Evaluation of Regionalization Planning Efforts in Kansas and Massachusetts

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Report prepared by Justeen Hyde, PhD
Institute for Community Health
Introduction

The public health system in the United States is comprised of national, state, and local agencies, all of which are tasked with the responsibility of preventing injury and disease and promoting the health and wellness of the general public. While national and state public health agencies provide the necessary policymaking, priority setting, financing, and oversight of public health activities across the country, local public health departments in most states are ultimately responsible for delivering and implementing essential public health services.

Despite the demand for high quality and equitable public health services, most local public health departments across the county have faced a number of challenges over the last several decades. These challenges include decreases in municipal, state and federal funding at the same time that demand and need for expanded responsibilities to protect public health are needed. Such forces have resulted in a public health workforce that is stretched very thin, with limited capacity to provide essential public health services to its constituents. This is especially true for smaller departments that serve suburban and rural communities.

To overcome many of the challenges facing small local public health departments, public health officials in Kansas and Massachusetts are engaged in a process to “regionalize” public health services in their state. Regionalization of local public health services may be defined in many ways and encompasses a range of organizational models, e.g. from the development of inter-local agreements to share services and resources to the consolidation of two or more health departments. While cost efficiency is often a primary motivator for regionalization across service sectors, this is not the case for local public health leaders in both states. Rather, the interest is in improving the quality and equitable provision of public health services.

Although Kansas and Massachusetts are very different in terms of geography, population density and demographics, economy, and governmental organization, there are similarities. One important similarity is the commitment of both states to local governmental authority, otherwise known as “home rule” authority. This authority allows for local municipalities or counties to maintain control over how local public health services are administered and financed. Proponents of home rule argue that it allows for local municipalities and counties to be more flexible, responsive, and innovative in how they approach local problems as well as relieve the state legislatures of parochial issues. However, both proponents and critics recognize that it also has led to inefficiencies and gaps in the provision of essential public health services. Ultimately, public health officials in Kansas and Massachusetts hope that regionalization will lead to improvements in the collective capacity and efficiency of the overall state public health system, especially for populations served by smaller local public health departments.

Interest in improving the collective capacity and efficiency of local health departments to equitably provide essential public health services to all citizens has emerged within the context of a national effort to develop formal standards for local health departments. With input from local, state and national public health professionals and elected officials, NACCHO has played a key role in facilitating the development of a nationally recognized framework called the “Operational Definition of a Functional Local Health Department.” Underlying the standards that make up this framework is the belief that “…everyone, no matter where they live, should reasonably expect the local health department to meet certain standards.”

National standards for local public health are reflected in the 10 essential services for local public health. These services and responsibilities are as follows:

1. Monitor health states and understand health issues facing local communities
2. Protect people from health problems and health hazards
3. Give people the information they need to make healthy choices
4. Engage the community to identify and solve health problems
5. Develop public health policies and plans
6. Enforce public health laws and regulations
7. Help people receive health services
8. Maintain a competent public health workforce
9. Evaluate and improve public health programs and interventions
10. Use and contribute to the evidence base of public health

On their own, many small, local health departments do not have the resources to meet accreditation program standards. As a result, several states have begun thinking about how to increase the capacity of local public health in order to not only meet accreditation standards, but also to provide citizens with services that they need and should expect. Kansas and Massachusetts are two such states.

This report presents findings from a qualitative evaluation of the efforts of public health leaders in Kansas and Massachusetts to develop plans for regionalizing local public health. Funded by NACCHO and the Robert Wood Johnson Foundation, the evaluation was designed to document the planning activities of each state and gather feedback from a variety of participants on the strengths, challenges and lessons learned from the processes undertaken. Each state has taken a different approach to developing and assessing the feasibility of regional public health services. We believe the experiences of these two states will be of use to other local and state entities that are faced with the challenge of reorganizing their local public health services in order to meet national standards and local needs in the 21st Century.

Methods
The evaluation period spanned approximately 13 months, from the end of November, 2007 to the end of December 2008. Multiple qualitative methods were used to evaluate the successes and challenges of planning for regionalization in Kansas and Massachusetts. The ICH evaluation team utilized a case study evaluation approach to investigate the strategies employed by local public health leaders to carry out their respective project goals. Case study evaluations are valuable when projects under investigation are grappling with broad, complex questions that are addressed in complex circumstances. Although the methods used in case study evaluations may be qualitative or quantitative (usually a combination of both), the methods used in the proposed evaluation were primarily qualitative and included feedback from multiple local stakeholders. Case studies using qualitative methods are most appropriate when “the question being posed requires an investigation of a real life intervention in detail, where the focus is on how and why the intervention succeeds or fails, where the general context will influence the outcome, and where researchers asking the questions will have no control over events.” The end product of this approach is a detailed analysis of the context, approach, successes and challenges faced by local public health officials as they worked through a process for developing and gaining support for regional service models.

The primary methods used for this evaluation study included one-on-one interviews with local public health leaders, other local stakeholders (e.g., academics, public health or county commissioner association leaders, etc.) and NACCHO-funded consultants, observations of planning meetings and summits, and documentation of information shared during monthly conference calls. Information shared during planning

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3 Ibid, pg 444.
meetings, statewide meetings or summits, and monthly conference calls was documented in the form of field notes. Separate field notes were kept for activities in each state. Included in these notes were observations made by members of the evaluation team. Below is an overview of the evaluation activities in each state.

<table>
<thead>
<tr>
<th>Evaluation Activity</th>
<th>Kansas</th>
<th>Massachusetts</th>
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<tbody>
<tr>
<td>One-on-one interviews</td>
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<td>Observation of planning meetings</td>
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<td>Observation of statewide meetings</td>
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<td>Conference calls</td>
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The Principal Investigator conducted nearly all one-on-one interviews and participated in most of the planning meetings in both states. All interviews were audio-recorded and professionally transcribed. Once transcribed, they were entered into NVIVO 7, a qualitative data management program. A detailed codebook was developed for the interviews in each state. One member of the evaluation team coded all interviews. A sample of interviews was selected for “double coding” to ensure accuracy and consistency in coding. Discrepancies in the coding of this sample of interviews were discussed within evaluation team meetings and consensus on appropriate coding of text segments was obtained. The primary coder documented any questions that arose during the coding process and discussed them with the Principal Investigator.

Once the coding of interviews was complete, the Principal Investigator reviewed all the information categorized within each code. Salient themes were identified as well as discrepancies in opinions and experiences. The results of this analysis are presented in the main body of this report. The results are supplemented when appropriate with information shared during planning meetings, statewide meetings, and conference calls.

**Organization of Report**

The remainder of this report is divided into two primary sections. The first is a presentation of the case study conducted with Kansas. Public health leaders implemented a process and assessed the feasibility of expanding the regional approach developed for emergency preparedness planning to include cooperation in the delivery of additional essential services. The second is the study conducted with Massachusetts. Public health leaders in this state focused their energies on developing potential regional models for public health in the state, identifying and rectifying potential barriers to the implementation of these models, and obtaining political support from legislators and key public health leaders. Both states represent a different approach to planning for regionalization. This report provides an overview of each approach and a summary of lessons learned from participating public health leaders. The hope is that other public health entities who are considering the reorganization of local public health systems will learn from the experiences of Kansas and Massachusetts and create a planning process that is useful and effective. It is in the spirit of learning that these results are presented.
Kansas
The State of Kansas is the geographic center of the 48 contiguous states in the nation. It is the 15th largest state in the United States with respect to square mileage and ranks 33rd with respect to population size. With a population of 2,775,997 people, it is one of the least densely populated states in the country. There are 105 counties that make up the state, only 14 of which are considered urban or semi-urban (6 and 8 respectively). The remaining 91 counties are a mixture of rural and frontier counties.

The composition of counties within the state has changed over the last few decades as a result of a major rural exodus due to the mechanization of the agricultural industry. Although agricultural outputs, such as cattle, sheep, wheat, sorghum, soybeans, cotton, corn and salt, remain important to the overall economy, the mechanization of the agricultural industry has led to a large-scale movement of people out of rural areas and into urban ones. The majority of counties in Kansas today are considered rural or frontier counties. The declining population within these counties has a number of impacts, including a declining tax base that can be used to pay for government and civil services. Public health is one such service that is funded largely by local county government.

Local Public Health in Kansas
Local public health authorities in Kansas provide a variety of different programs and services. While it varies from one county to another, these services often include: family planning, childhood immunizations, adult vaccinations, Women, Infants and Children (WIC) and other maternal health programs, healthy start home visits, a range of health education and advocacy programs (e.g., tobacco control), a range of inspectional services, emergency preparedness planning, and many more. In addition to local public health services, many departments in rural and frontier counties serve as a medical safety net for its citizens. Home health care services aimed particularly at elderly and disabled populations are among the many services provided to local residents. As one local health administrator explained:

While most rural health departments don’t provide full medical home services, kids can get their shots there, they often have home health services for seniors, and blood pressure checks. They provide medical services that otherwise don’t exist in those small towns. It [local health department] is pretty well recognized as being an essential service out there.

Many of the local health administrators who participated in this study provided a combination of traditional public health and one-on-one medical care to county residents. Throughout the study there were many discussions regarding the role of individual health care services within public health departments, particularly whether or not these services add to or detract from the primary responsibilities of local public health departments. However, many participants did not see a clear divide between individual and public health services. As one local administrator explained:

You know public health is a portion of my job that serves lots of people. But because we’re a small county, we also do one-on-one care. Is it all important and does it all eventually add up to public health? Yes. Because if I take care of that one person and they don’t go out and spread something, then I’m serving a lot of people. That’s the way I look at it...

As in many rural states, local public health officials in Kansas play a critical role in reducing medical service gaps. Home health care and other medical services are recognized by county officials and residents not

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only as a way to address important needs in rural counties, but also as a source of revenue from fee-for-service reimbursements. The diverse roles that local public health officials play across the state, the needs they address, and the ways in which they are funded are critical to understand and consider when thinking about regionalization.

Need for Regionalization
Like other local governmental services, local public health departments in Kansas are funded largely through county tax dollars. As a result, local public health services are directly impacted by the ebb and flow of populations. Rural and frontier counties have had to contend with decreases in county funds as a result of a declining tax base while simultaneously experiencing an increase in responsibilities for protecting the public’s health (e.g., emergency preparedness planning) and grappling with newly defined national standards for local public health departments.

Although decreasing funds for local public health services and shifting responsibilities and expectations are of great concern to public health leaders in Kansas, the impetus for discussions about regionalization has stemmed from the belief that “all people, no matter where they live in Kansas, should reasonably expect to have their health protected with a standard level of public health services.” The Kansas Association of Local Health Departments (KALHD), whose mission is to strengthen local health departments through technical assistance, communication and advocacy, has played a central role in facilitating the development of regional approaches to the provision of public health services in the state. Edie Snethen, Executive Director of KALHD, was instrumental in securing support from the National Association of County and City Health Officials (NACCHO) and the Robert Wood Johnson Foundation (RWJF) to develop a “bottom-up” approach to regionalization of services in the state.

