



**Massachusetts Department of Public Health
Public Health District Incentive Grant Program
REQUEST FOR RESPONSES: IMPLEMENTATION GRANTS**

Title of Grant Program: Public Health District Incentive Grant Program

Comm-Pass Document Number: 203816

1. GRANT PURPOSE

The purpose of the Public Health District Incentive Grant Program is to provide financial support for groups of municipalities to enter into formal, long term agreements to share resources and coordinate activities in order to improve the scope, quality, and effectiveness of local public health services for their combined populations.

The Public Health District Incentive Grant Program is funded under the federal Patient Protection and Affordable Care Act of 2010 (a.k.a., national health care reform) as part of the U.S. Centers for Disease Control and Prevention (CDC) “National Public Health Improvement Initiative” (NPHII). It is one of 14 programs funded nationally by CDC through the Prevention and Public Health Fund created in 2010. It is intended to permanently strengthen the local public health infrastructure in Massachusetts by taking maximum advantage of limited resources to protect population health, prevent injury and disease, and promote healthy behaviors through policy change and service delivery at the regional level.

The program incorporates principles and recommendations of the Massachusetts Regionalization Working Group, a collaboration involving the state’s five professional public health associations, Boston University School of Public Health, local public health officials, the Massachusetts Department of Public Health, and other government partners. The program also incorporates recommendations issued in April, 2010 by the Regionalization Advisory Council, formed by an act of the Massachusetts General Court and chaired by the Lieutenant Governor. Further information is provided below in Appendix A: Background and Resources.

2. PROGRAM GOALS

The Public Health District Incentive Grant Program has six major goals:

- 1) Improve the scope and quality of local public health services in Massachusetts, consistent with the “Ten Essential Services” of health systems defined by CDC (see Appendix A).
- 2) Achieve optimal results with available resources for protecting and promoting health and preventing injury and disease.
- 3) Reduce geographic disparities in the capacities of local public health systems to carry out the responsibilities of Boards of Health under state laws and regulations (see Appendix A).
- 4) Promote policy change to remediate persistent and emerging public health challenges.

- 5) Strengthen the qualifications of the state's local public health workforce and the capacities of Boards of Health to perform their legal responsibilities.
- 6) Prepare for voluntary national accreditation of local health systems.

MDPH intends to use funds available under this initiative to help achieve the goal of covering the largest land area, largest number of municipalities, and largest percent of the state's population possible in public health districts. MDPH also encourages formation of districts that provide comprehensive services and combine their staffs under unified management. For districts that share some—but not all—staff, services, and management, MDPH favors sharing to the maximum extent possible.

3. CONTACT INFORMATION

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4. ELIGIBLE APPLICANTS

Applications for implementation grants are open only to the eleven groups of municipalities that received Public Health District Incentive Grant Program planning grant awards in response to the Massachusetts Department of Public Health (MDPH) Request for Responses Document Number 107212 posted to Comm-Pass in December, 2010.

Proposals for implementation grants may be submitted on behalf of eligible applicants by:

1. A lead municipality chosen from among the municipalities applying to form a public health district;
2. A Regional Planning Agency chosen by the applicant municipalities to serve as their administrative and fiscal agent; or
3. A regional Council of Governments chosen by the applicant municipalities to serve as their administrative and fiscal agent.

Implementation grant applications must document support for the proposal *from each municipality* in the prospective district by the respective:

- Municipal chief executive (e.g., mayor, town manager, town administrator, board of selectmen chair), *and*
- Board of Health or health commission.

Implementation grant applications must also:

- specify the district's lead municipality or designated administrative/fiscal agent, *and*
- include certification by the chief executive of such lead municipality or administrative/fiscal agent that they acknowledge and accept that role.

Legal Authority

For the purposes of this grant program, a public health district may operate under an inter-municipal agreement executed pursuant to MGL Chapter 40, Section 4A, or as a public health district created pursuant to MGL Chapter 111, Section 27A or 27B.

Municipalities are not required to have signed inter-municipal agreements or to have created a statutory public health district before submitting a PHDIG implementation grant application. (See governance performance requirements, page 6 below, for more information.)

5. FUNDING STRUCTURE AND DURATION

The Public Health District Incentive Grant Program is being funded primarily through a five year award from CDC to the Massachusetts Department of Public Health (Grant Number 1U58CD001323-01 under Program Title CD10-1011, Strengthening Public Health Infrastructure for Improved Health Outcomes). **Federal support for the program each year is subject to Congressional appropriation and satisfactory year-to-year performance.**

In the first year of the program (beginning September 29, 2010), MDPH provided planning grants to eleven groups of municipalities selected on the basis of a competitive Request for Responses (RFR) process. These eleven planning grant recipients are now eligible to apply for multi-year implementation grants to fund district start-up and operating costs under this RFR. MDPH anticipates approving implementation awards for five groups of municipalities.

Implementation grants are expected to be provided to each selected district for a period of four years. The first year of implementation funding for each district will define that district's "full funding" level. The second of implementation funding for each district will be level with full funding. The third year of implementation funding for each district will be funded at 75 percent of full funding. The fourth and final year of implementation funding for each district will be at 50 percent of full funding. Districts will be expected to develop and implement plans to sustain their operations without additional MDPH support after the grant program ends.

