

**POTENTIAL FOR INTER-MUNICIPAL COLLABORATION ON
THE DELIVERY OF LOCAL PUBLIC HEALTH SERVICES**

**A Preliminary Assessment of Seven Municipalities
in the MetroWest Region of Massachusetts**

FINAL REPORT

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EXECUTIVE SUMMARY

With support from the MetroWest Community Health Care Foundation, a preliminary assessment was conducted with seven towns in the MetroWest region of Massachusetts during the Summer and Fall of 2009 to collect comparative information on municipal Board of Health/Health Department services, as well as capacity and interest in increased inter-municipal collaboration for the delivery of local public health services. In conducting this assessment, information was collected through interviews and surveys of Health Department staff and Executive Management/Leadership in Ashland, Holliston, Hopkinton, Medway, Sudbury, Wayland and Weston. Interviews were also conducted with representatives of other agencies involved in public health service delivery and individuals involved in developing or managing inter-municipal public health services in other areas of Massachusetts.

A. Preliminary Assessment of Potential Inter-Municipal Collaboration

1. **Current level of inter-municipal collaboration:** Some public health resources are already shared across municipalities; although at a minimal level. Examples include: multiple towns contracting with the same agency for public health nursing support; utilizing the same contractor for animal control; and towns contracting with health agents/directors from other towns for routine or back-up inspection services. Additionally, several towns have enacted shared services arrangements in other areas of service (i.e. non-public health) and consequently have experience with sharing staff through inter-municipal agreements.
2. **Additional Opportunities for Inter-Municipal Collaboration:** There are several additional possibilities for increased or more formal collaboration on particular public health functions. Among these functional areas are Public Health Nursing; Food, Camp, and Pool Inspections; Emergency Preparedness; Tobacco Compliance; Health Education and Health Promotion.
3. **Potential Structure for Collaboration:** In the near term, the most likely structure or model for increased collaboration is through negotiation of shared service arrangements which are allowable under provisions of state law (MGL Chapter 40, Section 4a). In such a structure, partnering municipalities share certain staff or services through inter-municipal agreements with while retaining their own Boards of Health and Health Departments.
4. **Potential Structures in the Longer Term:** A core group of personnel shared through a central resource across multiple towns could become the nucleus of a cafeteria-style approach to supporting multiple municipal health departments (e.g. a central resource for staff providing services in the areas of routine inspectional services, emergency preparedness planning, and public health education and promotion).

Representatives of two towns in the southern grouping also indicated some interest in exploring a more comprehensive district arrangement in which towns would either be served by common staff overseen by a regional committee composed of representatives

from each town or in which one town would purchase all services from another town or regional entity. Each town could also maintain, at their discretion, a municipal Board of Health with local control over policies and ordinances.

B. Challenges and Concerns

- 1. Limitations of Current Capacity:** Each of the municipalities participating in this baseline assessment of collaborative potential and opportunities currently maintains staffing levels that are at or near full capacity relative to their respective workloads. Further, the current array of services and corresponding workload is highly focused on inspection and enforcement of mandated services; primarily in the area of environmental health and food safety. None of the health departments are comprehensive departments in the sense that they provide a full range of public health services as described by the Operational Definition for Local Health Departments described by the National Association of County and City Health Officials.

The limitations of current capacity means that none of the towns participating in the assessment perceive that they currently have excess staff or service capacity available to share with other towns by contract or other mechanism. Thus, inter-municipal collaboration or sharing of services would entail either increased capacity or re-configuration of existing capacity.

- 2. Limited Initial Cost Savings Potential:** While opportunities exist for increasing formal collaboration and coordination of services across towns, these opportunities should not be construed as offering significant cost savings initially. Rather, the opportunities that exist may afford increases in the quality, coordination and capacity of services with any efficiency gained from shared services resulting in enhanced expertise and timeliness of services for residents.
- 3. Public Presence:** Representatives of health departments and town management in nearly all cases stated the need for a continued health department presence in each municipality that would be available during predictable and convenient hours to respond to public questions, concerns and complaints in a timely manner.
- 4. Start Small and Grow:** Most participants in the assessment process recommended that efforts to increase and formalize inter-municipal collaboration should begin with smaller efforts that can be successful and form the foundation for greater collaboration over the long term. This recommendation aligns with the observation of the State workgroup on public health regionalization and the Pioneer Institute study on regionalization that “most successful regionalization efforts stem from grassroots as opposed to a top down mandate.”
- 5. Work with Groups of Similar Communities:** Another common recommendation from the key informants for this assessment is that groupings of towns pursuing greater collaboration should have commonalities or “partners that would work” and that these partnerships should be self-selected.

C. Recommendations for Next Steps

In the interest of further improving the capacity and performance of local public health service delivery through enhanced inter-municipal collaboration, the municipalities and other partners in this effort, such as the MetroWest Community Health Care Foundation, are encouraged to consider the following approaches.

1. Support Development of Shared Services Arrangements: Needs and opportunities have been identified to formalize collaboration between towns on particular public health functions. Among these functional areas are: Public Health Nursing; Food, Camp, and Pool Inspections; additional Septic/Title V-related expertise; Emergency Preparedness; Tobacco Compliance; Health Education and Health Promotion.

In a shared services arrangement or shared service district, selected local public health services are carried out under formal agreement between consortiums of municipalities while other services continue to be maintained by individual towns and their respective Boards of Health. Through such agreements, one municipality may agree to employ staff with specific expertise (such as in the functional areas identified in the preceding paragraph) with other municipalities agreeing to contract for a portion of staff time or identified set of services.

Alternatively, participating municipalities may agree to jointly contract for certain services from a third party. If the third party provides a variety of public health services, that could become the nucleus of a cafeteria-style approach to supporting multiple municipal health departments in the MetroWest region.

2. Health Education and Health Promotion Services Development: Most municipal Health Departments currently provide minimal health education and health promotion services as most local public health resources are devoted to required environmental health and sanitation, housing and inspection services. Additionally, individual municipalities are limited in their capacity to acquire additional resources to support a broader range of community and public health activities as a result of limited grant-writing expertise, limited competitiveness of individual municipalities for potential funding sources, and concerns about establishing new services with municipal funds that may be better provided through partnerships with regional and state entities, including non-governmental health agencies.

Municipalities and other partners should consider employing a Regional Coordinator for Health Education and Health Promotion development. The primary role of this Coordinator would be to work with consortia of municipalities and non-governmental health partners to develop enhanced capacity by leveraging partnerships and acquisition of new resources for health education and health promotion. In this capacity, the Coordinator could support community health assessment; program planning and development; and coalition development functions for regional partnerships, but would have minimal involvement in direct delivery of health promotion services.

3. Exploratory Planning and Development of Comprehensive Services Districts: In contrast to shared services district arrangements, all local public health services are carried out by one set of employees on behalf of two or more participating municipalities in a Comprehensive Services District. Participating municipalities may still choose to retain their respective Boards of Health or opt to delegate governance and legal policy making authority to a Regional Board of Health.

Current interest in this type of arrangement is low among the towns participating in the assessment. An important factor in this level of interest is the need for more specific information on how such an arrangement would be structured including clarification of such features as cost, assurance of public responsiveness, and impact on local control in terms of both policy and management. Satisfactory clarification of these issues would involve additional inter-municipal discussions and planning involving town executives and boards of health. Such an exploratory planning process would address options for the specific structure, characteristics and feasibility of a Comprehensive Services District, as well as analysis and business planning activities to include specification of anticipated outcomes such as improved capacity, quality, coordination, efficiency and plans for sustainability.