Regionalization of local public health services can be conceptualized and accomplished in many different ways. The Kansas approach to regionalization of public health services is called “Regional Cooperation.” Recognizing that Kansas is a strong home-rule state and that local communities have historically provided significant support for public health, the Kansas approach to regionalization attempts to preserve home rule authority while increasing the capacity of local health departments to meet emerging national standards as defined by NACCHO’s Operational Definition of a Functional Local Public Health Department. Regional Cooperation is defined as a group of local health departments working together through formal inter-local agreements to provide a specific range of services that could not be provided by each individual local health department. The goal of a Regional Cooperation model is not consolidation. Rather, the goal is for local health departments to work together in order to increase their individual and collective capacity to provide essential public health services to all Kansans.

Overview of the Kansas Regional Cooperation Project
Funds from NACCHO, through a grant from RWJF, were used to support on-going efforts in the state to increase the capacity of local health departments working together to provide essential public health services. Specifically, funding was used for technical assistance and support to test an approach that would help multiple counties move toward Regional Cooperation. Two emergency preparedness regions volunteered to pilot the approach and provide feedback. Funding also supported legal, social marketing and finance consultants, each of whom were dedicated to investigating the feasibility and support for Regional Cooperation.

The two public health regions that participated in the pilot project were North Central Kansas and Northeast Corner Kansas Regions, both of which were originally formed in 2003 to meet national

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expectations for emergency preparedness planning and response. These two regions, while contiguous, are
diverse in population size and density. The 13 counties that make up the North Central Region (Clay, Cloud,
Dickinson, Ellsworth, Jewell, Lincoln, Mitchell, Osborne, Ottawa, Republic, Russell, Smith, Washington
counties) have a collective population size of 89,000 and a population density of 8.7 people per square
mile. The Northeast Corner Kansas Region is made up of 8 counties (Atchison, Brown, Doniphan, Jackson,
Jefferson, Marshall, Nemaha, Shawnee counties) with a total population of 261,000 people and a
population density of 54.9 people per square mile. Three of these counties (Atchison, Brown and Jackson)
have a consolidated public health administrative structure that is referred to as the Northeast Kansas (NEK)
Multi-County Health Departments. Figure 1 provides a map of the location of the two regions within the
state.

Figure 1

The formation of the public health regions depicted above is often touted as one of the strengths of the
project. The 15 regions public health regions in Kansas were originally formed to meet the expanded
responsibilities for emergency preparedness and response that emerged after September 11, 2001. As with
many states with de-centralized public health departments, Kansas had to grapple with the problem of how
to efficiently distribute federal emergency preparedness dollars to local communities in a manner that
would facilitate success in meeting national benchmarks and deliverables. Given the central role of home
rule authority in local government, the Kansas Association of Local Health Departments, in collaboration
with Kansas Department of Health and Environment, agreed that counties should work together to
accomplish emergency planning goals and that the formation of these working partnerships – referred to as
regions – should be developed using a “bottom up” approach.

Members of the KALHD were actively involved in creating this “bottom up” approach to emergency
preparation regions. The membership decided that 18% of funds for local public health entities should be
used for regional incentive grants. Counties were provided three basic guidelines for establishing a region:
1) a region must include at least 3 contiguous counties; 2) each county, regardless of population size, had to
agree to equal representation within the governance structure; and 3) all counties within a region had to
sign formal inter-local agreements that would allow them to work together and share resources during
emergencies. Entering into a region was and continues to be a voluntary decision for each county. Out of
the 105 counties in Kansas, 103 have opted to participate in a region to enhance their capacity for
emergency preparedness planning and response.
Utilizing the success of partnerships formed through emergency preparedness dollars, KAHLD decided to build upon the efforts made in emergency planning and response to include additional public health functions. The goal of Regional Cooperation in Kansas is to build the capacity of local health departments to provide a comprehensive array of public health services. The approach does not entail a consolidation of health departments. Rather, it supports cooperative planning for and delivery of select public health services. Using an incremental approach, local health departments will work together to address common challenges and gaps in service while still maintaining local authority over public health issues.

**Approach to the Regional Cooperation Process**
The approach used to help move each participating region towards Regional Cooperation was comprised of three primary phases. Below is an overview of the primary activities associated with each phase of the project. Following this brief description is a more detailed description of each phase, the strengths and challenges experienced by participants within each region, and recommendations for improvement.

**Phase 1 – (September 2007-December 2008)**
The goal of Phase 1 was to create a vision for the public health regions by applying NACCHO’s Operational Definition of a Functional Local Health Department. The “kick off” for the project was a one day meeting held in September, 2007 with participating local health administrators in each region, state and national public health leaders, and project consultants. The purpose of the meeting was to describe the Kansas vision for public health and impetus for the project, expectations of local health departments, and a timeline of events. Between October and December of 2007, the counties of the Northeast Corner Region and the North Central Region participated in assessments using the Operational Definition metrics and financial reviews. Both of these activities were designed to assist regions in the identification of gaps in public health services within their communities and within the region as a whole.

**Phase 2 (January 2008-August 2008)**
Phase 2 activities focused on the implementation of a process designed to: a) facilitate the identification of strengths and gaps in the provision of essential public health services at the community and regional levels, b) come to consensus on a regional approach to meeting an identified need, and c) develop a strategic plan for meeting the need. During this phase, each region met four times. The first meeting was dedicated to presentation of findings regarding individual and collective strengths and gaps. The remaining meetings were dedicated to consensus building and strategic planning.

**Phase 3 (September 2008- December 2008)**
The final phase of the project was dedicated to identifying and sharing lessons learned from the project with local, state and national public health stakeholders, state county commissioners, and other elected officials. Activities included a statewide summit sponsored by the Kansas Association of Local Health Departments and the Kansas Association of Commissioners and presentation of the findings at state and national meetings.

**Project Successes**
The process developed to guide each region towards the identification of and planning for a regional cooperation project was largely a success. Although there were many lessons learned along the way, most participants felt as though the activities associated with each phase of the project were helpful in moving them along a thoughtful and data-driven planning process.

The results from the assessment phase in each region highlighted a number of strengths and capacities in the delivery of high quality public health services. Both regions demonstrated the greatest capacity in the
Essential Service 2 – Protect people from health problems and health hazards. Many were not surprised with this finding given that many of the indicators under this essential service are related to bioterrorism and preparedness requirements. Investment in building the capacity of local public health departments to meet these requirements has resulted in the ability of counties and region to fulfill this essential service. Many demonstrated strengths in their involvement of community stakeholders in program planning. County public health leaders also demonstrated the ability to collaborate with other health officials within and across counties to fill some important gaps in service delivery.

The assessment process also highlighted variability in the capacity of local public health departments in each region to meet the standards defined in the Operational Definition of a Local Public Health Department. Not surprising, many of the gaps in capacity were the same for each region. Gaps included the following:

- Data Collection, Processing and Maintenance for health issues
- Community Health Needs Assessment and Health Improvement Planning
- Evaluation and Program Planning
- Policy and Legislative Advocacy for Health Improvement
- Relationship with Academia
- Legal Review and Regulatory Activities

By the end of September, each of the regions had developed a strategic plan based on the results of the assessment tool for their first regional cooperation project. Each region selected a project that was not only feasible and appropriate given their collective strengths and gaps in the delivery of public health services, but also priority areas for their individual counties and regions. In both cases, the projects selected were considered to be foundational – an important first step towards building their capacities to better provide other essential public health services. Below is a brief description of the initial regional cooperation projects identified by each region along with their defined goals and strategic plan.

North Central Kansas Region
The local public health administrators in this region decided to focus their first Regional Cooperation effort on improving communications between local public health and the governing bodies and citizens they serve. Specifically, their goal was to develop a regional communication plan that focuses on education on what public health is and the resources and services they provide to local residents. Improving communication with local governing officials and the public was also believed to be a foundational step towards increasing their visibility and their use as a trusted source of information.

The North Central Region developed a number of objectives and strategies to facilitate the realization of this goal. Their initial objectives were as follows:

1) Identify the general categories of messages and mode of distribution to share information with a variety of audiences
2) Develop process and protocol guidelines for consistent communication across the region
3) Develop regional communication materials
4) Establish a regional healthcare communication coalition to build partnerships for the ongoing evaluation of public health communication and for information exchange.

The hope of this group was that by focusing on communications, they would be able to increase their capacity to fulfill Essential Service #3 – Inform, Educate and Empower Individuals and Communities about Health Issues.
Northeast Corner Region

This region decided to focus their efforts on developing protocols and processes to support data collection, integration and sharing. All counties in the region recognized the importance of using consistent data sources to identify health problems and needs and to evaluate programs and services. Although most counties receive funding from local or state government to provide similar services, each county health department relies on different reports to evaluate the success of their programs and to identify additional health needs in a given area. Their goal was to have consistent sources and types of data to evaluate their services and to use data-driven quality improvement methods to enhance programs and services.

There were a number of objectives and strategies developed for this particular area. They were as follows:

1) Establish a decision-making structure for the regional cooperation project
2) Identify program data categories and needs to build consistency in measurement values across similar programs in the region
3) Engage identified stakeholders to build a mass of support and collaboration for consistent data gathering, compilation, and integration
4) Develop or modify written protocols and procedures for data gathering, compilation and integration
5) Develop a comprehensive communication plan for stakeholder groups and local, state and federal governments to inform them of data needs necessary to monitor and evaluate program outcomes

By focusing on the data collection, integration and sharing, this region hopes to improve their collective capacity to fulfill Essential Service # 9 – Evaluate the effectiveness, accessibility, and quality of personal and population-based health services. Consistent use and reporting on health data was viewed as a critical first step towards addressing many of the other gaps that they identified through this process, such as community health assessments, development of quality improvement plans, and evaluation of programs and services. Agreement on the use of common data sources and reporting strategies was also considered to be necessary if counties were to work together to leverage resources for public health services.

Strengths, Challenges and Recommendations to Improve the Planning Process

In this section of the report, feedback on the planning process is presented. Drawing on interviews with county health administrators, NACCHO-funded consultants, and observations of planning meetings, the strengths, challenges and recommendations for improving the process developed for regional cooperation will be presented. When appropriate, quotes drawn from one-on-one interviews are included to illustrate key points. Individual names and regional affiliation have been excluded to protect the confidentiality of participants.

The planning phases described in this section of the report are as follows:

1) Introduction of the regionalization pilot to local public health administrators
2) Use of the Operational Definition of a Functioning Local Public Health Department metrics to assess strengths and gaps across each region
3) Planning meetings to facilitate selection of a regional cooperation project
4) Summit with local governing officials and county health administrators to build support for regional cooperation

Introduction of the regionalization pilot to local public health administrators

In September of 2007, health administrators from the two participating regions met in Topeka, KS for a day long meeting with NACCHO staff, KALHD representatives, local and state public health professionals, and consultants. The purpose of the meeting was to “kick off” the regionalization project by providing an
overview of the purpose and goals of the project and plans for implementation. There was also some basic information shared about NACCHO’s interest in regionalization, particularly as a strategy for increasing the capacity of local public health departments to perform the nationally recognized 10 essential services for public health and thus achieve accreditation status.

Most, but not all of the health administrators from the 21 participating counties were able to attend the meeting. About half of the local health administrators interviewed reported feeling excited about the project after attending the meeting. These individuals had a fairly good understanding of the project before attending the meeting and were interested in building off the success of the collaborative planning for emergency preparedness to expand capacity in other areas.

