

Draft Recommendations of the
Public Health Regionalization Working
Group

January 18, 2006



Public Health
Prevent. Promote. Protect.

Co-Chairs Harold Cox, Boston University, School of Public Health
Judith Kurland, Office of Mayor Tom Menino

Members Kathy Atkinson, Massachusetts Dept of Public Health
Kerry Dunnell, Cambridge Health Alliance
John Grieb, Cambridge Health Alliance
Jennifer Infurna, Office of Representative Peter Koutoujian
David Johnson, Office of Senator Susan Fargo
Richard Lehan, Massachusetts Dept. of Environmental Protection
Cheryl Sbarra, Massachusetts Association of Health Boards
Frank Singleton, Lowell Health Department
Phoebe Walker, Franklin Regional Council of Governments
Geoff Wilkinson, Massachusetts Public Health Association

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Executive Summary

Massachusetts is one of the few states in the nation that has no county or regional public health system, and no direct state funding for local boards of health and health departments. Instead, there are 351 local public health agencies statewide, each responsible for providing (or assuring access to) an identical set of services, whether it be for Boston (pop. 600,000) or a town such as Monroe in Franklin County that has approximately 100 inhabitants.¹

While larger municipalities are able to meet most, if not all their responsibilities, smaller communities are forced to perform public health triage, providing only those services deemed most essential or that engender the greatest sense of urgency. The obvious result is that some communities are better protected than others.

A recent survey of local public health officials by the Massachusetts Coalition for Local Public Health found that:

- Many local public health departments in Massachusetts are stretched too thin to meet growing demands in the wake of the September 11 terrorist attacks.
- More than 70% of local health officials in Massachusetts report they do not have enough staff to consistently fulfill their responsibilities to the public.
- Local public health budgets in Massachusetts are not keeping pace with inflation.
- There is a striking disparity in public health resources available to smaller communities versus larger ones and to communities in western Massachusetts versus those in eastern Massachusetts.

Over the past couple of decades, there has been an erosion of funding for state programs that support local public health, including cuts to public health nursing, the state laboratory, adult immunization programs, and school health services. In addition, both the state Office for Local Health and most regional health agent positions have been eliminated. Meanwhile, local boards of health and health departments still have to compete annually with the local school, fire, police, and other municipal departments for limited municipal resources.

In recent years, new state and local responsibilities have emerged—typically without funding—that include a doubling of septic system inspection requirements to dramatic increases in demand for food establishment and housing inspectional services. Since 9/11, concerns about bioterrorism and emerging diseases such as avian flu and SARS, have transformed local public health responsibilities from what had been merely a series of challenges to a set of responsibilities that have become entirely overwhelming.

¹ 2000 Census

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Massachusetts cities and towns have shown they can work together effectively to protect the health of their populations. Several networks of communities in the state have long-standing cooperative agreements to coordinate public health services.

Local health officials have been creative in working together to address unexpected crises, such as West Nile virus, outbreaks of hepatitis A, and the anthrax scares, that knew no municipal boundaries. The state's tobacco control program has demonstrated effective cooperation among multiple communities.

In addition, the state established a system of federally funded regional and subregional coalitions in 2002 to coordinate planning and preparation for public health emergencies. This system has shown promising results, and it is clear to many local health officials that some of the gains that have been made in the area of emergency preparedness can largely be attributed to the development of these coalitions.

Research into the practices of other states supports the lessons of our limited experience with cooperation among cities and towns in Massachusetts: *public health regions work*, just as they do for a variety of other public sector responsibilities ranging from transportation to public safety to libraries. A regional approach allows municipalities to share costs, to benefit from economies of scale, and to coordinate planning to improve health outcomes.

This report arises out of the experience of public health officials and advocates in Massachusetts who have grown increasingly frustrated in trying to meet an increased demand for public health services without adequate resources. The Public Health Regionalization Working Group is concerned that:

- Nearly one fifth of the public health workforce in Massachusetts will be eligible to retire in the next two years.
- Health inspectors and public health nurses are already in short supply.
- Educational requirements and salaries for essential public health personnel vary dramatically among different cities and towns.
- Many elected and appointed local health officials have limited chances to participate in training opportunities.