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OPPORTUNITIES FOR INTER-MUNICIPAL COLLABORATION ON THE DELIVERY OF LOCAL PUBLIC HEALTH SERVICES

A Preliminary Assessment of Seven Municipalities in the MetroWest Region of Massachusetts

With support from the MetroWest Community Health Care Foundation, a preliminary assessment was conducted with seven towns in the MetroWest region of Massachusetts during the Summer and Fall of 2009 to collect comparative information on municipal Board of Health/Health Department services, as well as capacity and interest in increased inter-municipal collaboration for the delivery of local public health services. In conducting this assessment, information was collected through interviews and surveys of Health Department staff and Executive Management/Leadership in Ashland, Holliston, Hopkinton, Medway, Sudbury, Wayland and Weston.

The primary contacts for scheduling interviews in each town were the Town Managers/Administrators and the Town Health Directors/Agents. Primary contacts were also invited at their discretion to include other individuals such as Board of Health members, Selectmen, other municipal staff in the interview process. A survey of Health Directors/Agents was also administered to collect specific information on health department capacity, functional areas of emphasis for service delivery, and needs and opportunities for improvement in capacity and services to include opportunities and opinions on the potential for increased inter-municipal collaboration. Completed surveys were received from 5 of the 7 municipalities participating in the assessment.

Interviews were also conducted with representatives of other agencies involved in public health service delivery and individuals involved in developing or managing inter-municipal public health services in other areas of Massachusetts. See Appendix 1 for a list of individuals interviewed for this assessment.

A. Overview of Current Health Department Capacity and Operations

Table 1 on the next page provides a snapshot of demographics and health department staffing and budgets for the participating towns. Observations from the information in this table include:

- Towns in the ‘northern grouping’ of Sudbury, Wayland and Weston have higher per capita income and, perhaps reflecting this characteristic, have per capita health department expenditures that are two or more times that of municipalities in the ‘southern grouping’ of Ashland, Holliston, Hopkinton and Medway.

- The percentage of health department expenditures met by revenues from fees varies widely. This may result from a combination of factors including variation in fee schedules, differences in the relative volume of work for specific types of services, and differences in approaches toward raising and appropriating the necessary funds for departmental operations (i.e. user fees versus taxation).

Table 2 displays a matrix of health department staffing for each municipality including contracted staff.

Table 1: Snapshot of Municipal Demographics and Health Department Capacity (2009)

	Ashland	Holliston	Hopkinton	Medway	Sudbury	Wayland	Weston
2008 estimated US Census	15,807	13,901	14,338	12,785	17,207	12,996	11,711
1999 Income per capita	\$31,641	\$32,116	\$41,469	\$27,578	\$53,285	\$52,717	\$79,640
Health department budget	\$110,724	\$123,676	\$112,455	\$136,600	\$368,000	\$606,445	\$238,000
Health department budget per capita	\$7.00	\$8.90	\$7.84	\$10.68	\$21.39	\$46.66	\$20.32
Health Department FTEs (includes contracted staff)	1.6	2.2	1.54	2.0	4.64 (includes social worker)	8.5 (includes school health)	3.25
Percent of budget from fees	28%	53%	22%	NA	8%	27% (excluding cost of 4.5 FTE Community Nurses)	57%

Table 2: Health Department Staffing Profile (2009)
(FTEs; includes contracted staff)

	Ashland	Holliston	Hopkinton	Medway	Sudbury	Wayland	Weston
		estimated					estimated
Health Director	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Health Agent/Technical Assistant(s)		0.2	0.4		0.5	1.0	1.0
Administrative Support	0.6	1.0	0	1.0	1.0	1.29	1.0
Food Inspector (function may also be included under health agent)			0.075	as needed	0.09	as needed (annual cost approx \$9K)	
Public Health Nurse	Agency contract	Agency contract	0.063		0.4	0.71	0.25
School Health Nurse						4.5	
Social Worker					1.0		
Mental Health Counselor					0.43	Agency Contract*	Agency contract
Animal Inspector		as needed	as needed		0.09	as needed	
Animal Control		as needed	as needed		0.14	as needed (annual cost approx \$10K)	
Total Staff and Contracted FTE	1.60	2.2	1.54	2.0	4.64	8.5	3.25

*Wayland contracts with Human Relations Services for Mental Health Counseling services at an annual cost of approximately \$47,000.

Table 3 on page 12 displays the areas of relative emphasis for local health department service delivery according to allocations of effort indicated by the survey responses of participating municipal health departments. The information is displayed according to the 10 Essential Public Health Services which comprise a framework for categorizing the work of public health and include the following categories of public health services or functions.

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

The Essential Services Framework for characterizing the work of local Health Departments participating in this assessment for several reasons. First, the National Association of County and City Health Officials (NACCHO) has applied this framework in developing the Operational Definition of a Functional Local Health Department. Along with ‘Administrative Capacity and Governance’, this framework has also been adopted by the Public Health Accreditation Board, a voluntary national initiative intended to improve the capacity and quality of public health departments. <http://www.naccho.org/topics/infrastructure/accreditation/OpDef.cfm>. Secondly, the Massachusetts Public Health Regionalization Project has identified the provision of the 10 Essential Public Health Services to all residents through an integrated public health system as a “critical element”. It is recognized that the core activities and associated resources of most municipal health departments in Massachusetts will by necessity be focused on state-mandated environmental health and inspection functions. However, for the purposes of this assessment, the 10 Essential Services provide a useful framework for identifying gaps and opportunities for enhanced services that could potentially be realized through increased inter-municipal collaboration or increased state resources in support of regional public health services.

As Table 3 shows, the areas of greatest emphasis among towns participating in the assessment are Administrative, Enforcement of Laws and Regulations, and Diagnosis of Health Problems and Hazards. The exceptions are in Sudbury and Wayland where social work services and school health services, respectively, comprise a significant core capacity associated with the public health function of assisting people to receive health care services.

The emphasis on investigation of health hazards (includes investigation of complaints and emergency preparedness) and enforcement (includes inspectional services) is not surprising given the nature of state requirements placed on local health departments and the relatively small

population base for individual municipal health departments in Massachusetts. Consequently, capacity is limited at the municipal level to perform other important public health functions including health status monitoring, health education and promotion, and mobilization of community partnerships and interventions.

Table 4 on page 13 displays similar information more specifically by highlighting the top 10 functional or task areas for each municipality according to level of staff effort. The level of staff effort was determined by the distribution of staff time according to survey responses from the Boards of Health/Health Departments survey responses. Appendix 2 for the full list of 34 functional areas that were then grouped into 9 of the 10 Essential Public Health Services plus Administration. The tenth Essential Service – Public Health Research – was not included.