I have witnessed what regionalization has done for public preparedness. When I came on as an administrator, regionalization saved me. It helped me so much. So I saw how important that was. I could not have accomplished what I needed to do by myself. My work was really strengthened by the region, so it did intrigue me. How can we do other projects as a region? But I had some concerns too. I didn’t want to become a consolidated health department like they have in some states. I didn’t want a regional public health department...because we have similarities but we definitely have differences. But the more we talked, I began to understand that the goal was not consolidation.

Others who favored the project from the beginning had had previous success with shared services in other arenas, particularly environmental health services.

In our region, before BT [bioterrorism], we partnered with others to do environmental services. We already saw a need to work together in order to get things done. Nothing is better to me than to have things standard when it comes to how you put in your waste water system or how you license and install it. If an installer can be licensed and know that he can work in 6 counties, wow. He doesn’t have to meet each one’s separate code. The more we can make things the same, the easier it is on the public. And so I think we all had that concept from the beginning in our region.

Although most participants reported having a good experience with Regional Cooperation for emergency preparedness planning, some reported a less favorable impression of the project following the meeting. These individuals tended to have a different understanding of what they had agreed to participate in prior to coming to the kick-off meeting. In particular, some thought they were coming together to develop strategies for sharing services, such as family planning or nutrition education and programming. They were not expecting to participate in a project of national interest that was designed to develop a strategy for increasing the capacity of local public health departments to meet the 10 essential services for local public health.

We went to the meeting and we had no clue. And then we saw a lot of people around the table that we didn’t know. We didn’t know why we were there. It was a little intimidating. I thought it should have been explained to us ahead of time...When I left there that day I was confused about whether or not the goal was to consolidate health departments. There were a lot of weird feelings after that meeting. I felt like there was a loop that we were kind of left out of before this meeting.

Others were concerned that the underlying interest in the project was to develop a strategy for consolidating local public health departments. Most participants who initially felt this way learned over time that this was not the goal of the project. However, it did taint their feelings about the project in the beginning and led to a slower embracing of the project.
**Recommendations for Initial Planning/Kick-Off Meetings**

Bringing participants together to jointly discuss the vision, goals, and objectives of any new project can be an important strategy for building a common foundation of understanding across participants and enthusiasm for the work that lies ahead. Some participants reported feeling as though the kick-off meeting accomplished these goals. Others did not. Those who did not report a favorable experience with the kick-off meeting tended to have a limited understanding of the goals of the project ahead of time and what was expected of local public health administrators. Recommendations for improving initial meetings are as follows:

1) Make sure participants have a basic understanding of the vision and goals of a project before the initial kick-off meeting. Sharing this information ahead of time may help prevent feelings of confusion and concern during the initial meeting and enable participants to come prepared to discuss the project in a more meaningful way. Participants identified a number of ways that participants could be informed about a new project. These included: a) email or mail the original proposal for review ahead of time; b) consolidation of the proposal into a new project “fact sheet,” with identified need, goals, objectives, and timeline included; c) oral presentation about the project at an existing regional meeting or through a conference call.

2) Another recommendation was to invest time upfront in developing a common understanding and vision for local public health. Kansas, like most states, has local public health departments serving counties that are diverse in population size, needs, and access to resources. Local public health officials often play a variety of roles within their counties and fill resource needs when able and appropriate. These differences undoubtedly influence perceptions of the roles and expectations of local public health departments. As one participant explained:

   We had a meeting a couple of weeks ago with county commissioners and health department directors. It was pretty obvious that there is still confusion across the state, probably across the country, about what is public health. So many departments, particularly in the rural areas, have picked up direct services to meet the needs of citizens with limited health care access. And so those lines have become really blurred in some areas and I think it’s going to be hard for local health departments to tell their public, “We are a public health agency. We are not a primary health care provider of services and are moving away from that.” Some departments will need help communicating this to the public.

This participant and several others recommended investing time in developing a common understanding of what public health is and the essential services that local public health departments are expected to provide. Given the national push for developing standards for local public health departments, these participants recommended beginning with the Operational Definition of a Functional Local Health Department developed by NACCHO. Understanding the definition of local health and the essential services is an important and necessary first step before assessing the strengths and gaps in local public health capacity.

**Use of the Operational Definition of a Functional Local Health Department Metrics to Assess Capacity**

NACCHO’s Operational Definition of a Functional Local Health Department Capacity Assessment for Accreditation Preparation is an agency self-assessment for local health departments to use in measuring
themselves against the standards in the Operational Definition. The instrument is based on the framework of the 10 Essential Public Health Services for Public Health, which represents a spectrum of public health services that every jurisdiction should provide to citizens. It includes indicators—or measures—in use by local health departments across the country, and offers an idea of what indicators may be used in the national accreditation program. The assessment instrument is divided up into 10 sections, which correspond to each of the essential services. Each standard has a series of questions associated with it. Local public health providers are asked to assess their performance in meeting the Model Standards using a five-point scale (ranging from No Capacity to Optimal Capacity).

In order to complete the assessment tool, a consultant was hired to coordinate and conduct the assessments with each of the 21 local public health departments participating in the project. A copy of the instrument and associated guidance was emailed to each health administrator ahead of their scheduled time to meet. Participants were encouraged to look through the guidance and questions before meeting with the consultant. On the scheduled date, the consultant met with the health administrator and, if desired, other local public health staff within the county to complete the instrument. Once complete, the consultant “scored” the results for each county, identifying individual strengths and gaps in comparison to the optimal standards for local health departments. Once all assessments were complete for a region, she then analyzed and summarized the strengths and gaps in performance for the region as a whole. This regional perspective provided an opportunity for local health administrators to identify similarities and differences in performance. The results of this regional assessment also provided a springboard for discussion about the first regional cooperation project.

Experiences with the Operational Definition of a Functional Local Health Department Assessment Tool

Participants reported a mixture of feelings about their experiences completing the Operational Definition assessment tool. The majority reported initially feeling intimidated when they first received the instrument. For some, it was the sheer length of the instrument that created anxiety. For many others, the instrument was different in form than other instruments they had previously completed. With most local public health funding earmarked for specific programs and services, previous experience with surveys was often focused on programs or topic areas. The Operational Definition metrics, on the other hand, asked program providers to think about the services they provide across programs and services, focusing more generally on departmental practices with respect to data collection, monitoring and analysis and advocacy. Many were confused about how to answer the questions given the “siloed” nature of funding and focus on specific standards and deliverables for each program and service rather than a set of general standards and deliverables for the health department.

Those who reported more favorable experiences completing the assessment tool tended to have a good understanding of the 10 Essential Services framework as well as at least a fair understanding of how the results of the assessment process would be used to help their region select a regional project to work on. While these individuals were familiar with the 10 Essential Services, they found it helpful and educational to see the model standards and indicators for each.

It was good for me to have a system of checks and balance and to see what expectations are for public health. We might come close or we might not come anywhere close to doing that. It’s also good for me to see where we started and where we’ve come. I think we’ve made improvements...

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was just a really good reflection and be able to sit back and think about exactly what we do. ... It helped me set some goals that I would like to do in the future.

Some participants also noted that the experience was intimidating, but they had some faith that the process would be instructive and useful.

[The assessment] went better than expected. Don’t get me wrong, I didn’t expect it to be (laughing) painful or anything. To be quite honest you never know with questions being asked of you, you always have that little bit of fear like, “Am I going to score ok?” Then you just have to remind yourself this is all about improvement. I’m going to be totally honest about this, find out where our gaps are, where we have capacities and where we don’t. I had not done something like that before and so I was glad that we were able to start with an assessment like that.

However, not everyone found the completion of the instrument to be either of interest or a good learning experience. Many had not been through such as assessment before and were concerned that the state or some other entity would judge them based on the standards without fully understanding rural public health.

If I had to totally do it on my own it would have been a lot of guess work. [It is written in] a language we are not familiar with. I tried to spend some preparation time and that was kind of stressful. I was of thinking, always in the back of my mind, I’m not going to be doing this job much longer because we don’t do what health departments are supposed to do or whatever... I felt I was threatened by some of the questions.

Other participants who struggled with the Operational Definition metrics reported feeling as though the indicators did not capture much of their day-to-day work. This was particularly true for individuals working in rural health departments whose primary focus is to provide one-on-one home healthcare services.

I hardly felt like it was related. It was kind of- I remember thinking they’re going to take one look at this and they’re going to close us down. They’ll think we don’t even qualify as being called a health department!

**Recommendations for Improving the Use of the Operational Definition of a Functional Local Health Department Instrument as a Planning Tool**

Participants had a number of recommendations for other local public health departments or jurisdictions that are considering the use of the Operational Definition assessment tool as a springboard for strategic planning.

1) Invest time in preparing local public health officials to complete the assessment. Public health leaders interested in regionalization should expect great variation in exposure to and understanding among local public health officials of the newly developed national standards for local public health departments (as defined in NACCHO’s Operational Definition of a Functional Local Health Department). When asked what people thought would help make the completion of the assessment process a better experience, several noted that more background information on the 10 Essential Services and associated metrics would have been helpful.

I thought all along that I wish I had more training on the 10 Essential Services. I just think I needed more background information. There was no overarching framework to work with. It was just
given to us. I’ve read it but I don’t really understand how it applies, what we are going to do with it, and what it is going to look like in 10 years?

In addition, many felt that they had a more abstract understanding of the 10 Essential Services framework, but wanted more information about how the framework translates into everyday practice. Such an understanding would not only improve their ability to assess the capacity of their department to meet the standards, but also help local public health officials connect their everyday work to a larger public health agenda.

2) Utilize a consultant to assist with the administration of the instrument. Several participants noted that the language used in the instrument was not a language that they use in everyday practice. Some thought the instrument was “too academic,” while others were uncertain whether or not they interpreted the indicators correctly. Having a consultant who was familiar with the instrument and with their services was helpful in bridging the gap that many perceived to exist between their everyday language and that found in the instrument.

The consultant hired for this project had certain qualities that helped improve the process for participants. First and foremost, she was not perceived to be judgmental or to devalue any of the work that the local health departments performed. Many felt that she approached each department with a strengths-based perspective and was instrumental in highlighting many under-recognized accomplishments. Second, she took the time to explain each of the measures and was able to pull information across programs together in a way that individuals who are mired in service provision struggled to see. Finally, participants felt as though she was really committed to the project and that she was acting on behalf of their best interests.

This recommendation does come with its own set of challenges. First, hiring a consultant to facilitate the completion and analysis of the assessment tool requires funding. Funds may not always be available to groups interested in using the tool for planning purposes. Second, consultants have limited time and can only be in one place at a time. Administration of the instrument in all 105 counties in Kansas, for example, would take a fair amount of time and may result in a loss of momentum to a project.

Public health leaders interested in using the tool for planning purposes should determine the knowledge and capacity of local public health officials to complete the assessment instrument beforehand and develop a strategy for helping those departments with limited capacity.

3) Understand and address concerns about the use of the instrument before implementation. Given that the Operational Definition metrics are relatively new to most local public health officials and that many may have limited experience with self-evaluations, it may be advantageous to understand and allay fears that can often surface when being evaluated. For example,

Some of us were concerned that someone else would be looking at the numbers. We were leery of the assessment process itself because we were afraid we would come up lacking. I think I explained to someone in our group that an evaluation isn’t meant to always show the negative. It shows the positive too. And it shows just where you need to work better. Also, it can show that if somebody else’s got it right, don’t reinvent the wheel. To me that’s regionalization because if another county has a service that they’re doing well and you can incorporate a similar aspect of it to your county, you’ve essentially regionalized the service. In a crisis setting you have similar programs where you are able to work together on something. I never saw it as a negative but I was certainly aware of the tension.
Many participants suggested investing some time in explaining the purpose of a self-assessment and how the results will be used. As the individual above notes, highlighting the process as a learning endeavor for improvement many help ease fears about the use of the information for punitive purposes.

