to promote and protect the health of the public by advancing the quality and performance of all public health departments in the United States through national public health department accreditation.”

Source: *Public Health Accreditation Board. Guide to National Public Health Department Accreditation Version 1.0. Alexandria, VA, May 2011*

Public Health Regionalization. Regionalization is a consortium of local health departments collaborating under a formal agreement to provide a specific set of services. Goal of public health regionalization is to strengthen the public health system by creating a sustainable, regional system for equitable delivery of local public health services across a region. Regionalizing promotes consistent standard of care and equal level of services. Regionalization can equip each local health department to deliver the range of services their specific community requires. Regionalization also allows communities to access the skills they need, when they need them (even if those skills are not resident within their own health department). Regionalization has been shown to offer economies of scale for communities who band together. Local jurisdictions can choose from different models to ensure the best fit for their unique circumstances. Larger districts have greater capacity to apply for grants and are more competitive in grant applications, potentially bringing additional resources to their communities. Sharing resources, greater cooperation and communication, and more standardized training, will yield a stronger and better prepared local public health workforce.

Source: [Boston University Massachusetts Public Health Regionalization Project](#)

Appendix G

Special Commission on Local and Regional Public Health

Status Report Acronyms (under development)

BOHBoard of health

CDC.....U.S. Centers for Disease Control and Prevention

CJSCross-Jurisdictional Sharing

DPHMassachusetts Department of Public Health

FPHSFoundational Public Health Services

PHABPublic Health Accreditation Board

SCLRPHSpecial Commission on Local and Regional Public Health