Continued funding for implementation grants each year is subject to the availability of federal funds and to satisfactory year-to-year performance by grantees. MDPH could impose financial penalties on a district in case of inability or failure to meet contracted objectives.

Selected districts will have flexible use of implementation grants, subject to MDPH approval. Districts will be authorized to hire staff and cover additional allowable costs detailed below. In addition, MDPH will provide supplemental funds to enable districts to contract for legal support, technical assistance with required activities, training, and planning for long term financial sustainability. MDPH will contract separately for professional evaluation of the program.

Estimated Value of the Grant (Including Anticipated Renewal Options)

Total funding of PHDIG implementation grants is expected to be \$1,625,000, including \$1,380,000 in funding under federal contract plus \$245,000 in supplemental Memorandum of Understanding funding through a Determination of Need program managed by MDPH.

Anticipated Funding Available Under This Request for Responses

MDPH anticipates making first year (“full”) implementation grants of \$100,000 to each proposed district selected under this RFR.

Federal funding for the Public Health District Incentive Grant Program will be augmented through a Determination of Need Community Health Initiative (CHI) managed by MDPH. Districts that receive implementation grant awards will enter into contracts with MDPH to receive funds available through CDC and will also enter into Memorandums of Understanding approved by MDPH with a third party fiscal manager of CHI funds. Implementation grant award letters will specify the amount of funding to be provided from each source to total \$100,000 in first year support.

Allowable Costs

This Request for Responses is for *implementation grants* under the Public Health District Incentive Grant Program. Applicants may propose to use implementation grants for costs including, but not limited, to:

- Staff to perform essential services for the district, such as management, public health nursing (for population health services, not for direct clinical medical care for individual patients), epidemiology, environmental health services, program and policy development, and administrative support
- Employee benefits
- Contractors for legal, financial, organizational development, planning, health assessment, quality improvement, or other services
- Operating expenses for communications, training, travel, meetings, supplies, accommodations to facilitate community and stakeholder participation, etc.
- Overhead not to exceed 12 percent

Applicants may *not* use implementation grants for construction, building renovation, or purchase of capital equipment with depreciable value in excess of \$5,000 (S/L, five year method). Occupancy expenses not included in overhead must be approved in advance by MDPH.

PHDIG implementation grants are intended to *augment* currently available municipal resources in order to improve the scope and quality of public health services and permanently strengthen the local public health infrastructure. Implementation grants may not be used to offset or replace current municipal spending for public health staff or services. Financial penalties could be imposed on a district if PHDIG funds were being used for this purpose.

Anticipated Initial Duration of Federally-Supported Program:

- A. Implementation grants covering the period January 1, 2012 through December 31, 2012 will be awarded to approximately five applicants, with each applicant representing a group of municipalities that intends to form a public health district.

Anticipated Renewal Options of Federally-Supported Program:

- B. MDPH expects to provide options to renew implementation grants for an additional three years, through December 31, 2015, subject to successful performance reviews and the continued availability of funding.

- C. Supplemental funds for training, technical assistance, and consulting are expected to be provided to implementation grant recipients over the course of the program.

Final End Date of this Federally-Supported Procurement: December 31, 2015

Federal Funding

This program will be funded primarily with federal funds. *Funding is subject to federal appropriation or the availability of sufficient non-appropriated funds under the grant funding authority.* Grantees receiving federal grant funds will be considered sub-recipients for federal grant purposes and will be required to comply with applicable federal requirements, including but not limited to sub-recipient audit requirements under OMB Circular A-133.

The funds received in advance of expenditure by a grantee for a capital budget item must be held in a segregated non-interest bearing account and must be expended within 60 days (for policy information on spending capital funds see: Office of the State Comptroller, State Grants and Federal Sub-grants:

www.mass.gov/Aosc/docs/policies_procedures/contracts/po_procon_state_grants_fed_sub.doc).

Payment through Electronic Funds Transfer is required for any contract awarded through this solicitation. Please see Forms and Terms screen on Comm-Pass.

Funds Balance Forward Requirement for Capital, Trust and Federal Accounts Only

Any funds designated in the budget that are unspent in any fiscal year will not be available for expenditure in the subsequent fiscal year without a formal contract amendment re-authorizing these funds. The maximum obligation of the contract will automatically be reduced by the amount of the unspent funds from a prior fiscal year.

Anticipated Payment Methodology

- Lump Sum
 Periodic Scheduled Installments
 Cost Reimbursement Other (specify):

Single Or Multiple Grantees Required For Grant

- Single Grantee or Multiple Grantees

Other Contractual Obligations

Applicants that receive implementation awards will be required to submit program and financial reports not less than semi-annually, as specified by MDPH.

Applicant goals, objectives, and plans submitted in response to this RFR will be incorporated into contracts as a basis for performance reviews.

6. GRANT SCOPE AND PERFORMANCE REQUIREMENTS

The Purpose of this Request for Responses is to solicit implementation grant proposals from groups of municipalities that intend to enter into formal, long term agreements to share resources and coordinate activities in order to improve the scope, quality, and effectiveness of local public

health services for their combined populations. Implementation grants will be provided to assist groups of municipalities to form new public health districts based on plans developed with Massachusetts Public Health District Incentive Grant Program planning grants.