### 3) Planning for Regional Cooperation Project

Once the assessment process was complete and the strengths and gaps in capacity to deliver essential public health services were identified, each region moved into a planning phase. The goals of this phase were to develop a process for translating findings from the Operational Definition assessment process into a regional approach for addressing one or more gaps in capacity. A consultant was hired to facilitate the planning process and provide technical assistance in strategic planning. Legal, financial, and communication consultants also provided their expertise to these aspects of the planning.

The planning phase took approximately 8 months and occurred from January to August of 2008. During this time, each region was brought together 3 times to meet with the planning consultant. Each meeting was approximately 4-6 hours in length. The goals of the first meeting were to review the results of the regional assessment and make a decision about which capacity to address first. The second meeting was designed to develop strategies for fulfilling the requirements of the selected essential service. The third meeting was designed to review the proposed strategies, create a strategic plan, and decide upon next steps.

The planning phase did not follow the plan as originally proposed. There were several obstacles encountered along the way and many lessons learned. The first challenge experienced during this phase stemmed from a general lack of understanding among many local health administrators and some project consultants about the expected outcomes for this phase. This was to be expected to some extent given that it was the first time this process was being used and the expectations were evolving as the process unfolded.

Initially, the project team had engaged two separate consultants for the Phase 1 Assessment Work and the Phase 2 Planning Work. Once the Phase 2 work began, the project team realized the importance of continuity between the two phases of the project. The Phase 1 consultant was familiar with local public health in each county as a result of administering the assessment instrument and local health administrators were comfortable with her style and approach. A project adjustment was made so that the services of the Phase 1 consultant was continued through Phase 2.

A second challenge that many did not expect was that the planning meetings were “hard work.” Participation in the planning process was voluntary. Public health administrators in each county took on the responsibilities associated with the project on top of everything else they did on a day-to-day basis.

For most of us, we’re doing this on our own time. We had some financial support and so that’s kind of been good but it is a very exhausting process and on a full plate... It seems like there is always something. I always felt like I was having to re-shift and re-focus but I couldn’t do it until I walked out of the office. It’s like you didn’t have space or time to think about the project until you went to the meetings. And when you are in the planning meetings you just work, work, and work while you’re there.

The planning process was “hard work” in other ways. Many participants noted during the planning meetings that the project challenged them to think in new ways. Most administrators spend their days focused on service provision – the delivery, quality and financing of public health and home health services. The Regional Cooperation planning process challenged them to think outside of the service silos to which
they have become accustomed. Their challenge was to think across programs and services and select a project that would build the capacity of public health departments at the individual and regional levels.

Several participants also commented on the length of time it took to come up with their decision. Most felt that three planning meetings were not enough to get to the place where they felt they needed to be in order to take on the project. This was especially true in the North Central Region where there are 13 counties. Several noted that they really needed more time to come to consensus as a group. Others, however, thought that the amount of time needed was not the issue, rather it was a lack of clarity around what they were supposed to do that was the issue.

As a group we all get along well. I think maybe we just didn’t understand it.... If you tell us, “You need to get 100 blood pressures every month.” We can do that. I just don’t think we really understood what it was that we were working towards in the beginning.

Many participants also felt that that the length of time between meetings was a challenge. On average, the regions met every other month to plan for their regional cooperation project. This was too much time between meetings and they ended up spending the first part of every meeting trying to remember what was accomplished or decided upon in the previous meeting.

Despite these challenges, each region worked collaboratively to develop a strategic plan for their first regional cooperation project. Improvements were made along the way to help move the planning process forward. In one region, the introduction of Continuous Quality Improvement and Effective Planning Tools, such as the Force Field and Nominal Group Techniques, helped the group decide on the focus of their first project. These techniques were then incorporated into planning meetings with the other region, where they proved to be valuable tools again. By the end of the third meeting, each region had an initial regional project and a strategic plan to help them move forward. This was an incredible accomplishment.

**Other Activities During the Planning Phase**

While local public health leaders were meeting to identify and develop a plan for an initial regional project, other consultants were working on working on components of the project that were necessary for the pilot regions to move forward with implementation of their strategic plan. These consultants included experts in social marketing, public health financing and public health law.

The social marketing experts talked with a range of stakeholders, including representatives from the Kansas Department of Health and Environment, County Commissioners, and public health leaders to identify the most appropriate term for the regional work underway. In the original proposal, the process was referred to as Functional Regionalization. After eliciting input from a variety of stakeholders, the social marketers recommended the term Regional Cooperation as a way to refer to the effort. The Project Team agreed to adopt this term and put it into immediate use.

Legal consultants were asked to conduct research that assesses the legal grounds on which regional approaches to public health service delivery may be implemented. Consultants were asked to assess the following questions:

1) Do local boards of health and health departments have the statutory authority to address each of the 10 Essential Public Health Services?

2) Assuming such authority exists, may it be exercised through a regional organization formed through an inter-local agreement among several local boards of health and health departments?

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3) Assuming such authority may be exercised in such a manner, may an inter-local agreement be drafted in broad terms to address a full breadth of services identified in the Operational Definition, as opposed to being limited to a specific function or activity to be performed at the regional level?

4) Are there specific issues under the HIPAA Privacy and Security Rules which should be addressed in the inter-local agreement?

The research suggested that proper statutory authority for local health departments to provide the 10 Essential Public Health Services exists. Importantly, they found that local boards of health or health departments may work together, through inter-local agreements, to provide these services. Such agreements may be drafted in broad terms to include the full array of services, but they must specify how projects are to be identified and pursued. Finally, inter-local agreements should include commitment from each participating county to protect the confidentiality and security of protected health information, as specified by HIPAA Privacy and Security Rules. Importantly, the legal team did not identify the need for new legislation in order to move forward with the regionalization of public health services.

The financial consultant initially worked with the Project Team and then individual health departments to develop a cost-effectiveness model for regional service delivery. One of the challenges in performing this scope of work was the differences in budgeting, bookkeeping and financial reporting among local health departments. Without standardized budgetary processes, comparisons and assessments were difficult. However, the Project Team did move forward independently to conduct some financial analyses that were important to the effort. In their research on how local public health is financed in Kansas, the Project Team found that the state scores very high in comparison to other states in local contributions to public health services. However, Kansas scores among the lowest in receipt of federal and state funds for local public health. Drawing on findings from the “Financing Rural Public Health Activities in Prevention and Health Promotion,” they found that Kansas, like other rural states, have a difficult time competing for federal funding because they lack capacity in infrastructure and staffing. Both infrastructure and staffing are needed in order to perform necessary activities associated with high quality data collection and evaluation of population-based needs and services. This research helped the Project Team think about how to make the case for regionalization to county commissioners and other public health leaders in the state. In essence, the case to be made was not that counties need to allocate more money to local public health. Rather, counties need to work together so that resources can be leveraged to fulfill these and other important functions. The performance of these functions will help increase the state’s competitiveness for federal funds. This information was used in the Summit and is described in the next section.

Recommendations for Improving the Planning Process

There were diverse opinions about how to improve the process for selecting a regional cooperation project and planning for implementation of the project. Below is a description of the most commonly identified recommendations.

1) Continuity of support for local public health officials as they move through the process of identifying and defining a regional cooperation project is important. Confronting gaps in services can be a stressful process for individual health departments and regions. Consultants who have an awareness of the strengths, gaps and concerns of local health departments and have a trusting relationship with local health officials are best suited to facilitate a planning process. The Project Team was closely connected to the process and was able to quickly assess the need to maintain continuity between Phase 1 and 2. This responsiveness was key to the success of Phase 2 work.

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8 Meit, M, Hamlin, BN, Piya, B and Ettaro, L. Financing Rural Public Health Activities in Prevention and Health Promotion. Walsh Center for Rural Health Analysis NORC at the University of Chicago and The University of Pittsburgh Center for Rural Health Practice. 2008
2) Spend time during the initial planning meeting to thoroughly review the results of the assessment process as a group. Discuss how participants feel about the results, including concerns about the accuracy of the findings. Taking the time to process the results as a group will help build a common understanding of collective strengths and gaps. Disagreements about any results can and should be discussed upfront and resolved before moving forward with a selection process. Reviewing the results in detail will also provide a model for local public health professionals with limited experience using data to inform program planning and quality improvement efforts.

3) During the initial planning meeting, provide participants with a “roadmap” of where they are going in the planning phase. Outline expected outcomes and the process that they will take to achieve those outcomes. Provide participants with a chance to disagree or raise concerns with the outlined process and come to consensus on how to address them. Individuals who are leading an effort such as this will need to find a balance between providing enough structure to help a group move through a complicated process and allowing enough room for participants to “own” the process.

4) Participants who reported a more favorable experience with the planning phase of the project indicated that the use of quality improvement tools for public health practitioners were helpful in guiding their group’s decision-making. Exercises such as the Force Field Analysis, Cause and Effect Diagrams, and Multi-Voting helped facilitate decision-making among one region regarding project selection and strategies needed for implementation. The use of structured exercises to guide decision-making processes can help groups quickly come to consensus on a matter, particularly when there are a range of experiences and opinions at play.

5) Public health leaders may also consider increasing the number of planning meetings and decreasing the time between meetings. Some participants felt as though they needed at least one more meeting to help their group solidify a plan for moving forward. Others recommended one additional meeting during the initial planning phase to review the results of the assessment (as described in recommendation #1) and one additional meeting at the end to further discuss their goals, objectives and next steps.

6) The evaluator noted during her interviews with participants that there was not a consistent understanding of the regional cooperation effort that public health leaders within the same region selected to undertake. It is important that all participants share a common vision and understanding of what they are working towards. It is possible that one or two more planning meetings will help groups develop this common understanding. Some sort of check-in or assessment of understanding is advised, particularly if a group will no longer be working with an outside consultant to facilitate the process.

7) Finally, many participants noted during the interviews that they were concerned with their group’s ability and willingness to move forward with their regional cooperation effort without an outside facilitator helping them along. Public health leaders are advised to build in some sort of structure to check in with groups and provide assistance as necessary to ensure that they are implementing their identified strategies.

4) Statewide Summit on Local Public Health in Kansas
In September 2008, the Kansas Association of Counties and the Kansas Association of Local Health Departments held a joint summit on the state of local public health in Kansas. The summit brought together county commissioners and local public health administrators from each of the 15 public health preparedness regions across the state for a facilitated discussion about the current strengths and gaps in local public health and strategies for closing existing gaps. The specific objectives of the summit were as follows:
1) To create a common understanding of the distinction between public health and county health (clinical care)
2) To raise awareness about the capacities required to ensure that all Kansans receive a basic level of public health protections and provide information about the current gaps in these capacities
3) To discuss structural scenarios and funding patterns that may help close the capacity gaps.