The Working Group is convinced that the public health community must join together to *create and sustain a system of public health regions in Massachusetts*. This system would allow for a comprehensive array of services to be delivered to residents, and would maintain the existing strong links between local public health agencies and the Massachusetts Department of Public Health.

The Working Group believes that it is both possible and necessary to protect home rule in developing a regional public health system for Massachusetts. Individual municipal boards of health need not surrender regulatory authority under a regional system. In addition, the Working Group recognizes:

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- One size does not fit all when developing public health regions. For instance, various constellations of communities in Massachusetts could choose different structural models for regionalizing public health services depending on local factors like population density and budgetary constraints.
- The need to respect, support and accommodate existing arrangements for delivering regional public health services.
- Additional state funding can and should be distributed through a fair formula that requires local matching.

This report offers findings from national research and recommendations developed in cooperation with local public health officials from around the state. It is intended to foster discussion, generate ideas, and provide the foundation for crafting legislation to strengthen the public health infrastructure in Massachusetts.

The Working Group expects to refine its recommendations following a series of regional meetings with local public health officials during winter 2007.

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Introduction

Massachusetts has a long and proud tradition of public health. In 1799, Paul Revere established the nation's first public health board in Boston. Since then, each city and town in the Commonwealth has taken responsibility for the provision of public health services to its citizens. While this decentralized approach may have been appropriate during colonial times and even for decades afterwards, it is not an ideal model for delivering local public health services in the 21st century.

Today in Massachusetts, local public health services are currently delivered through a triad of providers: local public health agencies, the Massachusetts Department of Public Health, and private contractors.

Massachusetts is one of the few states in the nation that has no county or regional public health system, and no direct state funding for local boards of health and health departments. Instead, there are 351 local public health agencies statewide, each responsible for providing (or assuring access to) an identical set of services, whether it be for Boston (pop. 600,000) or a town such as Monroe in Franklin County that has approximately 100 inhabitants.²

While larger municipalities are able to meet most, if not all their responsibilities, smaller communities are forced to perform public health triage, providing only those services deemed most essential or that engender the greatest sense of urgency. The obvious result is that some communities are better protected than others.

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- Local public health budgets in Massachusetts are not keeping pace with inflation.
- There is a striking disparity in public health resources available to smaller communities versus larger ones and to communities in western Massachusetts versus those in eastern Massachusetts.

In addition:

- Nearly one fifth of the public health workforce in Massachusetts will be eligible to retire in the next two years.
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² 2000 Census

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- Educational requirements and salaries for essential public health personnel vary dramatically among different cities and towns.
- Many elected and appointed local health officials have limited opportunities to receive formal public health training that would provide them with the skills to make informed decisions about complex local health issues.

This report arises out of the experience of public health officials and advocates in Massachusetts who have grown increasingly frustrated in trying to meet an increased demand for public health services without adequate resources. The Public Health Regionalization Working Group is convinced that the public health community must join together to *create and sustain a system of public health regions in Massachusetts*. This system would allow for a comprehensive array of services to be delivered to residents, and could strengthen the links between local public health agencies and the Massachusetts Department of Public Health.

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Regionalization: **Why Do It?**

This report defines “public health regionalization” as two or more communities pooling their resources to provide public health services.

In an age of increasing public health demands due to a mobile population, health disparities, environmental threats, and the emergence of new and evolving communicable diseases, it is increasingly important to make effective use of limited public resources.

Research into the practices of other states supports the lessons of our limited experience with cooperation among cities and towns in Massachusetts: *public health regions work*, just as they do for a variety of other public sector responsibilities ranging from transportation to public safety to libraries. A regional approach allows municipalities to share costs, to benefit from economies of scale, and to coordinate planning to improve health outcomes.

A convincing argument has emerged for pooling the resources of multiple towns (either through districting or another mechanism) to provide state and local municipalities with the means to deliver public health services more efficiently and effectively. This idea is based on an extensive review of the literature and discussions with public health professionals around the country.

Many states outside New England rely on county government for organizing regional public health activities. The benefit of county government is that it brings an existing formal structure, a steady revenue stream, and a degree of flexibility and resources.

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Other states have created regions independent of county government in which municipalities have joined together for service-specific activities (i.e., tobacco control, emergency preparedness) or to provide a full array of public health services. A third trend has emerged whereby counties have begun to join together and regionalize their services. This has occurred in some states in which counties are sparsely populated but cover considerable square miles.