Table 3: Relative Level of Effort as a Percent of Total Health Department FTEs -
 ‘Essential Public Health Services’
 (from surveys of health department directors)

	Ashland	Holliston	Hopkinton*	Medway	Sudbury	Wayland	Weston
Total Health Dept. FTEs	1.60	2.20 (estimated) Survey info unavailable	1.54	2.00	4.64	8.50	3.25 (estimated) Survey info unavailable
Essential Public Health Service							
Administration (note: may include aspects of enforcement, planning and evaluation)	36%		12%	52%	22%	16%	
Enforce Laws and Regulations (Essential Service #6)	26%	Septic/Ti-V and other inspection services described as majority of workload	34%	29%	20%	13%	Septic/Ti-V and other inspection services described as 80% of workload
Diagnose & Investigate Health Problems and Hazards (ES#2)	26%		30%	15%	15%	7%	
Help People Receive Health Services (ES #7)	1%		8%	1%	35% (includes social work/ counseling)	58% (includes school health nursing)	
Health Information, Education, Promotion (ES#3)	3%		8%	1%	4%	4%	
Monitoring Health Status (ES #1)	6%		5%	2%	1%	<1%	
Mobilize Community Partnerships (ES #4)	1%		2%	<1%	<1%	<1%	
Develop Policies and Plans (ES #5)	1%		<1%	<1%	<1%	<1%	
Assure Competent Workforce (ES #8)	1%		1%	<1%	<1%	<1%	
Evaluate Effectiveness of Health Services (ES #9)	1%		<1%	<1%	<1%	<1%	

*The distribution for Hopkinton is based on the survey response that reported a total of 2.54 FTEs. Comments received on the draft final report from the Hopkinton Board of Health included a request that the total FTEs be adjusted to reflect recent changes in health department staffing.

Table 4: Top 10 Public Health Functions by Level of FTE Effort
(from surveys of health department directors)

Effort Level Rank	Ashland	Holliston	Hopkinton	Medway	Sudbury	Wayland*	Weston
		Survey info unavailable					Survey info unavailable
1	Other administrative duties	Septic and Well review/ approval/ inspections	Other establishment inspections and enforcement activities	Record-keeping and administrative reporting	Behavioral health services	School health services	Septic and Well review/ approval/ inspections
2	Record-keeping and administrative reporting	Food establishment inspections and enforcement activities	Septic and Well review/ approval/ inspections	Other administrative duties	Record-keeping and administrative reporting	Septic and Well review/ approval/ inspections	Food establishment inspections and enforcement activities
3	Food establishment inspections and enforcement activities	Public health emergency planning, exercises, response	Public health emergency planning, exercises, response	Solid waste management	Other administrative duties	Record-keeping and administrative reporting	Public health emergency planning, exercises, response
4	Immunization Clinics		Provide public health information and education	Food establishment inspections and enforcement activities	Septic and Well review/ approval/ inspections	Provide public health information and education	
5	Housing inspection and enforcement activities		Record-keeping and administrative reporting	Septic and Well review/ approval/ inspections	Social work services	Other administrative duties	
6	Septic and Well review/ approval/ inspections		Food establishment inspections and enforcement activities	Nuisance complaints – housing	Public health emergency planning, exercises, response	Public health emergency planning, exercises, response	
7	Nuisance complaints – air and water quality		Immunization Clinics	Nuisance complaints – air and water quality	Assist individuals to access needed health and human services	Departmental planning and review activities	
8	Nuisance complaints – housing		Other administrative duties	Housing inspection and enforcement activities	Educate public on health laws, regulations, & ordinances	Immunization Clinics	
9	Facilitation of disease reporting		Provide clinical screening services	Public health emergency planning, exercises, response	Animal control/rabies	Communicable disease surveillance	
10	Public health emergency planning, exercises, response		Nuisance complaints – housing	Other environmental hazard investigation	Provide public health information and education	Communicable disease investigation	

*Comments received on the draft final report from the Wayland Board of Health indicated a re-ordering of effort level to include ranking Septic and Well review as #1 and School Health as #2. The rankings are based on distribution of FTE capacity across public health functions which, in the case of Wayland, includes 4.5 FTEs of Community Nurses providing School Health Services.

B. Related Activities and Examples in Other Regions of Massachusetts

Led by the Massachusetts Public Health Regionalization Project, there are ongoing initiatives throughout the State to develop more cost-effective means of structuring and providing equitable, high quality public health services to all communities. The Regionalization Project's goal is "to strengthen the Massachusetts public health system by creating a state-funded regional structure for equitable delivery of local public health services across the Commonwealth." A "critical element" identified by this State level workgroup is to assure the provision of the 10 Essential Public Health Services to all residents through an integrated public health system. A number of reports, examples of regionalization, and references to enabling legislation can be found at the website for the Massachusetts Public Health Regionalization Project <http://sph.bu.edu/index.php/menu-id-616915.html?task=view>

The Regionalization Project Working Group has recommended the adoption of two models of regionalization for local health departments described as follows.

1. **Comprehensive Services District:** All local public health services for two or more municipalities are carried out by one set of employees. Governance and legal policy making authority are retained by the municipal boards of health or may be delegated to a Regional Board of Health. Legislation passed in 2009 (Chapter 529 of the Acts of 2008, An Act Relevant to Public Health Regionalization) was intended to create greater flexibility and remove certain barriers to formation of health districts involving a regional board of health.
2. **Shared Services District:** Select, but not all, local public health services are carried out under formal agreement between consortiums of municipal boards of health. Examples include sharing staff (e.g. Animal Inspector, Epidemiologist, Health or Environmental Inspector, Public Health Nurse, Sanitarian) and/or providing designated services (e.g. clinic operations, inspections, investigations).

The newly formed Melrose/Wakefield Health Department is a recent example of efforts to improve the delivery of public health services by combining capacity across municipal boundaries. Beginning in July 2009, the two towns entered into a 3 year contract in which Melrose employs health department staff who serve both towns and Wakefield reimburses Melrose on a quarterly basis. Each town has maintained their own board of health with staff serving under the direction of the Melrose Health Director (Ruth Clay). In addition to the Director, staff serving both communities includes a full-time sanitary inspector, two part-time public health nurses, and two new sanitary inspectors (who have replaced the Wakefield health agent position). A full-time administrative assistant remains in place in Wakefield to assure prompt assistance to the public.

According to Ruth Clay, the primary benefits of the new arrangement are improved quality and quantity of services, particularly in Wakefield. The towns have benefitted from the increased number of public health nursing hours potentially available in each town. One example of this benefit is an increase in the availability and convenience of flu clinics offered this past Fall.

Ruth Clay also noted that the arrangement does not yield significant cost savings overall, but has resulted in enhancement of services and increased flexibility. The primary challenge since beginning the new arrangement has been in the area of coordinating information systems across the two towns to facilitate work efficiently.

Established in 1926, the Barnstable County Department of Health and Environment is a long-standing arrangement for supporting public health services across multiple towns. The County Health Department provides a "cafeteria style" approach to support to the Cape's 23 towns. The towns maintain their own departments and health boards, but local health agents can order services and support they need from a "menu" of options that the County Health Department provides. According to George Heufelder, Director of the Barnstable County Department of Health and Environment, some of the more popular services are:

- Assistance with tobacco stings (no town does this on its own)
- Assistance with the design of alternative septic systems
- Bathing beach sampling during the summer (in all towns except Chatham)
- Landfill monitoring
- Restaurant inspections (particularly during the summer or when a town has a backlog)
- Indoor air quality monitoring
- Public health nursing services (e.g. towns can hire nurses at a reduced per diem rate to help them run flu clinics or can provide workplace wellness programs)
- Soil inspections
- Managing and partnering to implement the emergency preparedness grant
- Managing the MRC program
- Sick and vacation back-up of local health agents

The local health agents are primarily occupied with septic-related issues, so the County Department is able to help local health agents continue their day to day work "by putting out fires that would otherwise take up a lot of time." The County Health Department has been given jurisdictional authority by the towns and maintains a full-time field staff of five individuals each with specific areas of expertise. The County Department also organizes trainings for the local public health workforce and provides orientation to new Health Agents.