District Performance Requirements

Districts that receive implementation grants under this RFR will be required to meet the following criteria and performance standards:

District Composition

Applicant municipalities should be included together within one of the Executive Office of Health and Human Services (EOHHS) regions (see Appendix B). Exceptions may be considered based on compelling circumstances, such as existing municipal collaborations that cross EOHHS regional boundaries.

A new district must cover:

- a combined population of at least 50,000, not including summer-only residents, and/or
- a land mass of at least 150 square miles, and/or
- at least five municipalities, and/or
- a single county.

Implementation grant recipients will be permitted and encouraged to add municipalities to their districts at any time during the Public Health District Incentive Grant Program.

If a municipality withdraws from a district during an implementation grant period, MDPH will conduct a review to determine whether the district will still meet district composition requirements and whether it will still be able to carry out the essential proposed scope and quality of services that led to its funding. No municipality that withdraws from a district will be entitled to PHDIG funds to support independent operations.

Governance

Districts funded under this initiative will be required to establish governance structures involving representatives of all participating municipalities. District governance boards will be required to meet regularly under established rules of procedure to make democratic decisions about district policies, personnel, operations, and finances.

Each municipality shall retain its Board of Health legal authority unless a municipality votes to delegate part or all of its authority to the district governance board and the district board votes to accept it. Boards of Health must approve agreements to delegate their legal authority.

Each district must document within one year of an implementation grant award that all member municipalities have executed an Inter-Municipal Agreement for shared public health services as proposed in the grant application or that specific plans are being implemented to form a

comprehensive district under MGL Chapter 111, Section 27A or 27B (e.g., placement of enabling language on Town Meeting warrants).

Board of Health Legal Responsibilities

Implementation proposals should document gaps in the current capacities of proposed districts to meet legal responsibilities of Boards of Health for their combined populations.

In order to meet the responsibilities of Boards of Health to respond to reportable diseases, each district will be required to ensure that every municipality in the district joins and utilizes the Massachusetts Virtual Epidemiological Network (MAVEN) system within six months of an implementation grant award.

In addition, each district will be required to document that it is meeting the responsibilities of Boards of Health to address food safety, childhood lead poisoning, beach, camp, and indoor ice skating rink safety with qualified personnel for its combined population within one year of an implementation grant award.

Each district will be required to submit to MDPH a performance improvement plan by November 16, 2012 for addressing additional responsibilities of Boards of Health for its combined population over the course of the PHDIG program. (See Appendix A for a web link to MDPH's guide to BOH responsibilities).

MDPH encourages districts to establish regional sharps disposal programs to comply with recent statutory changes. MDPH also encourages districts to cooperate with the Department of Environmental Protection on septic inspections and related responsibilities outside the statutory authority of the state health department.

MDPH encourages shared staffing and service arrangements to meet legal responsibilities of Boards of Health, but municipalities will have flexibility in determining whether and how to share resources to meet specific responsibilities.

Planning and Health Promotion

In addition, each district will be required to:

- 1) Complete and publicize findings of a community health assessment (CHA) for the district's combined population within 18 months of an implementation grant award.
 - The CHA should utilize data from the MDPH Massachusetts Community Health Information Profile (MassCHIP) system, US Census Bureau data, and other resources
 - The CHA should include qualitative, as well as quantitative information. Implementation grant applications should specify plans for involving diverse community stakeholders in the CHA process and for how CHA findings will be disseminated.
 - The CHA should include analysis of community assets for addressing health priorities, as well as analysis of health needs.

- The CHA may include consideration of existing policies and policy opportunities to improve health in the district's combined population.
- The CHA may incorporate needs assessments, Youth Risk Behavior Surveys, health disparity reports, or similar information compiled by health departments, hospitals, regional planning agencies, community development corporations, Regional Centers for Healthy Communities, Community Health Networks, foundations, and other entities. Such information should be current (no more than five years old) and relevant to the population of the proposed district.
- The CHA should use or adapt one or more evidence-based protocols, such as the National Association of County and City Health Officials's MAPP process or CDC's CHANGE tool.

(See Appendix A for web links to information about CHA, the Public Health Accreditation Board, MassCHIP, CHANGE, and MAPP.)

- 2) Conduct a sustained, district-wide initiative to promote healthy weight and/or prevent and reduce tobacco use in the district's combined population.
 - Initiative planning should incorporate findings of a Community Health Assessment.
 - The initiative(s) must incorporate municipal policy change and use evidence-based strategies identified by CDC (see Appendix A, page 19, for a web link to CDC's *Community Guide*).
 - Implementation may begin at any time after a PHDIG implementation grant award, but should begin no later than in the second year of the PHDIG implementation program.
 - MDPH encourages integration of such initiatives with existing MDPH Massachusetts Tobacco Control Program collaborative activities and Mass in Motion municipal wellness programs, where possible.

