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Massachusetts: Increasing Local Collaboration

With support from the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the Centers for Disease Control and Prevention (CDC), NORC at the University of Chicago is compiling a series of promising practice reports highlighting successful practices in public health coordination on the state and local levels.

MASSACHUSETTS' PUBLIC HEALTH SYSTEM

Massachusetts has more local health departments than any other state, with one in each of its 351 cities and towns. State statute requires that each city and town establish an independent local health department (LHD), which is responsible for enforcing sanitary and environmental public health codes, issuing public health ordinances, and carrying out state-mandated public health programs. Most of the funding for local public health activities comes from local taxes and fees, as the state does not directly contribute funds for mandated enforcement activities.

In addition to the LHDs, the governmental public health system in the state includes the central office of the Massachusetts Department of Public Health (MDPH) and its five Regional Health Offices (including Central, Metro Boston, Northeast, Southeast, and Western Regional Health Offices). Staff within the regional offices serve primarily as contract managers and direct service providers for MDPH programs; some provide technical assistance to LHDs as needed, primarily in the area of environmental health. One LHD representative explained that the Regional Health Offices are a "good technical resource" available to the LHDs when needed.

NPHII HIGHLIGHTS

With funding through the National Public Health Improvement Initiative (NPHII), the Massachusetts Department of Public Health (MDPH):

- Awarded 11 grants to support local health departments (LHDs) in planning and assessing the feasibility of local health districts. (Grants engaged a total of 113 cities and towns with nearly 2 million residents.)
- Awarded 5 implementation grants based on the plans developed by LHDs through the planning phase of the project.
- Provided technical assistance to help grantees consider different models for improving the scope and quality of public health services and for strengthening public health infrastructure by working collaboratively with other LHDs.

While the public health system in Massachusetts is decentralized in structure, the state and local health departments, according to an MDPH representative, “work on the basis of mutual respectful partnerships.” MDPH communicates information, such as changes in policies or guidelines, to LHDs on an as-needed basis, typically through MDPH’s bureaus and programs at the state and regional level. In addition, there are professional associations including the Massachusetts Association of Health Boards (MAHB), Massachusetts Health Officers Association (MHOA), Massachusetts Association of Public Health Nurses (MAPHN), and Massachusetts Public Health Association (MPHA) that help LHDs communicate with MDPH.

INCENTIVE GRANT PROGRAM FOR REGIONAL PUBLIC HEALTH DISTRICTS

With funding from the Centers for Disease Control and Prevention (CDC), through the National Public Health Improvement Initiative (NPHII), MDPH launched an incentive grant program to support LHDs and other local entities in planning and implementing regional public health districts throughout Massachusetts. The overarching goal of the grant program is to improve the scope and quality of local public health services and to improve local public health infrastructure. MDPH has rolled out the incentive grant program in two phases—through competitive planning grants and implementation grants. MDPH released a Request for Responses (RFRs) to cities and towns in Massachusetts for funds to assess the feasibility of and develop plans for forming health districts that share services and staff in one of three models—consolidated districts, shared services, or contracting for certain services. According to an MDPH representative, the state encouraged districts that used the most comprehensive shared services arrangement possible. The RFRs stipulated certain criteria for forming health districts, including the size of the district (based on population or number of municipalities engaged) and a mix of support from municipal and Board of Health leadership.

MDPH developed the RFRs based on the principles identified by the Regionalization Working Group, which has been convening since 2004. Working Group members include representatives from LHDs, MDPH, and professional public health associations, as well as state legislators and other government officials. MDPH also sought and incorporated feedback from LHDs before the final RFRs were issued. For example, the requirement that the initiative be supported by a mix of local stakeholders was added to the RFR based on the experiences of a few LHDs who felt that municipal officials may view regional public health districts as opportunities to initiate cutbacks rather than to enhance public health. For that reason, applicants were required to demonstrate support from their Boards of Health. In addition, the state included in the final implementation RFR requirements about the qualifications of staff hired in full or in part by the incentive grant funds. In describing the development of the RFRs, an MDPH representative explained that the state sought to avoid the impression that it was “standing up on the lectern, dictating what [the local health departments are] supposed to do;” instead, he said, it is “a matter of listening carefully to see what people thought about the details and then adjusting it. That’s the key lesson: we have to be responsive. On the other hand it’s fair to say too that we have to have sufficient spine to go forward despite criticism.”

Using funding from NPHII, the state awarded planning grants to 11 districts that engaged a total of 113 cities and towns with nearly 2 million residents throughout Massachusetts. Only those districts who received planning grants were eligible to apply for implementation grants. MDPH received nine implementation proposals and awarded five implementation grants.

State-level Support

MDPH developed resources for LHDs to use throughout the planning and implementation process. MDPH hired two consultants to serve as liaisons working with the grantees. Experts were available to provide technical assistance on an as-needed basis in such areas as developing needs assessments, conducting evaluations, and creating legal documents like MOUs. In addition, MDPH created a toolkit that includes templates and

sample documents, as well as spreadsheets to help grantees gather and analyze information about the staffing, expenditures, and services of the health departments that are participating in the planning effort. This type of analysis is helpful in determining which services the LHDs might consider sharing. One local health official said the toolkit provided a “roadmap” for important considerations during the planning processes.