The agenda for the summit was developed following a pre-summit meeting with a select sample of county commissioners and local public health administrators. One of the major conclusions from the pre-summit meeting was that a significant portion of the summit needed to focus on creating a common understanding of local public health and expectations of local public health departments. As one person who participated in the pre-summit noted:

One of the biggest “aha” moments of that meeting was when we discovered that county commissioners really didn’t see a distinction between public health and county health, or direct service care. There was clearly not a good understanding among the commissioners on those two fronts.

The pre-summit meeting was influential in shaping the final agenda for the larger statewide summit. The first part of the summit was dedicated to creating a common understanding of local public health, including an overview of the 10 Essential Services that define public health and the capacities needed to provide these services. The conversation then shifted to the Kansas context where some of the gaps in capacity to provide essential services were presented. Drawing on the assessments conducted with the North East Corner and North Central Regions, the gaps in capacity to meet the essential services were then presented. Like other rural states, gaps in capacity are linked to a decentralized public health system, the small population size of most counties in the state, and limited funding for public health services. For example, rural health departments receive a higher portion of total revenues from state direct, federal pass-through and clinical services than urban ones. Federal pass-through funds are usually tied to specific programs or services and are not flexible enough to allow for adaptation to local needs or to support cross-departmental capacity building. Direct federal funding, which tends to be larger in dollar amounts and allow for some flexibility in spending, tends to be allocated through competitive grant processes that are difficult for rural agencies to access because of small size and limited staffing capacity. Like many mid-western states, local public health departments in Kansas will have a difficult time meeting national standards for local public health without some sort of organizational shift.

With accreditation for local public health coming in the near future, KALHD and KAC leaders raised the question of how to increase the capacity of local health departments in order to ensure that all Kansans have access to essential public health services. Drawing on public health service delivery models across the country, KAHLD leaders presented three organizational strategies that may help overcome these challenges. They included: 1) independent or stand alone health departments (the status quo), 2) consolidation of two or more health departments to create a regional health agency, and 3) regional cooperation among a consortium of health departments to provide a specific range of services. County commissioners and public health officials discussed the advantages and disadvantages of each of these organizational models. The discussions that ensued indicated that most participants strongly supported the regional cooperation model as a strategy for overcoming the gaps in capacity among local public health. The Kansas Association of Local Health Departments and the Kansas Association of Commissioners have had a strong working relationship over the years. Both expressed a commitment to work together to provide on-going education to leaders in their respective sectors in order to build the capacity of local public health through regional cooperation.
Next Steps
Each of the regions who participated in this development process have committed to implementing their strategic plan for Regional Cooperation. The regions will continue to meet regularly. Both are interested in identifying funding sources to support their efforts. At the state level, the Kansas Association of Local Health Departments will continue fostering dialogue with the local public health leaders and county commissioners to ensure that the need for Regional Cooperation is understood. In part, this work will entail on-going education about what public health is and the implications for local health department accreditation. This understanding is critical if any widespread support for reorganizing local public health is to be gained. Finally, participants in the effort hope to continue their dialogue and further refine the process they developed to plan for regional cooperation.

Major Accomplishments of the Regional Cooperation Project
At the conclusion of the project, participants in the Regional Cooperation project identified a number of benefits that resulted from their efforts. The first benefit was an increase in visibility and awareness of local public health at the county and state levels. At the county level, participants reported feeling as though commissioners had a greater understanding of public health services and expectations than before. Their leadership in developing an effective regional model may be of use to other service sectors across the state. Second, the process helped local public health administrators think about how to expand their cooperative planning beyond emergency preparedness. The hope is that cooperation in addressing other public health issues will be as successful as they have been for emergency preparedness. Finally, the project has expanded the long-standing collaboration between the Kansas Association of Commissioners and the Kansas Association of Local Health Departments. Both Associations understand that it is only by working together that the current gaps in public health service delivery will be decreased.

The Regional Cooperation planning work that KALHD representatives, consultants, and local public health officials from the North Central and North Eastern public health regions performed represents a critical movement from theory to practice. Such movements are, without question, hard work. As with any new effort, there were a few bumps in the road and unexpected events. Project leaders handled these events quickly and in collaboration with participating public health administrators. Moving innovative ideas into practice also help generate valuable lessons learned. We have a lot to learn from the experiences of participants in this project. Their reflections and recommendations will be of use not only to other public health regions across Kansas, but also to public health entities across the nation that are interested in reorganizing their local public health systems.
Massachusetts
The Commonwealth of Massachusetts is one of six states that make up the New England region of the United States. It has a population of approximately 6.4 million and is the smallest, but most populous, state in the New England region. It comprises a mix of urban, suburban, and rural areas, but most of the population lives in the Boston metropolitan area. Moving further west, the state becomes increasingly less populated. The state has seen both population increases and decreases over the last few years. However, the population size has remained roughly the same, with the loss of long time residents being replaced with immigrants from Africa, South America, and East Asia.

Massachusetts is most well known for its place in the history of the United States. The first Europeans to settle in North America were the Pilgrims, who initially settled along the state’s southern shores. Their settlement became the second most successful British colony in North America. Many were motivated to make the journey in hopes of finding religious freedom. But the struggles for such freedom continued for many decades to come and led to the development of new colonies such as Rhode Island and Connecticut. The struggle for freedom of religion and governance continued throughout the 1700s and well into the 1800s. Massachusetts became the center of the movement for independence from Great Britain. Many trace the protest spirit of Massachusetts to events such as the Boston Tea Party and the Battles of Lexington and Concord, which sparked the Revolutionary War.

One of the legacies of the protest spirit that led to America’s independence from Great Britain was a strong belief in local government. Like many states, Massachusetts is a ‘home rule’ state. Home rule legislation allows the people of every city and town the right to self-governance in local matters, limited only by the state constitution and the standards and requirements established by state law. Most states have approved one of two forms of ‘home rule’ – the home rule charter or an optional form of home rule. Massachusetts has approved home rule charters for municipalities while Kansas has optional forms of home rule. Home rule charters serve as “local constitutions” that are created and ratified locally. States with home rule charters have local municipalities with a greater control over local government, including the exercise of power over fiscal, functional and structural aspects of government.

Local Public Health in Massachusetts
Massachusetts has been a leader in public health since the early colonial days. Paul Revere established the first public health board in Boston in 1799. Since then, each city and town in the Commonwealth has been responsible for protecting the health of its citizens through the provision of public health services. Funding for local public health services comes largely from local tax dollars and revenue generated from fines and fees. There is no direct state funding for local boards of health or health departments.

Massachusetts is one of the few states that does not have 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. Although many states have decentralized public health systems, the challenge that Massachusetts faces is that the unit of government is at the municipal rather than county level. Municipalities range in population size from several hundred to more than 500,000 persons. Regardless of population size, all municipalities are expected to provide state mandated public health services in addition to locally mandated ones. Although larger municipalities may have the resources to meet most of their responsibilities, these are few in number. The majority of public health practitioners do not have the capacity to ensure that everyone in Massachusetts receives a basic

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level of public health protections as defined by the NACCHO’s Operational Definition of a Functioning Local Health Department.¹⁰

Need for Regionalization
There is a long history of interest in regionalizing local public health in the Commonwealth of Massachusetts in order to ensure equitable provision of services. The challenges of restructuring public health services within a context of local home rule have thwarted many previous efforts. However, a constellation of events in the late 1990s and early 2000s provided the kind of spark that local activists needed to reignite interest and support. These events included cuts in funding for state programs that supported public health nursing, the state laboratory, adult immunization programs and school health services. In addition, new state and local responsibilities emerged such as a doubling of septic system inspection requirements, expanded responsibilities for emergency preparedness planning, and increases in demand for food establishment and housing inspectional services.

Given the expanded responsibilities of local public health practitioners and cutbacks in funding to meet these responsibilities, there were few surprised by the results of the first statewide survey conducted with local public health officials to assess workforce capacity and responsibilities, financing, and perceived needs of local public health departments. Commissioned by the Massachusetts Coalition for Local Public Health in 2005, the study was conducted in collaboration with the Institute for Community Health. The study found that public health officials across the state focus most of their time on the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Food service regulation/inspection (95%)</td>
<td></td>
</tr>
<tr>
<td>Tobacco retailers regulation/inspection (84%)</td>
<td></td>
</tr>
<tr>
<td>Septic tank installation (92%)</td>
<td></td>
</tr>
<tr>
<td>Solid waste haulers regulation/inspection (77%)</td>
<td></td>
</tr>
<tr>
<td>Housing inspection (91%)</td>
<td></td>
</tr>
<tr>
<td>Food safety education (73%)</td>
<td></td>
</tr>
<tr>
<td>Enforcement of smoke free ordinances (89%)</td>
<td></td>
</tr>
<tr>
<td>Infectious disease surveillance (73%)</td>
<td></td>
</tr>
<tr>
<td>Swimming pools (public) inspections (84%)</td>
<td></td>
</tr>
<tr>
<td>Adult immunization (71%)</td>
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The results also highlighted a number of challenges that local public health officials face in carrying out these and other activities. For example, 70% of respondents reported inadequate staffing to meet basic regulatory and statutory responsibilities. Most health departments had not seen increases in allocations for local public health services despite rises in cost for employees, contractors, and materials. Many health departments also reported concern with an aging public health workforce, with approximately one-fifth of all inspectors and public health nurses in the state eligible to retire within two years. These and other findings have been used to highlight the need for restructuring local public health in the state.

During the formative phase of the project, one public health official also explained the need for regionalization in terms of the limited capacity of local public health departments to provide mandated services.

http://www.mphaweb.org/resources/strength_lph_6_06.pdf
People want to do a good job and there’s a lot of training put on, but there is no training that will teach you how to do public health inspection work. When you are responsible for 20 different subject areas, it is a real problem. You have people doing food inspections that were never trained to do food inspections...So I think the capacity issue is that you don’t have the bodies to provide all recommended public health services. Most departments have one person. They are expected to be experts on everything, which is unrealistic. Then you have communities where they don’t even have one person and they might have a half of a person.

Others who participated in the evaluation also noted that the lack of consistency in public health services across the state is of great concern. This lack of consistency is related to both the limited capacity of smaller public health departments, but also political will and commitment.

You have a current system with 351 communities that fund public health through their property taxes and have, through home rule, the ability to fund it as they see fit. They [municipal leaders] have different perspectives on the values and needs and roles of public health and that is not a rational system. We know that there places where things just aren’t happening... As you talk to people, you will likely hear some good stories about people changing diapers in the kitchen of the pizza place and other food inspection issues. So the benefit would be to provide some guidance to those 351 communities - not just guidance, but funding for locals to work together and with the state to accomplish all things that they needed to do.

Comments such as these were commonly echoed during the formative phase of this evaluation. Simply put, many believe that local public health officials in most municipalities are not able to fulfill their responsibilities to the public and meet performance standards given the resources currently available. A new organizational structure is needed that maximizes available resources and increases the capacity of municipalities to provide essential public health services to all residents.

**Massachusetts’ Approach to Planning for Regionalization**

Discussions about restructuring local public health in the Commonwealth have emerged recently from local activists and practitioners concerned with disparities in public health services across the state as well as positive experiences with collaborative programming, such as tobacco control measures, West Nile virus prevention, and emergency preparedness planning. Planning has been a grassroots, collaborative effort by local and state public health practitioners, legislative representatives and academics that call themselves the Working Group for Public Health Regionalization in Massachusetts.