Collaborations

MDPH encourages planning to integrate the activities of proposed public health districts with hospitals, higher education institutions, community health centers, MDPH contracted service providers, other health and human service providers, community development corporations, civic engagement organizations, and community organizing groups. Districts should also integrate activities with existing public health structures where possible, such as MDPH Massachusetts Tobacco Control Program collaboratives, substance abuse coalitions, emergency preparedness regions and coalitions, Community Health Network Areas, and Mass in Motion municipal wellness programs. MDPH also encourages collaborations involving Boards of Health and health departments with other municipal departments of government that influence the social determinants of population health, such as planning, transportation, economic development, and education.

Workforce Qualifications

MDPH intends to use funds available under this initiative to strengthen the professional capacity of the Massachusetts local public health workforce. Applicants that receive implementation grants will be required within one year of receiving the grant award notice to:

- Document that each municipality in the proposed district has written qualifications for its Board of Health (or health department, as applicable) staff and contractors, specifically including but not limited to the positions of health director (agent, commissioner, etc), public health nurse, and environmental health official (inspector, sanitarian, etc.).
- Certify that these qualifications are included in job and contract postings and considered in hiring and contracting decisions for each municipality in the district.

In addition, any person paid in whole or in part with PHDIG funds to work as head of a health agency, public health nurse, or environmental health professional— full or part time, whether as a municipal employee, district employee, or contractor—will be required to meet professional standards for that position as outlined in Appendix C below within one year of a PHDIG implementation grant award, except as follows:

- Current municipal employees will be entitled to a transition period of up to 24 months to achieve required educational, credentialing, and competency standards, provided that they meet experience standards for their positions within one year of an implementation grant.
- Districts may appeal to MDPH for consideration of additional time to address compelling and well documented challenges arising from workforce market conditions or other particular circumstances.

MDPH will provide technical assistance for districts to meet these workforce qualification requirements.

Districts formed under MGL Chapter 111, Sections 27A or 27B will also be required to meet statutory workforce qualification requirements for their employees. MDPH will promulgate workforce qualifications for these districts in early 2012, pursuant to Chapter 529 of the Acts of 2008.

Board of Health Training

MDPH intends to use funds available under this initiative to ensure that all members of Boards of Health (BOH) understand and are able to discharge their responsibilities under Massachusetts laws and regulations. Applicants for implementation grants will be required to:

- Document that all current Board of Health members from participating municipalities have completed formal training on BOH responsibilities, such as the Massachusetts Association of Health Boards certificate program or programs offered online or on-site by the Local Public Health Institute of Massachusetts (for more information, see Appendix A).
- Specify plans for ensuring that all current Board of Health members complete formal BOH training within one year of receiving approval for an implementation grant, and
- Specify plans for ensuring that all future Board of Health members complete formal BOH training within one year of their election or appointment.

Individual BOH members are expected to complete formal BOH training at least once, not annually.

Because BOH training resources are available online, MDPH will only consider waiving training requirements for BOH members who are experienced local public health officials or who provide

other compelling reasons meriting special consideration. Schedule demands of busy professionals will not be considered sufficient cause for waiving BOH training requirements.

Evaluation

Each district will be required to participate in a professional evaluation of the Public Health District Incentive Grant program conducted by the Institute for Community Health (ICH), which will operate under a separate contract with MDPH. The evaluation will be designed to meet the following goals:

- Assist funded districts to define and achieve desired results through performance management.
- Document program, policy, and financial impacts of the PHDIG program overall and for each district that receives an implementation grant
- Assure effective management of the PHDIG program by MDPH, in partnership with funded districts.
- Increase capacity of the local public health system to address the CDC 10 Essential Services of Public Health and prepare for voluntary national accreditation (see Appendix A for more information).

In addition, grantees will be responsible for developing their own local evaluation plan for the district. The local evaluation plan should minimally include goals, objectives, and a plan for documenting process and outcome data. In Year 1 of implementation funding, the ICH evaluation team will provide a series of workshops on evaluation methods and site-specific technical assistance to support grantees as they refine and implement their evaluation plans. In subsequent years, ICH will also help build the capacity of grantees to utilize evaluation data for quality improvement and performance management.

(For more information about performance management, see Appendix A.)

Accreditation Readiness

The CDC National Public Health Improvement Initiative, under which the PHDIG program is funded, is designed in part to promote accreditation of state, local, and tribal public health departments across the country. A voluntary national accreditation process will be available beginning in 2011 under the auspices of the Public Health Accreditation Board (PHAB), a private, non-profit organization supported by CDC, private foundations, and national public health associations. MDPH will provide information to all implementation grantees about the PHAB accreditation process and will offer technical assistance to districts that wish to become accredited.

7. RESPONSE REQUIREMENTS

Applicants must complete each of the following in order to submit an acceptable proposal:

- ___ Cover Letter signed by executive of lead municipality or administrative/fiscal agent
- ___ Cover Page Form (see below)
- ___ Narrative (See required sections and information below)

- ___ Attachment A – Local Support Documentation Form (see below) or, if available, a copy of an Inter-Municipal Agreement (IMA) executed since April 1, 2011 to create the proposed district. If an IMA is submitted, it must be accompanied by documentation of support for the proposed district by the Board of Health or health commission for each covered municipality.
- ___ Attachment B – Budget Form (see below)
- ___ Attachment C – Additional Comm-Pass Forms (see Forms and Terms screen)
- ___ Attachment D – Resume(s) of Proposed Lead Staff
- ___ Support Letters (Optional)
- ___ Logic Model (Optional)

Required Narrative Sections

Narratives should be organized according to the following outline and provide responses to all questions and requirements. Refer to District Performance Requirements, pages 6-10 above.