Funding for the County Health Department is primarily secured through county taxes and a deed tax. The Department has an "informal way of figuring out how much service a town is due from the department. Once that amount is exceeded, the Health Department will seek to put a contract in place for the additional services. For example, if a town wants County representation 2 days a week or more, they will put a contract in place with a standard, reduced per diem rate. The County Department also works with local departments to apply for grants and works by consensus with health agents during monthly meetings to review and direct grant expenditures.

C. Potential Areas for Inter-Municipal Sharing of Public Health Services

The following general functional areas present opportunities for increased collaboration across towns as indicated by information collected through surveys and interviews of health department directors and town executives of the seven MetroWest municipalities participating in the assessment.

1. Public Health Nursing

Southern Municipal Group: Ashland, Holliston, Hopkinton Medway

Representatives of three towns (Ashland, Holliston, Hopkinton) identified Public Health Nursing as an area for greater emphasis if additional resources were available (see Table 5). All four towns identified this as an area where they would like additional back-up (see Table 6).

None of the towns currently have a public health nurse on staff. Three towns have small contracts with Century Health for public health nursing (Ashland approximately \$900, Holliston approximately \$1500, Hopkinton approximately 0.5 hours per week at cost of approximately \$1200). Medway does not currently have dedicated public health nursing capacity.

As three of the towns are currently contracting separately with the same entity for public health nursing services, an opportunity may exist for the towns to coordinate the purchase of public health nursing services with improved efficiency and/or capacity.

Northern Municipal Group: Sudbury, Wayland, Weston

Representatives of two towns (Sudbury, Weston) identified Public Health Nursing as an area for greater emphasis if additional resources were available and Wayland identified a need for more capacity for “communicable disease follow-up”.

Wayland currently has a dedicated public health nurse who also oversees the school health services. Sudbury currently contracts with an agency for a public health nurse about 2 days per week. Weston currently also has a contract with an agency for public health nurse services about 10 hours per week.

An opportunity may exist for the towns to coordinate the purchase of public health nursing services with improved efficiency, capacity and flexibility to respond as needs arise.

2. Routine, Systematic Inspections (e.g. Food , Camp, Pool Inspections)

Systematic inspection of food and other licensed/permitted establishments is a service that is not necessarily a town-specific function. Individuals with appropriate certification could perform this function equally well across municipal boundaries. It is noted that individuals with certification in multiple technical areas are an asset to any town given the range of inspectional services mandated by the State to be performed by local Boards of Health/Health Departments. Additionally, several interviewees noted that it can be beneficial to clearly separate the functions of food inspection and septic review/inspection from a public health perspective (i.e. not having the same individual performing food inspections and septic inspections on the same day).

An opportunity may exist for the towns to coordinate the purchase of food inspection services with improved efficiency and/or capacity.

Southern Municipal Group: Ashland, Holliston, Hopkinton Medway)

Health department staff in each of the towns currently performs their own inspections of food and other licensed or permitted establishments. In some cases, independent food inspectors or health directors from other towns are contracted (Hopkinton, Holliston) to provide assistance with routine inspections or are available on an as needed basis (Ashland, Medway) to provide assistance on-call or as vacation back-up.

Northern Municipal Group: Sudbury, Wayland, Weston)

Health departments in Sudbury and Wayland contract for routine inspections of existing establishments with new establishment or problem follow-up performed by Health department staff. Weston Health Department staff currently performs all food inspections, but have noted this as an area where additional resources would be useful.

Unlike the inspection of food establishments, the Title V/septic work in each of these towns dominates the workload and requires significant in-town capacity to assure public responsiveness given the importance of a timely process to individual homeowners.

3. Public Health Emergency Preparedness

Because public health emergencies by their very nature do not follow municipal boundaries, this work involves a number of regional meetings, regional planning activities and coordination with the non-governmental health care delivery sector which is also regional in nature.

An opportunity may exist for the towns to coordinate some of the federal/state grants and other resources focused on public health emergency planning including Medical Reserve Corps development and training to support a common staff /consultant resource to represent the towns in regional planning activities and to assist with town specific plans and exercise deliverables.

Southern Municipal Group: Ashland, Holliston, Hopkinton Medway

Each of the Health Departments has experienced an increased time demand from public health emergency preparedness planning and exercise requirements. Additional resources or back-up to support this work was identified as a specific need in Holliston, Hopkinton and Medway.

Northern Municipal Group: Sudbury, Wayland, Weston

Each of the Health Departments has experienced an increased time demand from public health emergency preparedness planning and exercise requirements. Additional resources or back-up to support this work was identified as a specific need in Sudbury and Wayland.

4. Tobacco Compliance

As with food inspection activities, tobacco control activities to include sting operations to decrease the sale of tobacco products to minors are not necessarily town specific functions, but could be coordinated and resourced regionally.

Similarly, activities to educate and mobilize the community to prevent tobacco use are also suited to coordinated, regional action.

5. Health Education and Promotion

As with most other New England states, health education and health promotion activities are not typically provided in a substantial manner by small or medium-sized municipal public health departments that are primarily focused on environmental health, safety and infectious disease issues. Instead, health education and health promotion activities tend to be led by non-governmental health partners or coalitions in the local public health system, such as hospital systems, health centers, home health agencies and other community-based agencies, either directly or through contracts with the State Health Department.

As with the emergency preparedness function, it is recognized that the time of individual health directors is limited and that a regional approach to partnering and coordinating activities in this area would be the most efficient approach to planning, resource acquisition (e.g. grants and contracts) and implementation of public health education and promotion activities.

Southern Municipal Group: Ashland, Holliston, Hopkinton Medway

Health education, health promotion and wellness were identified in interviews and in survey responses as areas where the Health Departments are not focusing significant resources and as areas where the Health Departments would like to become more active.

While perhaps not taking the lead in these efforts, there are important opportunities for municipal health departments to become active partners with other public health system partners by directing their efforts to identified needs, by becoming partners in grant applications, and/or by subcontracting to facilitate activities within their region. As one example, a resource for increased health education and health promotion is through the existing link in several communities to Century Health which is developing a range of health promotion and wellness programs for the region and is interested in increasing partnerships with municipalities.

Northern Municipal Group: Sudbury, Wayland, Weston

Health education, health promotion and wellness were identified in interviews and in surveys as areas where the Health Departments are not focusing significant resources. Wayland, Weston, and to lesser extent Sudbury, also identified these as areas where the Health Departments would like to become more active.

While perhaps not taking the lead in these efforts, there are important opportunities for municipal health departments to become active partners with other public health system partners by directing their efforts to identified needs, by becoming partners in grant applications, and/or by subcontracting to facilitate activities within their region. As one example, a newly formed Prevention Collaborative in the region involving organizations associated with the MetroWest Free Medical Program is seeking partnerships with local community organizations to build community teams and resources to address a range of health promotion and wellness needs. Local health departments could potentially leverage this regional initiative to address identified needs of their residents.