From a financial standpoint, regional public health systems are advantageous because they spread the fixed costs of public health infrastructure over larger populations of beneficiaries and taxpayers.³ These systems realize economies of scale in delivering services such as health education and communicable disease surveillance. In Massachusetts, many of these services are currently provided in limited scope or not at all at the local level because of insufficient staffing and funding.

A regional system would also provide infrastructure for streamlining inspections of restaurants, buildings, summer camps, tattoo establishments, septic tanks, landfills, and other entities.

Regionalization: **Why Now?**

The need to strengthen the Commonwealth's public health infrastructure is not a new problem.

Over the past couple of decades, there has been an erosion of funding for state programs that support local public health, including cuts to public health nursing, the state laboratory, adult immunization programs, and school health services. In addition, the state Office for Local Public Health and most regional health agent positions (funded through MDPH) were eliminated in 1989.

Meanwhile, local boards of health and health departments in Massachusetts still have to compete annually with the local school, fire, police, and other municipal departments for limited municipal resources.

The typical local public health agency in Massachusetts has a staggering list of responsibilities that include, but are not limited to:

- Investigating and controlling outbreaks of infectious disease within the community.
- Insuring drinking water is potable and that sanitary conditions are maintained in restaurants.
- Investigating and responding to all complaints of unsafe housing, and conducting court enforcement of the housing code if needed to address public safety.

³ Glen P. Mays, PhD, MPH et al "Institutional and Economic Determinants of Public Health System Performance" March 2006, Vol. 96, No. 3, American Journal of Public Health, p. 529.

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- Inspecting ice rinks, tattoo parlors, swimming pools, summer camps, schools, and other establishments that could possibly impact a community's health.
- Developing and implementing health promotion programs related to nutrition, tobacco, exercise, alcohol, and other behaviors that affect health status.
- Reviewing all plans for new and repaired septic systems and personally overseeing all installations.

In recent years, new state and local responsibilities have emerged—typically without funding—that include a doubling of septic system inspection requirements to dramatic increases in demand for food establishment and housing inspectional services. Since 9/11, concerns about bioterrorism and emerging diseases such as avian flu and SARS, have transformed local public health responsibilities from what had been merely a series of challenges to a set of responsibilities that have become entirely overwhelming.

Small public health agencies in the Commonwealth are now in an extremely vulnerable position in which it seems almost certain that something important will fall through the cracks, as this anecdote illustrates:

The Massachusetts Department of Public Health sent a communicable disease report to a board of health in a small town in western Massachusetts. The board had no staff paid to complete infectious disease. The board's chair checked the BOH post office box every few weeks. When she picked up the form, it turned out to be intended for a neighboring town of fewer than 300 citizens that shared the same zip code. The BOH chair sent the report to the neighboring town. By the time the report reached the appropriate town and an investigation initiated, the infected person had died and everyone who could have been protected by a timely infectious disease investigation had been exposed.

Regionalization: **Would it work in Massachusetts?**

Massachusetts cities and towns have shown they can work together effectively to protect the health of their populations. Several networks of communities in the state have long-standing cooperative agreements to coordinate public health services.

Local public health officials have been creative in working together to address unexpected crises, such as West Nile virus, outbreaks of hepatitis A, and the anthrax scares, that knew no municipal boundaries. The state's tobacco control program has demonstrated effective cooperation among multiple communities.

In addition, the state established a system of federally funded regional and subregional coalitions in 2002 to coordinate planning and preparation for public health emergencies. This system has shown promising results, and it is clear to many local health officials that some of the gains that have been made in the area of emergency preparedness can largely be attributed to the development of these coalitions.

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The Working Group is confident that regionalization can succeed if stakeholders are willing to work together to create a system that works for Massachusetts.

Regionalization: **What would it look like in Massachusetts?**

The journey to regionalizing public health services in Massachusetts begins with thinking about how regional entities would be structured, staffed, and funded.

Municipalities themselves would determine the scope and framework of the proposed regional public health delivery system. The Working Group firmly believes that it is both possible and necessary to protect home rule in developing a regional public health system for Massachusetts. Individual municipal boards of health need not surrender regulatory authority under a regional system.

In addition, **one size does not fit all** when developing public health regions. For instance, various constellations of communities in Massachusetts could choose different structural models for regionalizing public health services depending on local factors like population density and budgetary constraints.