1. *Executive Summary (3 points):*

Provide a concise summary of the proposal, including district name, municipalities that will be included, district model (comprehensive or shared services), leadership for the district, and how performance requirements will be addressed.

2. *Planning Process (7 points):*

- a. Provide a concise description of the planning process leading to submission of the implementation grant application, including roles and responsibilities of consultants and municipal participants, decision making structure, and types and frequencies of meetings.
- b. Describe efforts to involve additional municipalities in planning and explain changes, if any, in the composition of applicants for the planning grant compared to applicants for the implementation grant.
- c. Complete Attachment A, Local Support Documentation Form.
- d. If additional communities are expected to join the district but are not included in the application, please explain.

3. *Needs and Assets (15 points):*

- a. Specify the population of each applicant municipality and the combined population for the district.
- b. Specify the land area for each applicant municipality and the total land area for the district.
- c. If the proposed district does not fall wholly within the boundaries of an EOHHS region, please explain. (Refer to Appendix B, below, for EOHHS regional map.)
- d. Identify distinguishing population characteristics for the proposed district, e.g., age, race and ethnicity, poverty, housing, education.
- e. Describe noteworthy recent achievements and/or outstanding public health system strengths of the proposed district.
- f. Describe current gaps in the capacities of cities and towns in the proposed district to meet legal responsibilities of Boards of Health for the district's combined population.

- g. Describe public health challenges facing the proposed district population. Provide factual justification, if available.
 - h. Identify opportunities for how the proposed district will enable municipal partners to improve the scope and/or quality of public health services for their populations.
 - i. Describe institutional partnerships and collaborative relationships that are expected to strengthen the performance and sustainability of the district.
4. *Goals and Objectives (10 points):*
- a. What is the vision that applicants have for the proposed district by the end of 2015?
 - b. Provide a mission statement or statement of purpose for the proposed district.
 - c. What are the long term goals for the district?
 - d. What are the short term (within two years) goals for the district?
 - e. What specific objectives will shape efforts to achieve short term goals? (Objectives should represent milestones that the district needs to achieve in order to reach proposed goals. A combination of process and outcome objectives is acceptable. Outcome objectives for the first year should be Specific, Measurable, Achievable, Relevant, and Time-bound (SMART), if possible. For a web link to information about SMART objectives, see Appendix A.)
5. *Performance Requirements (30 points):*
- a. Describe what kind of district model the partners intend to form, (e.g., comprehensive, shared services, or some hybrid). Why is this model expected to be most appropriate?
 - b. Describe plans for governing the proposed district, including the governance structure and *what* will be governed (e.g., what staffing, services, policy, financing, etc.).
 - c. Describe plans for ensuring that all municipalities in the district join and utilize MAVEN within six months of receiving an implementation grant award. If technical or infrastructure challenges may delay achievement of this requirement, please explain.
 - d. Describe how the district will fulfill additional Boards of Health responsibilities for its combined population, including development of a performance improvement plan to address current capacity gaps. (Refer to Board of Health Legal Responsibilities, page 7 above.)
 - e. Describe plans for completing and publicizing findings of a Community Health Assessment for the district's combined population within 18 months of receiving an implementation grant award.
 - f. Describe plans for developing a sustained, district-wide policy initiative to promote healthy weight and/or prevent and reduce tobacco use in the district's combined population, based on currently available data and planning. Describe how the initiative will be related to a community health assessment yet to be conducted, if applicable.
 - g. Explain whether and how applicant municipalities currently meet workforce qualification requirements for Board of Health staff and contractors (described above, page 8). Describe plans to meet workforce qualification requirements, and identify opportunities or challenges that applicants expect to address.

- h. Explain whether and how applicant municipalities currently meet Board of Health training requirements (described above, page 9). Describe plans to meet these requirements, and identify opportunities or challenges that applicants expect to address.
 - i. Describe the current state of interest in PHAB accreditation among applicant municipalities and state whether the district is likely to seek technical assistance on accreditation.
6. *Evaluation (10 points)*
- a. Describe the indicators you will use to assess the district's progress towards achieving proposed objectives. (How will you know if you are achieving what you have proposed? What information will you use?)
 - b. How will you gather the information you need? How often will information be gathered?
 - c. How will you report and use evaluation findings with district partners?
 - d. Who will be responsible for evaluation within the district and for working with the Institute for Community Health on evaluation activities?
7. *Personnel (15 points)*
- a. Provide a summary of current public health staffing and contracted services employed by the applicant municipalities.
 - b. Describe proposed staffing for the district, including how PHDIG funds will be used to support staffing needs.
 - c. Describe how the district will be managed.
 - d. Identify and describe qualifications of proposed district leadership, if known. Attach resumes for identified leadership.
 - e. Describe plans for contracted services for the district, if applicable.
 - f. Identify staffing-related issues that districts expect to address over time (e.g., collective bargaining agreements, impending retirements of key staff, etc.).
8. *Budget Narrative (10 points):*
- a. Explain how proposed implementation grant funds will be used. Refer to Allowable Costs detailed above, page 4.
 - b. Provide details to support expense line items in the Budget Form, Attachment B. Provide titles for personnel positions. Provide the percent of salary represented by payroll taxes and fringe benefits. Provide details about contracted service expenses (responsibilities, hourly or daily rates, project cost estimates, or other method used to project expenses). Provide details about projected training, meeting, material, communication, and other operating costs. Provide a detailed justification for proposed overhead costs.
 - c. Provide details to support revenue line items in the Budget Form, Attachment B. If other funding has been committed to support district operations by some or all of the applicants to form a public health district, provide details about the source, amount, grant terms, and expected duration of funding.