6. Other Potential Areas for Increased Collaboration

Other potential areas for collaboration identified by individual towns included HazMat collection (Sudbury), social work/mental health (Weston), additional sanitarian help (Wayland), and professional engineering consultation (Holliston).

Table 5: Public Health Functions Health Departments Would Emphasize More
If Additional Time and Resources Were Available

(from surveys and interviews of health department directors and town executives)

General Functional Area	Ashland	Holliston	Hopkinton	Medway	Sudbury	Wayland	Weston
Health Assessment/ Monitoring	Community Health Assessments			Monitor health status and health issues facing the community			
Disease/ Health Hazard Protection		Emergency Planning and emerging health threats	Communicable disease surveillance Public Health emergency planning/ exercise/ response	Protect public from health problems and hazards	Emergency preparedness coordination with other departments		
Health Information/ Education		Health education			Provide public health info and education	Healthy diet and nutrition information	Public health education
Health Promotion	Community Health Services	Health promotion Senior health and wellness	Conduct/ participate in health promotion programs	Public health promotion Improve programs of intervention		Programs to reduce stress and encourage healthy life styles	Health maintenance

Table 5: Public Health Functions Health Departments Would Emphasize More
If Additional Time and Resources Were Available
(continued)

General Functional Area	Ashland	Holliston	Hopkinton	Medway	Sudbury	Wayland	Weston
Public Health Nursing		Public health nursing	Additional Public health nursing		Additional Public health nursing		Public health nursing
Tobacco Control	Tobacco Control					Increase the educational aspects of tobacco products on health. Increase sting operations to decrease the sale of tobacco products to minors.	
Staff Development			Staff development		Staff training and development		
Other			School health services Record keeping/administrative reporting Assisting with access to care				Addressing urgent or acute mental health issues Improve timeliness/reduce back-log of food inspections

Table 6: Additional Training or Expert Back-up Needs/Interests
 (from surveys and interviews of health department directors and town executives)

Ashland	Holliston	Hopkinton	Medway	Sudbury	Wayland	Weston
Public Health Nursing	Public health nursing	Public health nursing	Public health nurse Food illness investigation		Communicable disease follow up	
		Emergency planning/response			Emergency Planning deliverables performed	
Risk Assessment	Professional engineering			Housing inspections/enforcement	Additional inspectional help from highly trained sanitarians to keep up with our workload.	Additional food inspection help to keep up with workload
OTHER TRAINING or BACK-UP NEEDS/INTERESTS						
		Electronic records management	Regulation Updates			
Grant Writing and Management			Tobacco compliance		Community education needs assessed with educational programs developed	Mental health/crisis response

D. Summary of Assessment Findings, Challenges and Recommendations

Potential for Collaborative Opportunities

1. **Current level of inter-municipal collaboration:** Some public health resources are already shared across municipalities; although at a minimal level. Examples include multiple towns contracting with the same agency for public health nursing support, the same contractor for animal control, and towns contracting with health agents/directors from other towns for routine or back-up inspection services. Health Department staff are also accustomed to providing peer support on technical questions and working collaboratively on a larger regional scale for public health emergency planning. Additionally, several towns have enacted shared services arrangements in other areas such as recreation (Sudbury-Wayland) and library services (Medway-Franklin) through inter-municipal agreements where one town employs staff and the other contracts for a portion of their time.
2. **Additional Opportunities for Inter-Municipal Collaboration:** There are several additional possibilities for increased or more formal collaboration on particular public health functions as described in Section C. Among these functional areas are Public Health Nursing; Food, Camp, and Pool Inspections; Emergency Preparedness; Tobacco Compliance; Health Education and Health Promotion.

Table 7 displays responses to a question regarding topical or task areas in which health departments have expertise to share with other departments in the region. Perhaps reflective of the dominance of work related to subsurface sewage disposal, five of the seven towns offered expertise in the area of septic system/Title V. It is also noted that respondents indicated they were generally willing to be available to answer technical questions or provide peer support, but that time for providing technical assistance outside their municipality was very limited.

3. **Potential Structure for Collaboration:** In the near term, the most likely structure or model for increased collaboration is through negotiation of shared service arrangements which are allowable under the provisions of state law (MGL Chapter 40, Section 4a). In such a structure, partnering municipalities share certain staff or services through inter-municipal agreements while retaining their own Boards of Health and Health Departments. For example, one town might be the host (by employment or contract) for regional food inspection services that other towns would agree to purchase according to an agreed upon methodology. A related suggestion was to develop a circuit rider approach for additional sanitarian capacity that could be supported by grants and fees.
4. **Potential Structures in the Longer Term:** A core group of personnel shared through a central resource across multiple towns could become the nucleus of a cafeteria-style approach to supporting multiple municipal health departments (e.g. a central resource for services in the areas of routine inspectional services, emergency preparedness planning, and public health education and promotion).

Representatives of two towns in the southern grouping (Ashland, Medway) indicated some interest in exploring a more comprehensive district arrangement in which towns would either be served by common staff overseen by a regional committee composed of representatives from each town or in

which one town would purchase all services from another town or regional entity. Each town would also maintain, at their discretion, a municipal Board of Health with local control over policies and ordinances.

There was limited or no interest among town representatives in the northern grouping (Sudbury, Wayland, Weston) in this more comprehensive type of arrangement; preferring instead to maintain oversight and accountability for core staff and services more closely within their respective municipalities.

It was noted in several towns that some health directors are nearing retirement and that, with retirements, consideration might be given to sharing a health director who would oversee a staff of health agents serving multiple towns.

Further development of these potential structures would require additional, focused inter-municipal discussions and planning to address such issues as costs and revenues, assurance of public responsiveness, impact on local control in terms of both policy and management, and sustainability.

**Table 7: Health Department Expertise
That Could Be Shared With Other Departments**
(from surveys and interviews of health department directors and town executives)

Ashland	Holliston	Hopkinton	Medway	Sudbury	Wayland	Weston
		Septic systems and well information	Title V	septic review/ inspections	Subsurface sewage disposal I/A systems	Septic/Title V – answer questions, otherwise limited time
Public relations		Public Health information			Public Health Nursing (limited time to just answer questions)	
			Food establishment inspection			
Landfill management						
Superfund Site management						

Challenges and Concerns

- 1. Limitations of Current Capacity:** Each of the municipalities participating in this baseline assessment of collaborative opportunities currently maintains staffing levels that are near full capacity relative to their respective workloads (see Table 8; please also pay special attention to the important qualifying statements associated with Table 8). Further, the current array of services and corresponding workload is highly focused on inspection and enforcement of mandated services; primarily in the area of environmental health and food safety. None of the health departments are comprehensive departments in the sense that they provide a full range of public health services as described by the 10 Essential Public Health Services (refer to Table 3).

The limitations of current capacity means that none of the towns assessed believe they currently have excess staff or service capacity available to share with other towns by contract or other mechanism.