The assistance that MDPH provided in working through the planning grant was viewed as very useful by local health departments. The liaisons provided insight on important considerations for forming health districts as well as tips for approaching the planning process. However one health department representative noted that some of the assistance may have been introduced “too early in the process for us to make full use of it.” This individual commented that the technical assistance might be more useful for the implementation grant opportunity.

CHALLENGES, LESSONS, AND OPPORTUNITIES

MDPH and the grantees acknowledge that discussions around regionalization can be contentious. They described several considerations that can help facilitate this process.

Framing the initiative. MDPH made sure the regional health district effort was grounded on the prior work and principles established by the Regionalization Working Group, which had already established buy-in from multiple stakeholders. MDPH has emphasized the need for the regional health districts to be “incentive driven and flexible,” as well as a “voluntary initiative that respects the legal authority of [LHDs].” The Regionalization Working Group also articulated a strong commitment to reducing capacity gaps and eliminating regional disparities. Geoff Wilkinson, Senior Policy Advisor at MDPH, explained that “Your residence should not determine the quality of public health protection and services that you receive.” He also commented that “we’ve gone out of our way to emphasize that the goals of the program are to improve scope and quality of services and that this is not a short-term strategy to save cost.” Messaging for this initiative is critical. For example, based on advice from local officials, MDPH has shifted away from describing efforts to identify “excessive management capacity” as this can sound threatening to health officials who fear regionalization efforts might lead to job cuts.

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Geoff Wilkinson, MDPH

Building support for collaborative efforts. The grantees offered several suggestions for building consensus among the LHDs in their regional health districts, including:

- Use the data-gathering phase of the planning process to identify how the regionalization plan will address the different needs of each community to ensure each feels it has something to gain through participation.
- Emphasize that regionalization might provide opportunities to better address chronic diseases and other public health issues beyond the mandated enforcement activities; these prevention initiatives might garner widespread support in the communities.
- Acknowledge that there are risks involved in regionalization discussions and address these concerns openly.
- Have concrete, “in the weeds” discussions about what the proposed arrangement would look like and its implications on budgets and staff. Health departments will be less likely to commit to a plan if they do not have a clear understanding of what the regionalization effort would mean for them.

To help navigate the sensitive topic of regionalization, several of the grantees hired consultants. One LHD representative explained that the consultant was a “key member of our leadership planning meetings” who contributed to discussions, drove the agenda, and provided general support throughout meetings. Another

grantee noted that a consultant with broad knowledge of municipal finance, legal agreements, and different regionalization structures proved particularly helpful throughout their planning process.

It is also important to maintain support and open communication within the health department. One local health official met individually with staff and discussed professional development opportunities to address concerns raised about the workforce requirements in the implementation RFR. These meetings also served as an opportunity to reinforce the message that the regional health district effort is not motivated by a desire to cut costs in the short term.

Determining whom to include in the district. Health department representatives commented on the benefit of engaging in planning efforts with LHDs with which they had pre-existing relationships. LHDs that have worked together in the past may have developed trust for one another—they know each other’s staff, and they understand the needs of each other’s communities. One LHD representative commented on their successful planning experience, saying that “If we hadn’t had that history of working together and that trust building, I don’t think it could have worked.” This individual elaborated that the pre-existing relationship is important because it enhances “the willingness of the people to not completely set aside the needs of their own department, but to think more broadly within the region to devote resources to beef up another community’s public health efforts because it benefits the whole region, although you might not see the direct impact in your town.” Several grantees mentioned the importance of ensuring that the LHDs considering regionalized approaches are geographically close to each other.

Taking adequate time to plan. MDPH’s intent in splitting the incentive grant into two parts was to provide local health departments with the time needed to carefully review options and to develop a well-thought out approach to health districts. One LHD representative explained that without the two-part funding it is likely that health departments “would have jumped into implementation without adequate planning. That’s what people want to do—to show results without planning. I don’t think it would have been as good a process.” Two municipalities who engaged in the planning effort said that they found great value in the experience and commented that even if they are not awarded an implementation grant it would not “be viewed as a waste of time.” At least one of the health departments with which we spoke was not awarded the second stage of funding.

Overall, the planning grants were viewed as a productive experience that offered local health departments the opportunity to review the work they accomplish within their communities. The initiative has also allowed the LHDs and MDPH to explore new models to improve the scope and quality of public health services.

FOR MORE INFORMATION

About the Incentive Grant Program:

- www.mass.gov/dor/local-officials/dls-newsroom/ct/new-state-incentive-grant-program-to-fund.html

MA Public Health Regionalization Project:

- <http://sph.bu.edu/Regionalization/massachusetts-public-health-regionalization-project/menu-id-617432.html>

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