- d. Describe in-kind services to be provided by the applicants, if applicable. Deduct In-Kind services from projected Total Cost to calculate the Total Request budget for PHDIG funds.
- e. Total Request may not exceed \$100,000.

Instructions for Submission of Responses:

Responses must be printed in a standard, 12 point font, such as Times New Roman. Narratives, excluding attachments, must not exceed 15 pages, using single spaced lines, double spacing between paragraphs, and one inch margins on the page. Proposals must include answers to all questions in the required narrative sections described above, pages 11–13. Submit seven (7) complete copies of the proposal, including cover letter and attachments, printed back-to-front if possible. One copy must include original signatures on the cover letter and on Attachment A, Local Support Documentation Form. (If an IMA is being submitted in lieu of Attachment A, it must be accompanied by a letter with an original signature documenting authenticity of the document, along with original signatures document Board of Health support for the IMA.)

In accordance with on-line instructions for Comm-Pass, the forms listed on the Comm-PASS “Forms & Terms” screen for this grant application must be submitted with your response. All forms referenced in the Response Requirements are available on Comm-Pass. (To access Comm-Pass on the Internet: Enter www.comm-pass.com in the url address field. Click on the Solicitations tab, and then click on Search for a Solicitation. Enter **203816** into the Document Number field, then press Search. “There is 1 Solicitation found that matches your search criteria” will appear at the top of the screen. Click on the eyeglasses on the top line to OPEN. The RFR is posted on the Solicitations tab.)

DEADLINE FOR RESPONSES: Friday, November 18, 2011 by 5:00 p.m.

Responses should be addressed and mailed or hand delivered to:

Geoff Wilkinson, Senior Policy Advisor
Office of the Commissioner
Massachusetts Department of Public Health
250 Washington Street, Room 2005
Boston, MA 02108

Responses may also be addressed to Geoff Wilkinson (title above) and mailed in care of or hand delivered to any of the MDPH Regional Health Offices (RHOs):

Western Mass. RHO (Northampton)

23 Service Center Rd., Northampton, MA 01060; (413) 586-7525

Central Mass. RHO (West Boylston)

180 Beaman St., Rte. 140, West Boylston, MA 01583; (508) 792-7880

MetroBoston RHO (Canton)

Donovan Health Building, 5 Randolph Street, Canton, MA 02021; (617) 541-4076

Northeast RHO (Tewksbury)

Saunders Building, Tewksbury Hospital, 365 East Street, Tewksbury, MA 01876; (978) 851-7261

Southeast RHO (New Bedford)

1736 Purchase Street, New Bedford, MA 02740-6821; (508) 984-0615

Responses must be RECEIVED at one of the addresses above by the deadline date and time.Will Bidders Conferences be offered? No YES**Bidders Conferences will be offered on Tuesday, September 20, 2011** at the following locations and times:

10:30 a.m. – 12:00 p.m. MDPH Western Massachusetts Regional Health Office, 23 Service Center Rd., Northampton, MA, large conference room

2:30 p.m. – 4:00 p.m. DentaQuest Oral Health Center, 2400 Computer Drive, Westborough, MA, large conference room

Will opportunity for written questions be offered? No YESQuestions may be emailed to geoff.wilkinson@state.ma.us until September 28, 2011. Answers will be posted on Comm-Pass on a weekly basis during the month of September, 2011. All questions must be emailed.

ATTACHMENT A (REQUIRED)



**Public Health District Incentive Grant Program
LOCAL SUPPORT DOCUMENTATION FORM**

Name of Proposed District: _____

Municipalities Included in Proposed District: _____

Check each box below to confirm that the applicants understand and intend to comply with the performance goals and requirements of the Public Health District Incentive Grant Program. Provide an explanation in Section 5 of the Application Narrative for any box that the applicants do not check.

The undersigned, duly authorized representatives of their municipalities, affirm that if awarded with an implementation grant, the Applicants will:

- Implement plans described in Narrative Section 5 for the proposed district, including governance, financial management, workforce qualifications, Board of Health training, and developing the proposed model of sharing staff and services.
- Implement plans described in Narrative Section 5 for required services of the district, including addressing specified responsibilities of Boards of Health, joining and utilizing MAVEN, completing and publicizing findings of a community health assessment, and conducting a sustained, district-wide initiative to promote healthy weight and/or prevent and reduce tobacco use in the district’s combined population.
- Submit periodic financial and program reports as required by MDPH.
- Cooperate in an independently funded evaluation of the District Incentive Grant program.
- The Applicants affirm that funds provided under this program will be used to augment rather than offset current municipal spending for public health staff or services.