- 2. Limited Initial Cost Savings Potential:** While opportunities exist for increasing formal collaboration and coordination of services across towns, these opportunities should not be construed as offering significant cost savings initially. Rather, the opportunities that exist may afford increases in the quality, coordination and capacity of services with any efficiencies gained from shared services resulting in enhanced expertise and timeliness of services for residents. This observation is perhaps best reflected by the comments of the Director of the Barnstable County Department of Health and Environment which offers an array of shared, cafeteria-style services and technical support functions for municipalities on the Cape.

“Many people think that if they combine three towns, then they might only need 2 health agents. I know of no town where that would be an appropriate thing to do. If anything, they need to be thinking about adding an additional health agent for support. If they are looking at regionalization as a way to save money outright, it won't work. It is about increasing quality of services. Increases in efficiency come later, as individual areas of expertise develop over time. For example on my staff, when a question about alternative septic system design comes in, we don't need to go to the books anymore. We have an in house expert so it probably takes half the time to issue the permit.”

George Heufelder, Director of the Barnstable County Dept of Health and Environment.

- 3. Public Presence:** Representatives of health departments and town management in nearly all cases stated the need for a continued health department presence in each municipality available during predictable and convenient hours to respond to public questions, concerns and complaints in a timely manner.

4. **Start Small and Grow:** Most participants in the assessment process recommended that efforts to increase and formalize inter-municipal collaboration should begin with smaller efforts that can be successful and form the foundation for greater collaboration over the long term. This recommendation aligns with the observation of the State workgroup on public health regionalization and the Pioneer Institute study on regionalization that “most successful regionalization efforts stem from grassroots as opposed to a top down mandate.”

5. **Work with Groups of Similar Communities:** Another common recommendation from the key informants for this assessment is that groupings of towns pursuing greater collaboration should have commonalities or “partners that would work” and that these partnerships should be self-selected. As indicated by Tables 1-3, the two groupings of towns involved in this assessment (Ashland, Holliston, Hopkinton and Medway in the south and Sudbury, Wayland and Weston in the north) appear to meet this criteria of commonality as measured by such factors as budget per capita, staffing levels, and major functions (most notably the extent to which septic/Title V-related services dominate the departments’ workloads).

Table 8: Estimate of Municipal Demand and Capacity for Inspection-Related Services Only
 (Please see important notes and caveats at the bottom of this table)

	Ashland	Holliston	Hopkinton	Medway	Sudbury	Wayland	Weston
# of Licensed/Permitted Establishments							
Restaurants	50	65	25	24	19	30	53
Other food-related establishments	35	Included above	42	43	19	24	included above
Recreational camps	10		2	3	12	6	17
Swimming pools/public beach	1		8	1	5	11	14
Tanning facilities	3		0	6	0	0	
Body art establishments	0		0	1	0	0	
Total Licensed/Permitted Establishments*	99	65	77	77	55	71	84
Estimate of FTE requirement for inspection of Licensed/Permitted Establishments*	0.66	0.43	0.51	0.52	0.37	0.47	0.56
Septic Review/Inspection							
Estimate of septic system cases**	36	77	38	25	130	121	270
Estimate of FTE requirement for septic system cases **	0.19	0.42	0.21	0.14	0.71	0.66	1.47
Estimate of Total FTE needed for inspections and septic compliance only	0.85	0.85	0.72	0.66	1.07	1.13	2.03
**Maximum Current FTE Capacity	1.00	1.20	1.20	1.00	1.60	1.60	2.00

*Estimate of FTE requirement for inspection of Licensed/Permitted Establishments is based on FDA estimate of 280-320 food establishment inspections per year per full-time inspector or about 150 establishments per inspector assuming semi-annual inspections. The estimate includes time for inspection, follow-ups inspections, complaint investigations, and administrative work, such as plan review, enforcement documentation, hearings, and court actions.

**IMPORTANT NOTE: Estimate of septic cases is a rough estimate from septic-related activity reports and survey responses. A septic 'case' involves on-site inspection(s) and issuance of a certificate of compliance. The estimate of FTE requirement assumes 10 labor hours per septic case on average including plan review, hearings, site inspection, travel time and other related tasks.

***IMPORTANT NOTE: The reference to maximum current FTE capacity is the current total staffing level of qualified sanitarians and food inspectors assuming no other duties. Thus, the FTE statistic does not account for significant other duties such as nuisance/complaint investigations, disease investigations, emergency preparedness activities, public health education and promotion, and assistance to individuals for accessing services.

Recommendations for Next Steps

In the interest of further improving the capacity and performance of local public health service delivery through enhanced inter-municipal collaboration, the municipalities and other partners in this effort such as the MetroWest Community Health Care Foundation are encouraged to consider the following approaches.

1. **Support Development of Shared Services Arrangements:** Needs and opportunities have been identified to formalize collaboration between towns on particular public health functions. Among these functional areas are: Public Health Nursing; Food, Camp, and Pool Inspections; additional Septic/Title V-related expertise; Emergency Preparedness; Tobacco Compliance; Health Education and Health Promotion.

In a shared services arrangement or districts, selected local public health services are carried out under formal agreement between consortiums of municipalities while other services continue to be maintained by individual towns and their respective Boards of Health. Through such agreements, one municipality may agree to employ staff with specific expertise (such as in the functional areas identified in the preceding paragraph) with other municipalities agreeing to contract for a portion of staff time or identified set of services.

Alternatively, participating municipalities may agree to jointly contract for certain services from a third party. If the third party provides a variety of public health services, that could become the nucleus of a cafeteria-style approach to supporting multiple municipal health departments in the MetroWest region.

2. **Health Education and Health Promotion Services Development:** Most municipal Health Departments currently provide minimal health education and health promotion services as most local public health resources are required for mandated environmental health and sanitation, housing and inspection services. One exception to this observation may be the Wayland Board of Health which directly employs a Public Health Nurse/Community Nurse Leader as well as 4.5 FTEs Community/School Health Nurses.

Additionally, individual municipalities are limited in their capacity to acquire additional resources to support a broader range of community and public health activities as a result of limited grant-writing expertise, limited competitiveness of individual municipalities for potential State and other funding sources, and concerns about establishing new services with municipal funds that may be better provided through partnerships with regional and state entities, including non-governmental health agencies.

Municipalities and other partners should consider employing a Regional Coordinator for Health Education and Health Promotion development. The primary role of this Coordinator would be to work with consortia of municipalities and non-governmental health partners to develop enhanced capacity by leveraging partnerships and acquisition of new resources for health education and health promotion. In this capacity, the Coordinator could support community health assessment; program planning and development; and coalition development

functions for regional partnerships, but would have minimal involvement in direct delivery of health promotion services.

3. **Exploratory Planning and Development of Comprehensive Services Districts:** In contrast to shared services district arrangements, all local public health services are carried out by one set of employees on behalf of two or more participating municipalities in a Comprehensive Services District. Participating municipalities may still choose to retain their respective Boards of Health or opt to delegate governance and legal policy making authority to a Regional Board of Health.

Current interest in this type of arrangement is low among the towns participating in the assessment. An important factor in this level of interest is the need for more specific information on how such an arrangement would be structured including clarification of such features as cost, assurance of public responsiveness, and impact on local control in terms of both policy and management. Satisfactory clarification of these issues would involve additional inter-municipal discussions and planning involving town executives and boards of health. Such an exploratory planning process would address options for the specific structure, characteristics and feasibility of a Comprehensive Services District, as well as analysis and business planning activities to include specification of anticipated outcomes such as improved capacity, quality, coordination, efficiency and plans for sustainability.