The Working Group has changed in composition over the last few years, but has had a consistent mission, which is to:

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

The initial scope of work for the group included the following:

- Identify regional models for public health service delivery that are appropriate for Massachusetts and develop criteria for these models (e.g., minimum population size served, geographic area covered, etc.)
- Generate local and legislative support for restructuring local public health
- Review and amend legislation that may prevent communities from working collaboratively to provide public health services
• Clarify the roles and responsibilities at local, regional and state agency levels to strengthen and support an integrated public health system
• Establish standards for local, regional and state performance, including workforce credentials and agency performance measures
• Recommend a system to routinely deliver comprehensive training programs for the local public health workforce. Training activities must include supervised field training and be coordinated with performance standards and measures.

The efforts of this group were bolstered in the Fall of 2007 when NACCHO provided funds for administrative support to help with the organization of the Working Group and technical assistance to address legal and financial issues.

Project Successes
Over the last two years, the Working Group has had a number of successes, despite the many challenges posed by federal and state budget cuts and pockets of local resistance to altering the current public health system. The first success was the expansion and solidification of the Working Group. Members of this group represent diverse sectors of the public health system and are committed to a collaborative and inclusive planning process. The second success was the development of Guiding Principles for the Working Group, which has helped focus their planning efforts by creating a shared understanding of core values. Once these core values were defined, the Working Group revisited the regional models drafted by previous members of the Working Group and revised the descriptions as appropriate. Following the creation of the Guiding Principles, the group identified legal, financial, governance and other issues that needed to be addressed in order to facilitate regionalization planning. They then created subcommittees to address each concern. At the time of this report, most subcommittees were still actively meeting to develop recommendations pertinent to their scope of work. One major success, however, was achieved by the legislative committee, which reviewed and amended key legislation that would allow local communities to pool resources and provide public health services across multiple communities. This legislation was passed in the Massachusetts Senate and House in January of 2009.

One of the challenges faced by the Working Group is the time that it takes to fundamentally reorganize local public health in the state. Some constituents want change to occur immediately while others are more cautious or wary of “quick fixes.” Members of the Working Group frequently reminded themselves that change is a process, not a finite product.

I think what we need to explain to people is the regionalization process in my mind is a process of setting up a structure which will allow regionalization to occur. It means putting the right rules on the books, figuring out the right financial structures and makes it attractive enough so people will opt for this, but not dragged into this. The example I go back to when I start thinking about a case on how regionalization will occur is in Connecticut where they had this on the book since the 1960’s and they are still working to get everybody regionalized. It is not going to happen overnight and the state is not going to come swooping down and make everybody regionalize. We will give them hopefully the tools to get it done.

In the sections below, the steps taken by the Working Group to plan for regionalization are described in detail. The successes and challenges faced along the way are noted as well as recommendations for improving the process when available. Included in this reporting are the following:

A) History and current composition of the Massachusetts Working Group on Public Health Regionalization
B) Development of Guiding Principles for the Working Group  
C) Identification and definition of regional models for public health service delivery  
D) Description of legal, financial, governance, workforce, and other issues that need to be addressed in order to facilitate regionalization and the strategies developed for addressing them  
E) Overview of how the Working Group has generated support for regionalization across the state

These represent the primary activities of the Working Group to-date. They also represent activities that benefitted from the support provided by NACCHO and the Robert Wood Johnson Foundation

A) Formation of the Massachusetts Working Group for Public Health Regionalization
In 2003, the Massachusetts Coalition for Local Public Health issued a report on the state of local public health in the Commonwealth. In this report, they highlighted the disparities in local public health services provided across the state and in the inability of most local boards of health or health departments to fulfill mandates and responsibilities. This report, coupled with funding cuts and increases in demand for services led to the formation of the Working Group for the Massachusetts Public Health Regionalization Project. The initial Working Group was relatively small and comprised mostly of academics and a few local public health practitioners. This group pulled together research on public health systems across the country and available local public health service data to highlight the need for regionalization in Massachusetts in order for comprehensive services to be delivered to all residents.

In this first report, the Working Group made a strong case for why the regionalization of public health services was important and laid the foundation for how regionalization could be realized. Drawing on research from other states and service sectors, the report highlighted the success of regional service delivery models. Regional approaches “allow municipalities to share costs, benefit from economies of scale, and coordinate planning to improve health outcomes.” In addition, they highlighted the success of several networks of communities across the state that already had cooperative agreements to coordinate public health services.

This first report also outlined the beginning of what would later be called the Guiding Principles of the Working Group. First and foremost, they suggested that protection of home rule was possible and necessary in developing a regional public health system. This group also recognized that “one size does not fit all” when developing public health regions. The group envisioned the development of several different regional service delivery models that local authorities could select from to meet population needs and budgetary constraints. Given that some communities had already developed cooperative agreements to deliver public health services, these arrangements also needed to be respected, supported and accommodated.

This new group sat down and brought a lot of public health expertise to the table. It was a lot of unpaid work, but we started setting the bedrock of what this thing was going to look like in this state. If the history of this thing is ever written, it needs to reflect that this group worked on its own time and did an incredible amount of research, did an incredible amount of work and an incredible amount of discussion. One of the nice things about this group, and I said it publicly, is that anything that anyone wanted to put on the table was OK. The group would go over it and figure out whether or not they thought it would work. You had a room full of people with very strong personalities who are quite willing to talk about, pretty much anything and, as a process, that actually worked very well. We did that for 18 months.

In early 2007, the Working Group held a series of regional meetings with local and state public health officials to further develop the ideas that they had fleshed out through previous research and discussions. Presentations were made to twenty-two organizations across the state, including fifteen public health emergency preparedness regions and sub-regions, boards of directors of the five public health organizations comprising the Coalition for Local Public Health, and two western Massachusetts forums for boards of health. In the Fall of 2007, the Working Group also made presentations to the certification programs offered by the Massachusetts Association of Health Boards.

These presentations led not only to the further development of a vision for regional public health services, but also expanded membership on the Working Group. In particular, they heard a need for greater diversity in local public health officials to ensure that the unique needs of rural, suburban and urban communities were represented in planning conversations. Participation was voluntary, with new members identified by members of the Working Group and self-selected through interest.

As the group got bigger, it got more difficult to get some of the work done. I would say the original nucleus of people still had done much of the work to-date, but expanding the group was invaluable. We got critical insight on ideas on a quicker basis than we had in the past. And expanding the group then meant the people who felt like they were on the outside of the process more somehow connected to the somebody who was at the table who could then say “here’s what we done.”... It also helped in the spread of the idea and growing credibility for it throughout the state.

However, not all members of the Working Group felt that the expansion of the Group was adequate or as thoughtful as it could have been. Some felt as though there was initial interest following the statewide meetings and there was no process or structure in place to harness the interest and keep people involved.

We really needed to have a better structure for involving people who are interested in the project – whether they support it or not. It is just group process 101. Not something we managed to pull off. ...

I think, yeah, that we need to be explicit in the time we take to work on the project and definitely, anybody who says they are interested, finding a place for them to be interested.

Today, the Massachusetts Working Group is comprised of approximately twenty people that represent various positions within the public health system in Massachusetts. Included are local public health practitioners from urban, suburban and rural health departments, representatives from the Massachusetts Department of Public Health and statewide public health associations, legislative leaders, and academics. The Working Group meets every other month in locations across the state and communicates in between meetings via email and conference calls.

B) Development of the Guiding Principles

Feedback from the presentations made in 2007 to various public health leaders and practitioners led the Working Group to develop Guiding Principles for the project’s work. The top three concerns about regionalization among local public health officials and health board members were: 1) a loss of local control over decisions made to protect the health of residents, 2) a loss of jobs that may result from consolidation of public health departments, 3) a loss of municipal funds to support the provision of public health services. As one member of the Working Group explained, none of the concerns raised are intended outcomes of regionalization, but the need to address them was essential.

The regionalization meeting we had a couple of weeks ago I thought went very well. We have some big problems though. There were a lot of people who walked into that meeting and said “no way in hell I am behind this regionalization” because of the fear and the skepticism about job security.
There were also concerns about towns thinking this was a way to save costs. For example, if Wellesley and Framingham got together, it will eliminate one of the director positions... This is what they were looking at. This is not the intention. The other thing too is you've got very different needs in the state and one size does not fit all. Some may need districting. Some of us may just need to share some resources through mutual aid agreements. One of the stunning facts of the state is that 85% of the population in Massachusetts lives within 30 miles in the city of Boston. So you are talking about large rural areas in most of the state. The needs are different. I think the Working Group heard these concerns and has come up with strategies for addressing them.

One of the strategies for addressing concerns expressed by local public health leaders across the state was the development of Guiding Principles for the group's work. These Guiding Principles are considered the essential elements and cornerstone on which the group is building plans for regionalization. The Guiding Principles are as follows:

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

These Guiding Principles are referred to by members of the Working Group in nearly all planning meetings. They are also communicated to others in each public presentation and in all dissemination materials. The development of these Guiding Principles has helped allay concerns about the intentions of the Working Group and ultimately been instrumental in garnering support at the local level for rethinkng the organization of local public health in the state.

**C) Identification and definition of regional models for public health service delivery**

Early meetings with local public health practitioners and research conducted across the state focusing on resources, needs and governmental structure led members of the Working Group to believe that one regional model would not be sufficient or acceptable in a state like Massachusetts. After review of regional public health models that are in operation across the nation and discussions with a variety of public health professionals, the Working Group initially identified four regional models for public health service delivery. Two of the models were eventually consolidated after careful consideration because they essentially represented the same concept. This resulted in three public health service delivery models that the Working Group put forth as recommendations.

**A) Comprehensive Services Model:** A comprehensive model is one in which two or more municipalities join together to create a centralized agency that is responsible for providing a full complement of public health services. All local public health services are provided by one set of employees. Governance may be retained by the municipal boards of health or delegated to a regional health district comprised of representatives from each municipality. 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.

**B) Shared Services Model:** A consortium of municipal boards of health working under formal agreement to provide select, but not all, public health functions or services. Examples include sharing staff (e.g. Public Health Nurse, Animal Inspector or Epidemiologist) or providing services...
(e.g. inspections, communicable disease investigation). Such an arrangement would be most beneficial to larger suburban towns that have well-developed, professionally run public health departments.

C) Stand-Alone Model: All public health functions or services are carried out by an individual municipality that does not belong to a Regional Health District. 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, and Springfield) that have the resources and capacity to operate as a single-municipality district.

Once the models were defined, the Working Group began identifying operational and governance details that needed to be fleshed out for each model. Some of these details are similar across the models. Others require more individual attention. For example, each group of participating communities will need to develop a governance agreement that is tailored to its particular organizational model. Filling out these models with concrete recommendations and guidelines has comprised the bulk of the work for the Working Group over the last year.

D) Description of legal, financial, workforce, governance and other issues that need to be addressed in order to facilitate regionalization and the strategies developed for addressing them

Once the regional models were defined, the Working Group identified a number of tasks and barriers that needed to be addressed in order for the project to move forward. The Working Group took the better part of one meeting to identify the work that needed to be done, and then broke up into sub-committees to address concerns and develop recommendations for each area. It was decided that each sub-committee would report back to the Working Group on their progress.

The Sub-committees and a brief description of their scope of work are below:

- **Legislation.** Review and amend legislation to align the Working Group’s Guiding Principles with the law. Provide education and consultative services to members of the legislature and others to ensure support for the amendments.