Signed on behalf of the Applicants (Form must be signed by the municipal chief executive and authorized Board of Health representative or health commissioner from *each* Applicant municipality. Original signatures are required. Attach additional signature pages, if necessary. Applicants may duplicate this form, if desired, in order to gather required signatures on multiple copies of the form.)

Signature

Municipality

Print Name

Title

Signature

Municipality

Print Name

Title

Signature

Municipality

Print Name

Title

Signature

Municipality

Print Name

Title

Signature

Municipality

Print Name

Title

Signature

Municipality

Print Name

Title

ATTACHMENT B (REQUIRED)—BUDGET FORM

Name of Proposed District:

Dates Budget will Cover: _____, 2011 until _____, 2011

EXPENSES	Total Costs	(In-Kind)	Total Request
Salaried Personnel (include name & position)			
<i>Sub-Total Salaried Personnel</i>			
Payroll Taxes and Fringe Benefits (provide % of salary)			
<i>Total Salaried Personnel</i>			
Contracted Services			
<i>Total Contracted Services</i>			
Training			
Meetings			
Materials			
Communication			
Other Costs			
<i>Total Other Costs</i>			
Total Direct Expenses			
Indirect Costs (max. 12%--include details in budget narrative)			
TOTAL EXPENSES			
REVENUE			
Municipal Cost Sharing			
Foundation Grants			
Other Revenue			
TOTAL REVENUE			
NET REVENUE OR EXPENSE			

APPENDIX A – BACKGROUND AND RESOURCES

National research indicates that for local health jurisdictions covering population sizes up to about 500,000 residents, the essential functions of a public health department are more efficiently and cost-effectively carried out by one larger department rather than several smaller ones.¹ Research and experience in other states suggests that:

- Public health districts may enable communities to expand the range of services available for their residents.
- Districts have the potential to allow communities to afford more qualified, professional staff by pooling resources and expertise.
- Districts have greater capacity to apply for grants and are more competitive in grant applications, bringing additional resources to their communities.

Unlike most states, Massachusetts does not have a county or regional system for local public health. The Commonwealth has 351 separate cities and towns, each with its own Board of Health responsible for providing or assuring access to a comprehensive set of services defined by state law and regulation. Although it ranks 13th in the nation for population size and 44th in land area, Massachusetts has more local health departments than any other state in the U.S.

Also unlike most states, Massachusetts has no dedicated state funding to support local public health operations. Local health departments and boards of health are supported primarily by local revenues. Local public health funding varies dramatically among communities, and size of municipal population is not a reliable predictor of funding levels.

It is not necessary, from a system perspective, for each city and town in Massachusetts to pay for management of its own health department. By sharing management and administrative costs across municipal lines, Massachusetts communities could reallocate resources to increase inspectional services, disease prevention and control, health education, tobacco control, underage drinking, and other services currently in short supply.

For the last several years, a Regionalization Working Group, operating with leadership and staff support from the Boston University School of Public Health, has been developing recommendations to promote public health districts in Massachusetts. The Working Group includes representatives from all five of the state's public health professional associations, local health officials, the state departments of public health and environmental protection, and legislators. Its efforts have been supported by national organizations and foundations, including the National Association of County and City Health Officers, the Kellogg Foundation, and the Robert Wood Johnson Foundation. Many Working Group recommendations were adopted by a special Regionalization Advisory Commission created in 2009 by an act of the Massachusetts General Court and chaired by the Lieutenant Governor.

¹ Mays, Glen P, Megan C McHugh, Kyumin Shim, Natalie Perry, Dennis Lenaway, Paul K. Halverson, and Ramal Moonesinghe. "Institutional and Economic Determinants of Public Health System Performance." *American Journal of Public Health* 96:3 (2006): 523-532.)

From the perspectives of both experienced municipal leaders and public health officials, the principal values of public health regionalization are to:

- Improve the scope and quality of services available to the public (such as coordinated, professional response to public health emergencies);
- Stabilize local costs and achieve maximum impact with limited resources; and
- Avoid municipal liability for health problems arising from unmet responsibilities.

There are vast disparities now in the scope and quality of public health services available, depending on where people live. Regionalization has the potential to ensure more equitable protection for the state’s entire population.

Regionalization should not be undertaken primarily as a short term, cost saving measure. Cost impacts may vary for different municipalities involved, and depending on when and how districts are formed, cost benefits may take several years to accrue. A 2008 Pioneer Institute report on regionalization noted, “While the cost benefits from regionalization are clear, the ability to provide better services is equally important.”²

Public health regionalization should be based on the following principles advanced by the Massachusetts Public Health Regionalization Working Group:

- 1) Equity—the state’s entire population deserves access to high quality services to protect public health and prevent injury and disease.
- 2) Impact—regionalization should strengthen the capacity of Massachusetts cities and towns to deliver the essential services of public health defined by the U.S. Centers for Disease Control and Prevention.
- 3) Respect—municipalities need incentives for voluntary participation and continued authority to establish and enforce local public health regulations.
- 4) Flexibility— municipalities may utilize different models of shared governance, staffing, management, financing, and enforcement to meet their needs; one size doesn’t fit all.
- 5) Sustainability—regionalization requires adequate and sustained funding and technical assistance to support a qualified public health workforce at the state and local levels.