The Working Group also recognizes the need to **respect, support and accommodate existing arrangements for delivering regional public health services**. A number of intermunicipal public health initiatives already exist in the Commonwealth, including in Barnstable County, Nashoba, the Franklin Regional Council of Governments, and the small health districts of Tri-Town, Foothills, Quabbin, and Eastern Franklin. It is essential to support and, where possible, build upon these structures.

In addition, a regional system could strengthen the links between local public health agencies and the Massachusetts Department of Public Health.

Finally, the Working Group feels strongly that **historical relationships must be respected**. Over time, cities and towns have established formal and informal working relationships with neighboring municipalities. In forming public health regions it will be important to respect these existing relationships and allow communities to choose their set of partners.

The following sections discuss some of the issues involved in establishing a regional public health system, including fundamental responsibilities, region size, organization and structure, governance, funding, and accreditation and credentialing. Legal and legislative issues are discussed in *Appendix 2*.

Fundamental Responsibilities

The Working Group believes that each region should be able to provide comprehensive public health services to the people it serves. In 2005, the National Association of County and City Health Officials (NACCHO) developed an “Operational Definition of a Functional Local Public Health Department” that outlines ten fundamental

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responsibilities of local public health departments. These responsibilities (often referred to as the “ten essential services of public health”) were developed within nationally recognized frameworks and with input from public health professionals and elected officials from across the country. They are:

1. Monitor health status to identify community health problems
2. Diagnose and investigate identified health problems and health hazards in the community
3. Inform, educate and empower people about health issues
4. Mobilize community partnerships 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 a competent public health and personal health care workforce
9. Assess effectiveness, accessibility and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

Region Size

Population density is a key element in determining the size of any given public health region.⁴ For instance, in an urban setting, having a region with a population of 500,000 is reasonable. In a rural setting, however, the geographic footprint needed to achieve that population size and the large number of individual municipalities present a set of challenges that argues for a smaller population base.

In reviewing national statistics, a regional public health department generally provides services to approximately 90,000 people and covers a geographic area of some 1,260 square miles. In contrast, local public health departments in Massachusetts typically provide services to an average of 18,000 people and cover an average area of just 31 square miles. This is inefficient from the standpoint of service delivery and economics.

⁴ Glen P. Mays, PhD, MPH et al “Institutional and Economic Determinants of Public Health System Performance” March 2006, Vol. 96, No. 3 American Journal of Public Health, p. 529.

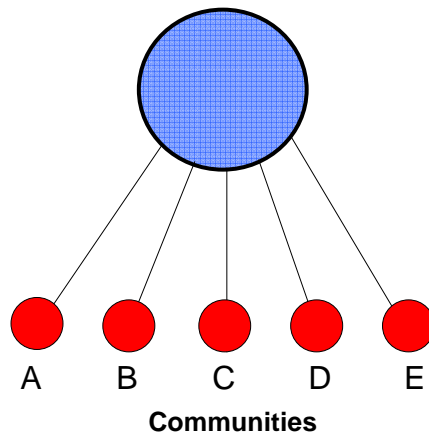
Organizational Models

Various communities will adopt different structures based on factors such as population density, type of community (e.g., rural, urban, suburban), and current ability to provide services. Here are four types of organizational models available to communities.

- A. **Comprehensive Services Model:** A comprehensive model is one in which a large number of municipalities join together to create a centralized agency that is responsible for providing a full complement of public health services. Such a model would be especially helpful in rural locations where no single town has the infrastructure to provide the proper array of public health services.