- **Funding.** Work with a NACCHO-funded consultant to develop a funding formula for each regional model.

- **District minimums.** Conduct research on other regional public health models and make recommendations related to population, land area, and geographic boundaries

- **Performance standards / Agency accreditation.** Research performance and agency accreditation standards (in conjunction with the Public Health Accreditation Board). Consider things that are specific to Massachusetts (such as use of MAVEN—the on-line surveillance system currently being implemented) as well as minimum staffing levels based on population and/or other measures (i.e. # food establishments, # septic systems).

- **Workforce credentials.** Describe minimum education levels, credentials, and certifications for each major job title in a local health agency (Board of Health member, Health Agent/Director, Health Inspector/Sanitarian, Public Health Nurse).

- **Regional governance.** Develop a template for regional governance structure (comprehensive model). This will help inform governance structures for other models.
Additional sub-committees were identified, such as social marketing and evaluation of regional pilots. However, the Working Group decided to postpone work in these areas until the work outlined above was accomplished.

Below is an overview of the work that was accomplished by each sub-committee by the end of the project period (12/31/08). Most of the sub-committees were still actively researching the issues associated with their topic and developing recommendations for the Working Group. For most areas, the primary issues or challenges were identified, but the recommendations were still in the process of being developed.

**Legislation Sub-Committee**

Early in the Working Group’s planning around regionalization, legal issues were considered a top priority to address in order for any significant momentum to be gained in garnering support for the effort. The process for addressing legal barriers to regionalization was carefully thought out and accomplished through the leadership of a public health legal specialist in the state. Her work was supported through NACCHO funds and has proven to be invaluable to the effort.

The first step taken by the legal sub-committee was to review existing laws in Massachusetts to see what might or might not be applicable to regionalizing public health. Amending existing laws is easier than introducing new ones. There were three laws that were found to be relevant to regionalization and public health. These laws were in Massachusetts Law Chapter 111, sections 27A, 27B and 27C. These three laws were written decades ago, but could be updated to reflect the Guiding Principles set out by the Working Group.

The second step was to meet with existing entities or health departments that were already engaged in some sort of regional service provision to see how they were operating. The hope was to amend the existing laws in a manner that would respect existing regional efforts and help bring them into compliance with the law. Three regional efforts were found across the state. Discussions with public health leaders in these areas helped inform changes in the law.

Finally, the legal team did a close reading of the existing laws and began suggesting changes that would align the laws with the Guiding Principles of the Working Group. In general, the changes made to each of the laws ensured the following: 1) that local authority vested in local boards of health was retained if two or more communities decided to share services or consolidate health departments; 2) the existing public health workforce was protected from layoffs if communities decided to regionalize services, and 3) funding for local public health is augmented, not taken away, as a result of regionalization. Two of the laws (27A and 27C) only needed minor modifications to be aligned with the Guiding Principles. The third law (27B) was considered the most important for regionalization and required more significant changes.

On March 3, 2008, the Working Group, along with its legislative partners, introduced a bill to amend existing legislation found in MA Law Chapter 111. The Bill – S.2784 - was sponsored by Senator Susan C. Fargo and Representative Peter J. Koutoujian, co-chairs of the Joint Committee on Public Health. Over the course of 10 months, the bill was revised several times to address minor concerns raised by legislative representatives. Members of the Working Group also met with legislative leaders periodically to garner support for the bill. Eventually, Chapter 111 was amended to become Chapter 529 of the Acts of 2008, an Act Relative to Public Health Regionalization.
An unexpected victory for the Working Group came late in the 2008-09 legislative session. Senate Bill S.2784 passed both the House and Senate on January 8, 2009, and was signed into law by Governor Patrick on January 15, 2009.

The revisions to Chapter 111 that are now found in Chapter 529 of the Acts of 2008 are described in a brief that the sub-committee issued shortly after the law passed. They are as follows:

- Cities may now enter into agreements to co-hire health directors. Only towns were allowed to do so before.
- Boards of Health must now vote to approve forming health districts. Under the old law, only City Councils or Town Meetings had authority to do so. Now, approval requires votes from both the Board of Health and the City Council or Town Meeting for all communities forming a district.
- The new law respects home rule authority of cities and towns. Under the old rules, communities that formed health districts were required to transfer their policy making authorities to those districts. Now, communities have the flexibility to decide whether to transfer or keep their board of health authority.
- New communities may now join existing health districts. They were not allowed to do so before.
- Communities have the flexibility to design governance agreements, financial terms, and service sharing arrangements that work for them.
- Chapter 529 includes a variety of protections for local public health workforces. Civil service, retirement, and compensation rights are protected under the new law for full time and part time municipal employees who are transferred into districts. Rights are also protected for employees of towns that withdraw from districts.
- The new law shortens the minimum time communities must participate in districts from five years to three years.
- Chapter 529 charges the Department of Public Health, in consultation with the Department of Environmental Protection, to develop workforce credentials for district directors and performance standards for districts.
- In turn, the new law provides the legal basis for state funding of start-up and operating costs of districts. The new law does not provide funding for districts. State support for district operating costs is subject under the law to financial appropriations by the legislature.

Members of the Working Group and other public health leaders across the state believe that the changes made to the law allow for greater flexibility and creativity in how governance and service sharing arrangements are developed.

Funding Sub-Committee
One of the biggest challenges faced by the Working Group is the development of recommendations for how regional health services should be funded. With limited dollars available for public health services, the goal is to develop funding standards for public health to maximize existing resources and ensure that residents can have equitable access to public health services.

What this subcommittee found in working with the NACCHO-funded financial consultant was that most funding formulas rely on a straight per-capita allocation. This is the manner in which federal funding is typically distributed in Massachusetts and other states. Some argue that simple per-capita formulas are inherently fair in that they treat each entity in the same manner. However, members of the working group

12 New State Law Changes Rules for Public Health Districts, prepared by Cheryl Sbarra and Geoff Wilkinson. PDF file can be found on the Boston University website: http://sph.bu.edu/index.php?option=com_content&task=view&id=671&Itemid=616915
were concerned that these formulas do not address the unique qualities and needs of individual municipalities, such as availability of health-related resources, economic status of residents, community expectations for public health, and the availability of other funding streams. One member of the Working Group expressed concerns with simple funding formulas as follows:

We have had one recommendation to develop a funding formula that specifies that each town will pay 2 bucks a head because that is what everybody else is paying and every life is worth the same as every other life. In fact, that is just not true. That is the dumbest thing I have heard about a formula. Why in a town like Newton [a wealthy community] is it $2 a head and $2 a head in a town like New Bedford or a town like Turners Fall. They have 8,000 people and 7,000 of them live below the local poverty level. They have no nurse, nothing. How is that fair? That is just politically expedient, it isn’t fair. It isn’t getting us to where we need to be.

At the time of this report, the sub-committee was still working with the financial consultant to finalize their recommendations. Of importance to the group is the development of a funding formula that can take into consideration the unique qualities of municipalities, such as poverty, population density and population size. The committee is also considering recommendations for providing incentives to small communities for forming regional public health districts and for having a larger number of communities included in their health districts.

District Size Sub-Committee
This sub-committee reviewed the district minimums found in other states with regional models and found that states typically develop minimums based on population size, geographic distance, or some combination of both. Given the diversity in the size of local municipalities and the relatively large rural municipalities found in the western part of the state, the sub-committee decided that one measurement for a district would not be adequate for the state. Following several lengthy discussions about their findings with the Working Group, the sub-committee put forth the recommendation that a health district should either serve a population of at least 50,000 OR cover a geographic area of 155 square miles OR an entire county. The Working Group agreed that these minimum requirements would provide sufficient flexibility for local municipalities in creating regions that are cost-effective and sustainable.

Performance Standards and Agency Accreditation Sub-Committee
The Working Group’s performance standards and agency accreditation sub-committee includes a representative who is currently sitting on the national Public Health Accreditation Board. The sub-committee has agreed to wait for the national standards to be released and to review them before making recommendations to the Working Group. The national standards are likely to serve as the foundation for performance standards for regional public health districts in Massachusetts.

Workforce Credentials Sub-Committee
The work of this sub-committee was accomplished largely through another statewide subcommittee formed by the Local Public Health Institute of Massachusetts (LPHIMA). This group began working in March of 2006 to develop a competency model and set of competencies for the local public health workforce in Massachusetts. The sub-committee was comprised of a mix of local practitioners and academics.

When the LPHIMA subcommittee was established in 2006, one of the first steps was to gather information on existing competency sets and models that might pertain to local public health. The subcommittee then

13 The history of the Local Public Health Institute of Massachusetts subcommittee on workforce credentials was provided by Kathleen MacVarish in her adaptation of the recommendations put forth by the subcommittee.
developed a model for local public health competencies, based on five specific positions held within the local agency, and a set of cross cutting competencies that pertained to all of these groups:

1. **Environmental Health Professionals** (defined as health inspectors, sanitarians, code enforcement officers, compliance officers, and environmental health specialists)
2. **Governing Bodies** (defined as elected and appointed Board of Health members, health commissioners, or legally designated health authorities)
3. **Heads of Local Health Agencies** (defined as heads of local health agencies, directors, health agents, health officers, or other administrative heads designated by the governing body)
4. **Head of Regional Health Districts** (defined as heads of a regional health district, directors, or other administrative heads designated by the governing body)
5. **Public Health Nurses** (defined as a nursing professional with educational preparation in nursing science with a focus on population-level outcomes).

Pre-requisites for each of the five positions were also developed. The draft competency model and sets were then compiled into one overall document, with some edits and revisions by the group. It was then sent to a number of representatives from various agencies, organizations, and associations for further review. Feedback from this group was incorporated into an updated document. The MA Public Health Regionalization Project’s subcommittee on Workforce Credentials reviewed and revised the updated document pertaining to workforce pre-requisites and the analysis and recommendations from BUSPH doctoral candidate Craig Andrade’s report (Public Health Workforce Credentialing for MA, Dec. 2008). Both subcommittees will convene to come to consensus on a final set of pre-requisites.

The result of the work of both sub-committees is a consolidated list of interdisciplinary, cross cutting competencies and specific Program Area competencies which can be used to identify training programs that address these competencies, and gaps where training needs may exist. The lack of standardized field training for many of the program areas has been identified as a major concern and should be a priority for new course development. These recommendations will be forwarded to Massachusetts Department of Public Health as suggested requirements for the local and district workforce.

The sub-committee of the Working Group recognizes that workforce credentialing is going to be a sensitive subject for many local public health practitioners. One member of the sub-committee explained:

> In terms of training and workforce requirements, that is going to be a big issue because we are arguing that regionalization would provide a greater degree of professionalism. We will need to track that and determine if it is actually the case. We are assuming that there are enough health care professionals to fill all the slots that we are trying to create with these regional entities between those already working in the field and those trying to get into the field. Well I am not entirely convinced that is the case. If it is not the case, we need to figure out how to train all of these local public health people. God bless the public health schools, but they don’t train people to do this stuff. Many of them don’t see this as their mission or part of their mission. I am not sure where are going to get the workforce from, especially since there are a lot of people looking at retirement in the next 5 years.