4. **Comprehensive Services Districts:** As mentioned, development of Comprehensive Service Districts among the towns participating in this preliminary assessment appears unlikely at this time. Such development may proceed sequentially from progress in the previous area (exploratory planning) to clarify the potential costs and benefits of improved capacity, quality, coordination, efficiency and sustainability.

APPENDIX 1

LIST OF KEY INFORMANT INTERVIEWS

1. John Petrin, Ashland Town Manager
2. Mark Oram, Ashland Health Director/Agent
3. Paul LeBeau, Holliston Town Administrator
4. Ann McCobb, Holliston Health Director/Agent
5. Norman Khumalo, Hopkinton Town Manager
6. Edward Wirtanen, Hopkinton Health Director
7. Suzanne Kennedy Medway Town Administrator
8. Bill Fisher, Medway Health Agent
9. Glenn Trindade, Medway Selectman
10. Allison Potter, Medway Administrative Services Assistant
11. Maureen Valente, Sudbury Town Manager
12. Bob Leupold, Sudbury Health Director
13. Fred Turkington, Wayland Town Administrator
14. Steve Calichman, Wayland Health Director
15. Julia Junghanns, Wayland Health Agent
16. Ruth Mori, Wayland Public Health Nurse/School Nurse Leader
17. Donna VanderClock, Weston Town Manager
18. Wendy Diotalevi, Weston Public Health Director/Agent

19. Judith Boyko, CEO, Century Health Systems/Natick VNA
20. Gary Hirsch, President, MetroWest Free Medical Program
21. Ethan Mascoop, Framingham Public Health Director
22. James White, Director of Public Health, Natick
23. Ruth Clay, Health Director, Melrose & Wakefield
24. George Heufelder, Director, Barnstable County Dept of Health and Environment
25. James Garreffi, Agency Director, Nashoba Associated Boards of Health
26. Geoff Wilkinson, Senior Policy Advisor, Massachusetts Department of Public Health
27. Cathy O'Connor, Director, Office of Healthy Communities
28. Ron O'Connor, Southeast/Metro West Regional Director, MDPH
29. Bill O'Connell, Central/Western Regional Director, MDPH
30. Paul Muzhuthett, Northeast Regional Director, MDPH
31. Linda Shepherd, Greater Boston Regional Director, MDPH

APPENDIX 2

INTERVIEW AND SURVEY INSTRUMENTS

- Key Informant Interview Guide: Health Director/Agent and Board of Health
- Key Informant Interview Guide: Town Manager and Selectmen
- Health Director/Department Survey

**MetroWest Community Health Care Foundation
Local Public Health Assessment**

Key Informant Interview Guide

Instrument 1: Health Director/Agent and Board of Health

Purpose: *The purpose of this interview is to gather information that will increase understanding of the structure and function of local public health services in the MetroWest area and to begin the process of assessing the potential for increased networking and collaboration across municipalities. This effort is being sponsored by the MetroWest Community Health Care Foundation. We are also interviewing other people involved with public health in your town as well as collecting copies of relevant reports and documents. Do you have any questions before we begin?*

Range of Services

1. Please describe the set of services provided by your local health department (*also provide a copy of the survey to be completed by the health director/board after the interview.*)

2. What public health activities require the most time and resources?

3. In what services or functions is the health department most proficient or effective? What services or functions would benefit from additional capacity or expertise?

Please obtain a copy of health department service statistics (and/or annual report if different) for 2007 and 2008. Also 2009 partial if available.

Staffing Profile

4. What is the staff composition of the health department? (*note: specifics such as FTEs will be obtained by the survey*)

- _____ Health Director/Administrator
- _____ Health Agent (if different than above)
- _____ Public Health Nurse
- _____ Environmental Health/Sanitarians
- _____ Inspectors (please define, e.g. food, building, etc. _____)
- _____ Social Services
- _____ Administrative Support
- _____ Other (please describe _____)

5. Are there staff in other municipal departments that have a key role in delivery of public health services (*e.g. landfill/recycling/haz mat monitoring*)? Please describe.

6. Does your department contract with other individuals or agencies to provide or support certain public health services? Please describe.

7. What local public health services, if any, do you rely on other agencies to provide for your town? (i.e. state, county, non-governmental such as health care agencies)

Health Department Budget

8. What is the annual budget for your health department?

Total expenditures \$ _____

9. Has this budget changed significantly in the last 2 to 3 years? Please describe.

10. What proportion of revenues for your health department come from the following sources?

- _____ Fees and Fines
- _____ Contracts
- _____ Grants
- _____ General town appropriation
- _____ Other revenue sources

Please obtain a copy of health department budgets for 2007, 2008 and 2009.

Governance

11. Does the health director report to the Board of Health? *(or another town official such as the Town Administrator)*

12. What do you see as the primary role of the Board of Health?

13. What are the most pressing issues currently faced by the Board?

14. Does the Board set or refer to any particular performance standards in reviewing the work of the Health Department?

15. Does the Board of Health communicate with Board members of neighboring towns about shared public health issues? Please describe.

Opportunities for Improved Local Public Health Capacity

16. In your opinion, are there opportunities for increased collaboration with neighboring towns in the delivery of local public health services? Please describe.

17. What specific services or types of expertise do you think could be improved or sustained more effectively if shared or collectively purchased across towns?

18. What are the main challenges to partnering with neighboring towns on delivery of public health services? Are you aware of any policy differences that would present challenges?

19. What information would you like to know about how public health services are delivered in other municipalities?

20. Do you have any other suggestions or recommendations you would like to share? Suggestions of other people we should contact?

THANK YOU FOR YOUR TIME

**MetroWest Community Health Care Foundation
Local Public Health Assessment**

Key Informant Interview Guide

Instrument 2: Town Manager and Selectmen

Purpose: *The purpose of this interview is to gather information that will increase understanding of the structure and function of local public health services in the MetroWest area and to begin the process of assessing the potential for increased networking and collaboration across municipalities. This effort is being sponsored by the MetroWest Community Health Care Foundation. We are also interviewing other people involved with public health in your town as well as collecting copies of relevant reports and documents. Do you have any questions before we begin?*

Range of Services

1. Please describe the set of services provided by your local health department (*also provide a copy of the survey to be completed by the health director/board after the interview.*)

2. What public health activities require the most time and resources?

3. In what services or functions is the health department most proficient or effective? What services or functions would benefit from additional capacity or expertise?

Please obtain a copy of health department service statistics (and/or annual report if different) for 2007 and 2008; also 2009 partial if available.

Staffing Profile

4. What is the staff composition of the health department? (*note: specifics such as FTEs will be obtained by the survey*)

- _____ Health Director/Administrator
- _____ Health Agent (if different than above)
- _____ Public Health Nurse
- _____ Environmental Health/Sanitarians
- _____ Inspectors (please define, e.g. food, building, etc. _____)
- _____ Social Services
- _____ Administrative Support
- _____ Other (please describe _____)

5. Are there staff in other municipal departments who have a key role in delivery of public health services (*e.g. landfill/recycling/haz mat monitoring*)? Please describe.

6. Does your department contract with other individuals or agencies to provide or support certain public health services? Please describe.