Comprehensive Services Model

Regional Public Health Agency

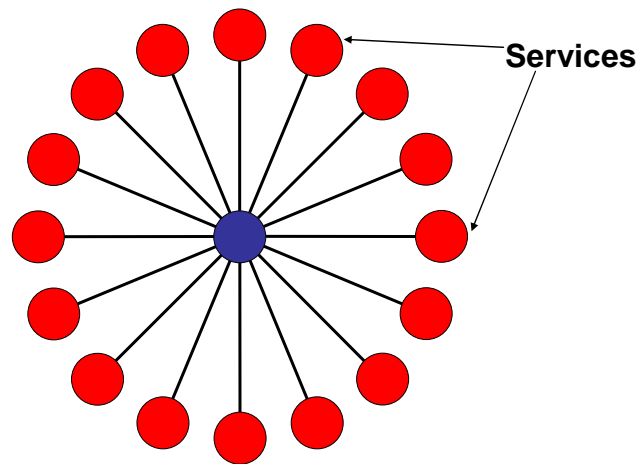


Discussion

1. The regional public health agency provides services to multiple small communities.
2. This model is inherently complex as it will require collaborative decision-making among multiple independent jurisdictions. Governance structure to ensure that no town is disempowered is needed.
3. Financial assessments will be required of each community. A system will be needed that is fair to each municipality.

B. Stand-Alone Model: While smaller towns will need to form alliances to meet the challenges of providing the ten essential services of public health, there are a few larger communities (e.g., Boston, Worcester, Springfield) that may find it advantageous to operate as a single-municipality district.

Stand Alone Model



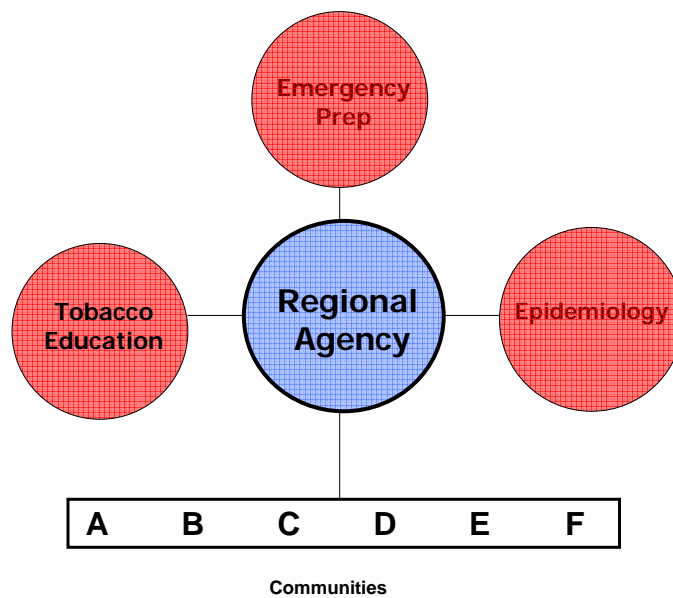
Discussion:

1. This model is most suitable for larger communities.
2. It is inherently simple because only one community is involved.

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C. Limited Services Model: Some regions will determine that a comprehensive model is not necessary and will elect to develop a model in which a limited number of core services are provided regionally. This was the case with the establishment of the emergency preparedness regions, which were created for the sole purpose of responding to the challenges of emergency preparedness. Such an arrangement would be most beneficial to larger suburban towns that have well-developed, professionally run public health departments.

Limited Services Model

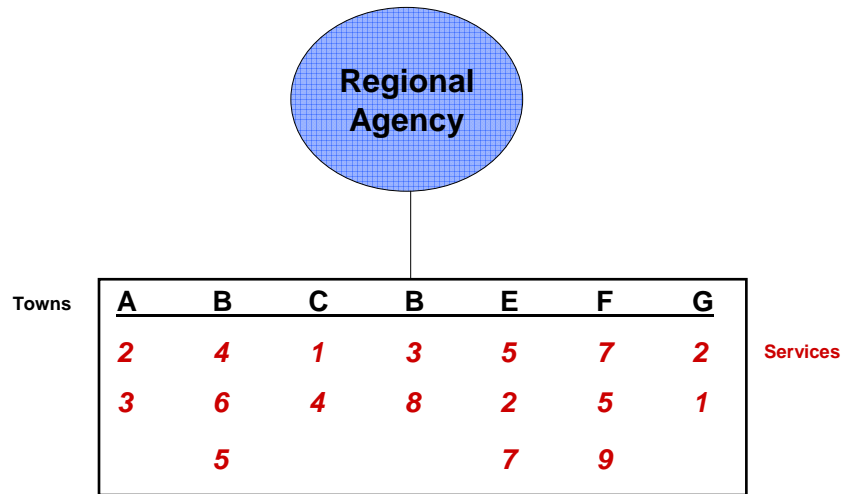


Discussion

1. Regions can tailor their common initiatives around their particular needs.
2. There is a danger that some services would fall through the cracks.
3. This model leaves open the possibility that some communities will continue to have disparities of public health protection by not requiring all towns to provide the same services through their regional entities.