In other words, although formal education and training are recognized as primary ways of increasing the capacity of local public health departments by ensuring a well-trained workforce, there are few mechanisms currently in place to provide the recommended training. With fewer and fewer people entering the local public health workforce, the need for a professionally trained workforce must coincide with efforts to increase the number of people interested in entering the profession.
Governance Sub-Committee

The task of this sub-committee was to develop a template for a governance structure that would be appropriate for a regional public health district. The work of this sub-committee was still underway at the time of this report. The sub-committee is developing a template for regional By-Laws. The draft recommendations are as follows:

- Each regional health district will be governed by a regional board of health that consists of at least one representative from each of the constituent municipalities. Any constituent municipality with a population unit greater than 10,000 may have one additional representative per unit or majority fraction thereof beyond the initial 10,000, but not to exceed five representatives.
- A representative’s term should be no more than 3 years and may be re-elected for a maximum of 2 terms
- Votes made by a district board of health may follow one of three models:
  a) Each member town shall have one vote in the decisions of the District.
  b) Each member town shall have one vote per 10,000 population or majority fraction thereof beyond the first 10,000, not to exceed a maximum of 5 votes.
  c) Each member town shall have a weighted vote by population.
- The Board shall meet at least four times per year, the date and place to be determined by the Board.
- In order to protect local Home Rule, in matters pertaining to an individual town, the Board shall have no voice. Such matters should be handled as strictly local issues between the local Board of Health concerned and the District Health Director acting in his/her official capacity as the local Board of Health’s employee. In matters affecting the group of towns as a whole, such as the setting of fees, decisions will be made at a District Board meeting.
- There will be a number of different ways that municipalities can create their annual budgets. These include population-based formulas or a formula that is based on a determined percentage of the district’s services a constituent municipality wants to use (calculated by #hours). Members of this sub-committee know that their recommendations may change based on requirements made by the Massachusetts Department of Public Health in order to qualify for allocation of future State regionalization incentive funds.

Also included in the By-Laws template created by the governance sub-committee is the incorporation of requirements for district public health officials and staff (i.e., officers of the board of health, regional health director, public health nurse). The sub-committee expects to have draft recommendations for the template ready by April of 2009.

Status of Sub-Committees and Next Steps

One of the major challenges facing the Working Group was the length of time that it took for the sub-committees to develop their recommendations and circulate them for feedback. As interest in regionalization began to percolate across the state, the Working Group struggled to maintain the momentum gained from the statewide presentations in the absence of concrete guidance to help local communities move forward. There were many requests for concrete guidance that would allow communities to move from an abstract concept of regionalization to a realistic vision and plan for change. Although members of the Working Group recognized the need to quickly move forward, they were also participating on a volunteer basis, with no additional financial supports or incentives. Without question, it has been difficult for many members to meet, identify the major concerns facing their sub-committees, and develop recommendations that account for the vast differences in local public health across the state.
The slower than anticipated planning process has led many members of the Working Group to think critically about the importance of timing for an initiative like this. In particular, a key lesson learned is that you have to be ready for action once interest is generated.

Recommendations from each of the sub-committees were expected to be provided to the larger Working Group by April of 2009. At the time of this report, most sub-committees had presented drafts of their work and were incorporating feedback from a variety of participants in preparation for the presentation of final recommendations. The recommendations of the sub-committees will then serve as the foundation for a White Paper on Regionalization in Massachusetts. This report will be disseminated widely across the state to local public health practitioners, representatives from municipal and state governments, and academics. The hope is that the recommendations developed by the Working Group will be used as a springboard for local communities who are interested in reorganizing their local public health services.

**F) Generating support for regionalization across the state**

Without doubt, one of the biggest challenges faced by the Working Group over the last few years has been the willingness of local and state public health officials to talk about changing the public health system in the state.

I think the biggest challenge initially was getting people to talk about it. For a long time there were just a handful of people that seemed open to some kind of change. They were the ones who came to the Steering Committee... It has grown though. Maybe one of the biggest challenges is getting people to actually be open to the idea of thinking about regionalization as a viable model in the state.

One of the turning points for the Working Group was when they reached out to local public health officials during the winter of 2007 and presented their preliminary ideas about regionalization. Through presentations made at a variety of regional public health meetings, members of the Working Group learned that there was potentially more support for rethinking the organization of local public health than originally expected. One member explained,

I think it is difficult to characterize it because there are some little towns who are supportive of it, some little towns who hate it and the same for mid-size and others. There are urban towns who are supportive and others who hate it. I think it really comes down to the individual health director who sets the tone for the town’s willingness to participate.

The challenge was to engage public health leaders who “loved and hated” the idea of regionalization and get them involved in the planning process. To some degree, this is what the Working Group did following the statewide presentations. As noted previously, they expanded membership on the Working Group by inviting respected local public health leaders to sit at the planning table. Support for regionalization was not a requirement for participation. Rather, the Working Group needed and wanted local professionals who were open to hearing new ideas and thinking creatively about how to address the growing problems facing the public health system. Expansion of the Working Group to include more local public health practitioners did help bolster support for regionalization in some pockets across the state.

In an effort to build on the momentum gained from the presentations made across the state to various constituent organizations and to gain support from political representatives, the Working Group decided to hold a statewide conference on regionalization in the Massachusetts State House. In February 2008, local and state public health officials sat together with representatives from both the House and Senate to hear about the case being made for regionalizing local public health, the Guiding Principles of the Working
Group, and preliminary ideas for regional models. The Working Group fielded questions from participants and gathered input on both the content of their ideas and the process for moving forward. Feedback from this conference included the following:

- Recommendations put forth by the Working Group need to be made in a manner that ensures that local communities can be creative in how regional services are organized.
- Many local public health officials are concerned that this is a state-led initiative that will be mandated from the top. Members of the Working Group should continuously remind people that this is a grass-roots initiative with active involvement of local and state public health officials.
- Municipal governing bodies need to be brought into the conversation about regionalization as soon as possible. These leaders will ultimately make decisions about regionalization and their support is needed.
- Any regional models for local public health service provision need to be developed with the state in mind. The state Department of Public Health may need to reorganize as well in order to ensure that essential services are provided.
- Members of the Working Group should identify legal ways to protect local contributions to local public health services and ensure that state contributions augment, not replace, local funding.

This feedback was not surprising to members of the Working Group and was generally aligned with the spirit of their recommendations to-date. Many felt energized by the support that was provided for the work.

Shortly after the meeting at the state house, legislation was introduced with the support of a member of the House and a member of the Senate. The Working Group continued to seek support for the legal changes through outreach and education to members of state congress. There was little political opposition to the amendments made to the legislation, and as noted above, recommended legislation passed in January of 2009.

The Working Group knows that it needs to continue garnering support for the effort among local public health officials and governing bodies. After a flurry of work by the various sub-committees to flesh out the models and develop more concrete recommendations for regionalization, the Working Group is hoping to conduct another series of outreach meetings across the state. These have yet to be scheduled.

One of the successes of the Working Group has been the support they have earned over the years for an issue that historically has been an unpopular topic. When asked about the strategy that underlies their success in opening up the dialogue, one member of the working group explained:

> It is like a bedrock of most politics. You sit down and talk to people and see what they are up to. Basically, I think we have done a lot of work around the structures and some of the financing and stuff like that. We are in a position that were we just need to meet with anyone that wants to meet with us and some people who don’t want to meet with us... More recently we have gotten more of a unified message. We have taken a lot of disparate ideas from talking with people, developed some regional models, have some ideas about how much it might cost and how it would impact different types communities. Now it is getting that message out and showing that this is really a genuine effort of a broad cross section of the public health workforce.

**Recommendations for Planning for Regionalization**

Members of the Working Group had a number of recommendations for other public health entities who may be interested in regionalizing local public health services in their states. They are as follows:
1) Make sure you have the right people involved in the planning process from the beginning. Identify people who are knowledgeable about local public health and bring them together. Others may be included in the planning group, such as academics and state public health officials, but a sustainable effort needs to be informed by local practitioners.

2) Identify potential opposition to the idea of regionalization early on and engage those individuals. Some will agree to participate and their perspectives will challenge the group to think carefully about their recommendations and craft them with a broader audience in mind.

3) Create a planning environment that is open and conducive to the generation of ideas. Encourage dialogue and respectful, constructive feedback. Members of a planning group also need to be willing to talk about preliminary ideas with a variety of constituents and be open to incorporating feedback from others as appropriate.

4) Develop a strategy for providing education to and sharing ideas with local and state governing bodies. Their support is crucial. They will likely initially need basic education about what public health is and what is expected of a functional local health department. Create two-way communication tracks and use them regularly so that the concerns (if any) of the decision-makers are known and addressed proactively.

5) One of the most important recommendations is to conceptualize planning for regionalization as a process that encompasses more than just structural issues. Developing models and recommendations for how regions can function is just one aspect of the work that is needed. As one member of the Working Group explained:

   The truth of the matter is that it took us 20% of our time to figure out the structures, the financial stuff and things like that and 80% of our time was spent running around, talking to people, running our ideas up flagpoles, assessing what makes sense. Coming up with the three models did not take much time at all.

Planning groups need to recognize who the important players are, understand their personalities, identify fears and concerns, and develop strategies for working with all of these personal characteristics.

   You got to realize you are going out there and potentially threatening everybody who works in local public health. You need to figure out how you can support them and give them some sense of comfort about how this is going to work and what your intentions are. If they feel that their jobs are threatened by the effort, the conversation will end.

6) Finally, planning for regionalization is a process, and often a very long one. Given the unique characteristics of local public health departments across the country, there is no simple recipe to follow. Public health leaders interested in regionalizing services should know from the beginning that it is a process, marked by incremental changes that sometimes propel you forward, and sometimes send you back to the drawing board. Commitment to the effort is crucial and can be sustained when “small wins” are recognized and celebrated.

**Moving the Process Forward in Massachusetts**

The gray cloud of economic turmoil that seems to be permanently hovering overhead in the United States may have a silver lining for the regionalization effort in Massachusetts. In the fall of 2008, the Governor cut more than $28 million from the Massachusetts Department of Public Health budget, nearly 5% of its appropriation. These cuts yielded an array of staffing and program reductions that impact the public’s
health, including the department’s immunization program, substance abuse services, public health hospitals, family health services, HIV/AIDS programs, and health promotion and disease prevention initiatives. In January 2009, Massachusetts’ cities and towns braced for hundreds of millions of dollars in additional cuts in state funding. The ripple effects of the economic crisis are felt across all service sectors and in all communities across the state.

As state and municipal budgets have tightened, an increasing number of public health and municipal leaders are recognizing that current systems must change if residents are to be provided with even basic public health services. Cuts in municipal budgets have sparked new conversations about regionalization. With the passage of legislation in Chapter 529, an increasing number of communities are beginning to talk with one another about sharing public health services. Some municipal leaders have opened the door as a knee-jerk reaction to budget cuts and threatened to close down their public health departments all together. However, these reactions are few and will likely not result immediately in drastic changes.

The Working Group is currently developing strategies to take advantage of the doors that are opening. Their first task has been to complete the work identified for their sub-committees and come to consensus as a group on the recommendations made. Once finalized, the Working Group will begin another series of statewide presentations to discuss the recommendations developed. Modifications will be made as appropriate.

In addition to finalizing and disseminating the group’s recommendations, new funding from the Robert Wood Johnson Foundation has recently been obtained. This funding will support efforts to develop a data-informed process for local communities to use when making decisions about regionalization. This process will draw on lessons learned from both Kansas and Massachusetts in their respective efforts to regionalize local public health services in their states.