Health Department Budget

7. Who has authority for determining the annual Health Department Budget request in your town? *check all that apply.*

- Board of Health
- Selectmen
- Finance/Budget Committee
- Town Manager
- Other _____

8. What is the annual budget for your health department?

Total expenditures \$ _____

9. Has the health department budget changed significantly in the last 2 to 3 years? Please describe.

10. What proportion of revenues for your health department come from the following sources?

_____ Fees
_____ Contracts
_____ Grants
_____ General town appropriation
_____ Other revenue sources

Please obtain a copy of health department budgets for 2007, 2008 and 2009.

Governance

11. Are Board of Health members appointed or elected?

12. Does the health director report to the Board of Health? *(or another town official such as the Town Administrator)*

13. What do you see as the primary role of the Board of Health?

Opportunities for Improved Local Public Health Capacity

14. In your opinion, are there opportunities for increased collaboration with neighboring towns in the delivery of local public health services? Please describe.

15. What specific services or types of expertise do you think could be improved or sustained more effectively if shared or collectively purchased across towns?

16. What are the main challenges to partnering with neighboring towns on delivery of public health services? Are you aware of any policy differences that would present challenges?

17. What information would you like to know about how public health services are delivered in other municipalities?

18. Do you have any other suggestions or recommendations you would like to share? Suggestions of other people we should contact?

THANK YOU FOR YOUR TIME

**MetroWest Community Health Care Foundation
Local Public Health Assessment**

Health Director/Department Survey

Purpose: *The purpose of this survey is to gather additional information to supplement the baseline interview. As described in the interview, the purpose of this information collection is to increase understanding of the structure and function of local public health services in the MetroWest area and to begin the process of assessing the potential for increased networking and collaboration across municipalities. This effort is being sponsored by the MetroWest Community Health Care Foundation. If you have any questions about completing this survey or about the project in general, please contact Jonathan Stewart at 603-573-3303.*

Please return your completed survey to Lauren Skelton by:

Email: Lauren_Skelton@jsi.com
or Fax: 617-482-0617
or Mail: JSI
44 Farnsworth Street
Boston, MA 02210-1211

THANK YOU FOR YOUR TIME AND ASSISTANCE!

BACKGROUND INFORMATION

1. Town Name _____

2. How many years have you served as Health Director/Agent for this City/Town?

_____ years

3. Are you a full-time or part-time health director?

Full-time (*skip to question 4*)

Part-time

a. If you are part-time health director, do you hold another position within your municipality?

No Yes (please specify _____)

WORKFORCE

4. For each staff person or consultant in your department including yourself, please provide:
- a) **number of paid hours per week** the person works for the department on average (an estimate is fine);
 - b) **degrees and certifications** related to the position; and
 - c) a brief description of each person's **role or duties**.
(please copy and attach additional pages as necessary)

Position	Weekly paid hours on average	Related degrees/ certifications	Role/duties
a. Health Director			
b.			
c.			
d.			
e.			
f.			
g.			

PERCENTAGE OF TIME BY MAJOR FUNCTIONS

5. For each staff person or consultant in your department including yourself, please estimate the percentage of time on average spent across the major public health functions or services provided by your department. Please note that the total estimated allocation should equal 100% for each position (i.e. you do not need to adjust for part time status). Please copy and attach additional pages as necessary.

FUNCTION	POSITION					
	a) Health Director	b)	c)	d)	e)	f)
	% time on:	% time on:	% time on:	% time on:	% time on:	% time on:
1. Obtaining/reviewing information describing the community's health	%	%	%	%	%	%
2. Facilitation of disease reporting	%	%	%	%	%	%
3. Participation in periodic community health assessments	%	%	%	%	%	%
4. Communicable disease surveillance	%	%	%	%	%	%
5. Communicable disease investigation	%	%	%	%	%	%
6. Nuisance complaints – air and water quality	%	%	%	%	%	%
7. Nuisance complaints – housing	%	%	%	%	%	%
8. Mosquito and other insect control	%	%	%	%	%	%
9. Animal control	%	%	%	%	%	%
10. Other environmental hazard investigation	%	%	%	%	%	%
11. Immunization Clinics	%	%	%	%	%	%
12. Public health emergency planning, exercises, response	%	%	%	%	%	%
13. Provide public health information and education	%	%	%	%	%	%
14. Conduct/participate in health promotion programs (not including clinical screening programs – see #25)	%	%	%	%	%	%
15. Lead/participate in community health coalitions	%	%	%	%	%	%
16. Review and update public health laws, regulations, ordinances	%	%	%	%	%	%

17. Educate public on health laws, regulations, ordinances	%	%	%	%	%	%	%	%	%
18. Food establishment inspections and enforcement activities	%	%	%	%	%	%	%	%	%
19. Other establishment inspections and enforcement activities	%	%	%	%	%	%	%	%	%
20. Housing inspection and enforcement activities	%	%	%	%	%	%	%	%	%
21. Septic and Well review/approval	%	%	%	%	%	%	%	%	%
22. Solid waste management	%	%	%	%	%	%	%	%	%
23. Tobacco Control activities	%	%	%	%	%	%	%	%	%
24. Assist individuals to access needed health and human services	%	%	%	%	%	%	%	%	%
25. Provide clinical screening services	%	%	%	%	%	%	%	%	%
26. Home visiting	%	%	%	%	%	%	%	%	%
27. Social work services	%	%	%	%	%	%	%	%	%
28. School health services	%	%	%	%	%	%	%	%	%
29. Behavioral health services	%	%	%	%	%	%	%	%	%
30. Departmental planning and review activities	%	%	%	%	%	%	%	%	%
31. Staff training and development	%	%	%	%	%	%	%	%	%
32. Record-keeping and administrative reporting	%	%	%	%	%	%	%	%	%
33. Other administrative duties	%	%	%	%	%	%	%	%	%
34. Other (describe):	%	%	%	%	%	%	%	%	%
35. Other (describe):	%	%	%	%	%	%	%	%	%
36. Other (describe):	%	%	%	%	%	%	%	%	%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%

LICENSED ESTABLISHMENTS

6. Please estimate the number of licensed establishments in your community for which your department has inspection responsibilities (*or indicate not applicable if you do not inspect certain facility types.*)

- _____ Restaurants
- _____ Other food-related establishments
- _____ Recreational camps
- _____ Swimming pools
- _____ Tanning facilities
- _____ Massage establishments
- _____ Body art establishments
- _____ Day Care facilities
- _____ Other
(please specify _____)
- _____ Other
(please specify _____)
- _____ Other
(please specify _____)

NEEDS AND OPPORTUNITIES

7. What public health activities or functions would you like your department to emphasize more if you had the time and resources? (*refer to the list on question #5 if helpful*)

- a) _____
- b) _____
- c) _____
- d) _____
- e) _____
- f) _____

8. In what areas would you and/or your staff be interested in having **additional training or expert back-up**?

a) _____

b) _____

c) _____

d) _____

e) _____

f) _____

9. Please list topical or task areas in which you feel you and/or your department have **expertise to share** with other departments in the region.

a) _____

b) _____

c) _____

d) _____

e) _____

f) _____

10. Please share other comments or ideas for improving the capacity, sustainability or effectiveness of your department.

THANK YOU VERY MUCH FOR YOUR RESPONSES!