D. Cafeteria Service Structure: In many regions, there is a diversity of competencies such that not all towns would require the same level of support. It may become necessary for a central agency to provide a wide range of services that each participating municipality would contract for, dependent on individual need.

Cafeteria Service Provision



Discussion:

1. Provides a great degree of flexibility for participating communities.
2. Is expensive in that the central agency is responsible for providing services that may or may not be used by a large number of participants.
3. Uneven usage makes coherent governance by participating communities difficult.
4. Difficult to ascertain how to direct state funds when each town is doing something slightly different.

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Governance

As with any confederation, all participants must have a clear understanding of their roles and responsibilities. This is especially true in Massachusetts with its history of strong home rule.

If regionalization was to be embraced at the local level, it is essential that the underlying agreement provide municipal leaders with a clear understanding of how decisions would be made and assures them that they will continue to have an active role in determining the provision of local public health services.

Essentially, the regional agreement would be a contract between the central agency and the participating communities, as well as a document that provided a collective sense of purpose among the local public health agencies.

One critical task in developing a governance structure is assuring that power is properly apportioned between the operational agency and communities. It will also be important to develop mechanisms that would assure that all communities have an active and appropriate voice in decision-making.

Each group of participating communities will also need to develop a governance agreement that is tailored to its particular organizational model. See *Appendix 1* for a template of a governance agreement.

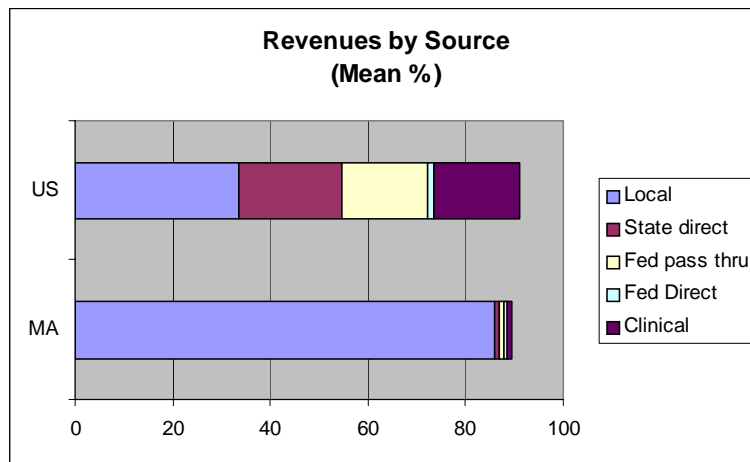
Funding

As Massachusetts explores the desirability of public health regionalization, funding will become a critical issue.

At present, the state's local public health agencies are underfunded and wholly dependent on a combination of local taxes, fees, and designated funding (e.g. emergency preparedness, tobacco control) from the state health department. The success of a regional public health system in Massachusetts would hinge on expanded state and local support.

Other states fund public health regions typically through a combination of local assessments, fee-based revenue, state funding, and federal grants. In Massachusetts, local public health is almost entirely dependent upon local support, with the state and federal governments playing a relatively modest role, as illustrated in the following graph from the National Association of County and City Health Officials (NACCHO).

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One of the biggest challenges in funding regional public health systems is determining how the limited dollars under consideration would be distributed. Most funding formulas rely on a straight per-capita allocation. This is the manner in which federal funding is typically distributed in Massachusetts (e.g., the CDC Cooperative Agreement for the state's emergency preparedness regions). Simple per-capita formulas are inherently fair in that they treat each entity in the same manner. Conversely, these formulas don't address unique qualities of individual municipalities, such as varying levels of need for services, community expectations for public health, and the availability of other funding streams.

A number of states have adopted a different approach to allocating funds that rewards communities for regionalizing their services. Connecticut, for instance, bases the amount of direct state support on the degree to which communities are regionalized. Connecticut's per capita rate of reimbursement for a functioning district is \$2.09. For large, stand-alone entities that are capable of providing the necessary services, the per-capita reimbursement drops to \$1.79 (e.g., Hartford or New Haven). Finally, the rate of reimbursement drops to a per-capita \$1.02 for towns that are stand-alone entities with no professional staff and inadequate services.

Public health professionals in other states have also identified socioeconomic and health status factors that should be part of a funding formula. Such factors include poverty rates, tobacco use, and teenage pregnancy. The challenge is to include those factors that will encourage change without discouraging communities that have and continue to provide an appropriate array of services with desired outcomes.

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Currently every city and town in the Commonwealth is responsible for funding local public health. There is some concern that, as more state funding is made available, communities will elect to decrease their level of support. Typically, funding schemes include provisions that match a town's existing level of financial support. This will provide a clear incentive for towns to maintain their current level of support.

The challenge is to develop a formula to achieve the goals of regionalization that considered fair by stakeholders. In recognition of the associated difficulties, many states have delegated the creation of a funding formula to a knowledgeable, but disinterested party. Frequently academics have been asked to develop these formulas, although there are other available options.

Accreditation and Credentialing

The Working Group considered the role that accreditation and certification should play in delivering public health services in Massachusetts. There is a national initiative spearheaded by NACCHO and other public health organizations to implement a voluntary accreditation of public health departments across the country. Another initiative spearheaded by Association of Schools of Public Health proposes to give certification to workers in the health department. These two initiatives aim to improve the delivery of services and to identify a set of standards that the public can expect from the public health system.

One important rationale for forming regions is to assure a reasonable set of services as specified by the "ten essential services of public health." An accreditation program using this framework could provide incentives and directions for improving public health. Likewise, specific requirements for individuals that serve as Director Public Health in Massachusetts communities could raise the quality levels of personnel.

There are many questions and issues relating to these topics. Additional time is needed to explore fully these important components.

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Recommendations

Below are six recommendations from the Public Health Regionalization Working Group.

RECOMMENDATION #1: *Develop various model organizational structures to accommodate regional differences.*

Models identified in the organizational structures section of this document are potential examples of how communities could develop regions.

Fundamental to any discussion about public health regionalization is a determination of how a region should be organized. In discussions with representatives from around the state, and with professionals nationally, the following overarching principles have emerged:

- A. One size won't fill all;
- B. The need to respect, support, and accommodate existing structures;
- C. Respect historical relationships.

RECOMMENDATION #2: *Develop governance structures that state the manner in which the region will meet its goals while guaranteeing an equal voice in decision-making among the participating communities.*

Governance: Central to any consideration of regionalization is the development of an agreed-upon set of governing principles. As with any confederation, there needs to be a clear understanding of roles and responsibilities among all participants. This needs to be considered in developing mechanisms to assure that all communities have an active and appropriate voice in decision-making.

RECOMMENDATION #3: *Fund the regions in such a manner that they will be able to contribute fully in delivering the Ten Essential Services of Public Health.*

A basic finding of this work is that local public health is under-funded, wholly dependent upon a combination of local taxes, fees and designated funding (e.g. emergency preparedness, tobacco control) from the Massachusetts Department of Public Health. A successful regional effort will be dependent upon greatly expanding the amount of funding, as well as the structure of that funding.

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RECOMMENDATION #4: Develop performance standards and reporting requirements for the newly created public health regions.

Performance standards and reporting requirements for public health regions will be developed cooperatively with the Massachusetts Department of Public Health and representative public health organizations. These requirements will reflect the needs and capabilities of local public health and be reviewed by a representative body on a regular basis.

RECOMMENDATION #5: Insure that all regions have appropriate levels of services commensurate with the Ten Essential Services of Public Health.

Each region will demonstrate that they have developed the professional staff needed to provide the ten essential services of public health. It is strongly recommended that an accreditation process be established as a part of regionalization process, and that regional health directors meet basic levels of credentialing.

RECOMMENDATION #6: Build on existing legislation for developing regionalization.

Relevant state law should be thoroughly reviewed to determine how existing statutes might be amended to achieve regionalization.

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Appendix 1: Governing Agreements

Some basic elements of governance agreement include:

Statement of purpose: A mission statement.

Membership: This is a list of the member communities.

Administrative Responsibilities: This section defines roles and responsibilities for the host agency, and identifies the manner in which it will be held accountable by the region's communities. Some of the administrative elements included in this section may include:

- The establishment and composition of an executive committee
- The manner in which the executive committee makes decisions
- The establishment of other standing committees
- The establishment of regional meetings (e.g., annual, quarterly, monthly)
- How regional decisions are made
- Reporting requirements, (e.g. monthly, quarterly or annual reports)
- The process for communities to leave a region
- Adding new community members.
- Amendments to the documents

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Appendix 2: Legal and Legislative Perspectives

Several existing state laws provide a context and legal framework for the regionalization initiative, and therefore preclude the need for new omnibus legislation. These laws require a thorough review to determine how they could be amended to accomplish the regionalization goal.

A. The Establishment of Regional Public Health Units:

1. *Intergovernmental Agreements:* Two state laws authorize the broad use of inter-municipal agreements and the establishment of Regional Planning and Economic Development Districts, respectively:
 - a. *G.L. c. 40, §4A:* Governmental Units, joint operation of activities: This statute allows individual communities to enter into agreements with other communities for the provision of services, activities, or undertakings.
 - b. *G.L. c. 40B, §14:* Regional Planning and Economic Development Districts: allows for the above type district to be formed to provide research, technical assistance and to compile data.
2. *Health Districts:*
 - a. *G.L. c. 111, §§27A, 27B & 27C:* Regional Health Districts: These three statutory provisions address the establishment and structure of regional health districts serving two or more municipalities. More specifically, Section 27A applies to the establishment of a regional health district by two or more towns. Section 27B more broadly authorizes municipalities to establish a regional health district such as Nashoba Associated Boards of Health. Section 27C provides a state funding mechanism for regional health districts established pursuant to Section 27B, which is limited to reimbursement of costs for “initial capital outlays.”
3. *Informal Agreements:* There have been instances in which towns have voluntarily formed collaborations to achieve specific goals. Most recently, this occurred for the purpose of enforcing tobacco-related statutes and regulations, and local by-laws and ordinances. In these situations, one municipality acts as the host agency to handle day-to-day administration, such as benefits and salary.

The weakness of such an arrangement is that it is generally issue-specific and subject to change depending on a multitude of variables such as availability of resources. Once the funding disappears or the issue itself is adequately addressed, these relationships often terminate or otherwise lapse. In addressing public health regionalization, it will be important to establish a

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more stable structure, one that supports the goal of providing a comprehensive program of public health services.

B. Additional Concerns

1. *Funding:* Secure and adequate funding must be established in order for public health regionalization to succeed. While this is addressed more fully earlier in this document, it is important to remind ourselves that legislative action is absolutely necessary to support the proposed regions. For example, Massachusetts G.L. c. 111, §27C, limits state funding to the start up costs associated with establishing a public health district, and expressly excludes the costs of “supplies, salaries and other expenses for the ordinary maintenance and operation of such district.” As a part of this legislation development process, 27C should be amended to expand the scope of state funding to cover all the currently excluded costs.
2. *Structure:* Massachusetts G.L. c. 111, §27B provides, in pertinent part, that a regional health district established thereunder:

. . .shall have all the powers and shall perform all the duties conferred upon, or exercised by, the boards of health and health departments of the constituent municipalities under any law or ordinance pertaining thereto, except in so far as the regional health district may by majority vote delegate certain powers and duties to the constituent municipalities.

The Section 27B district structure may be too prescriptive for some communities because it envisions the district having all the powers and performing all of the duties of the constituent local health boards or departments, unless the district chooses to delegate a portion of them back to the constituent municipalities. This broad delegation of local authority and duties may deter some communities from joining a regional health district. Consequently, another legislative change to consider is amending Section 27B to give the constituent municipalities more authority to determine the scope of delegation of their powers to the district.

3. *Labor Issues:* Establishing some regions might require the redeployment of staff from a municipal to a regional entity. In so doing it will be important to develop language that protects these employees from losing retirement, sick time and other benefits that they have accrued over time. This is one of the most complicated aspects of this process and one that has consistently been cited as a concern among public health officials. Further review should be undertaken to explore existing options and develop new alternatives. A next step is to assess whether the existing language in Sections 27A and 27B on these labor issues warrant amendment to make these statutory provisions more acceptable to concerned stakeholders.

Recommendations of the Public Health Regionalization Working Group

Clearly the legal underpinnings of regionalization are crucial to its success. There already exists a small body of law that supports this initiative. The work here will be to examine that law and develop recommendations that fully support local public health.