The Massachusetts Public Health Regionalization Working Group has defined two major models for public health districts:

Comprehensive Services District—all local health services for municipalities participating in the district 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 health board.

Shared Services District—a limited number of local public health services—not all—are carried out in common for municipalities participating in the district. Shared services models may include agreements that *all* district members will share *certain* services (e.g., public health nursing, environmental inspections, clinic operations), or agreements that the district will provide a “cafeteria” style menu of services from which participating municipalities may choose whatever services they desire from the district.

² “Regionalization: Case Studies of Success and Failure in Massachusetts,” *Pioneer Institute* 43 (2008):2. <http://www.pioneerinstitute.org/pdf/wp43.pdf> The paper includes a chapter on the Nashoba health district.

Different governance, management, and cost sharing arrangements are possible under each of the models. For more information, including case studies of existing public health districts in Massachusetts, visit http://sph.bu.edu/images/stories/scfiles/practice/status_report_9-1-09.pdf, p. 7 and Appendix 3.

For more information about local public health and public health regionalization in Massachusetts, MDPH recommends the following web links:

- Boston University School of Public Health (Regionalization Work Group reports): <http://sph.bu.edu/Regionalization/massachusetts-public-health-regionalization-project/menu-id-617432.html>
- Coalition for Local Public Health report on the Massachusetts local health workforce: http://mphaweb.org/resources/strength_lph_6_06.pdf
- Massachusetts Regionalization Advisory Commission website: <http://www.mass.gov/?pageID=gov3subtopic&L=5&L0=Home&L1=Our+Team&L2=Lieu+tenant+Governor+Timothy+P.+Murray&L3=Councils%2C+Cabinets%2C+and+Commissions&L4=Regionalization+Advisory+Commission&sid=Agov3>
- MetroWest Community Health Care Foundation Regionalization Initiative: <http://mchcf.org/KeyInitiatives/RegionalPublicHealth/tabid/203/Default.aspx>

For the MDPH *Manual of Laws and Regulations Relating to Boards of Health*, visit: http://www.mass.gov/Eeohhs2/docs/dph/emergency_prep/board_of_health_manual.pdf

For information about Board of Health (BOH) training:

- Visit the Massachusetts Association of Health Boards website at <http://www.mahb.org/Certification/certification.htm> for information about their BOH certification program, offered annually in multiple sites, or
- Visit the Local Public Health Institute of Massachusetts website at <http://www.masslocalinstitute.org/> for information about their online Local Public Health Orientation course (<http://www.masslocalinstitute.org/?p=541>) or their on-site Local Public Health Foundations course (<http://www.masslocalinstitute.org/?p=731>; <http://www.masslocalinstitute.org/?p=1372>). Online courses are also available on CD.

For information about voluntary national public health accreditation, visit the Public Health Accreditation Board website at: <http://www.phaboard.org/>

For information about the Ten Essential Services of Public Health defined by the U.S. Centers for Disease Control and Prevention (CDC), visit: <http://www.cdc.gov/od/ocphp/nphpsp/Documents/Essential%20Services%20Presentation.ppt>

For information about Community Health Assessments, visit:

- CDC website at: <http://www.cdc.gov/healthycommunitiesprogram/tools/change.htm> for information about the Community Health Assessment and Group Evaluation (CHANGE) tool

- National Association of County and City Health Officials (NACCHO) website at <http://www.naccho.org/topics/infrastructure/mapp/index.cfm> for information about Mobilizing for Action Through Planning and Partnerships (MAPP).

For information about evidence based interventions to address tobacco, obesity, and other diseases, visit the CDC Community Guide website at:

<http://www.thecommunityguide.org/index.html>

For information about Performance Management, visit:

http://www.phf.org/improvement/ViewResourceLink.aspx?source=http://www.phf.org/resources/ols/Pages/About_Performance_Management.aspx&title=About%20Performance%20Management

For information about Specific, Measureable, Achievable, Relevant, and Time-bound (SMART) objectives, visit the Institute of Medicine website at [http://www.iom.edu/About-IOM/Making-a-Difference/Community-](http://www.iom.edu/About-IOM/Making-a-Difference/Community-Outreach/~media/Files/About%20the%20IOM/SmartBites/Planning/P1%20SMART%20Objectives.ashx)

[Outreach/~media/Files/About%20the%20IOM/SmartBites/Planning/P1%20SMART%20Objectives.ashx](http://www.iom.edu/About-IOM/Making-a-Difference/Community-Outreach/~media/Files/About%20the%20IOM/SmartBites/Planning/P1%20SMART%20Objectives.ashx)

For information about the MDPH Community Health Network Areas, visit the MDPH Office of Community Health website at www.mass.gov/dph/ohc and click on “Community Health Networks.”

For information about MDPH data systems:

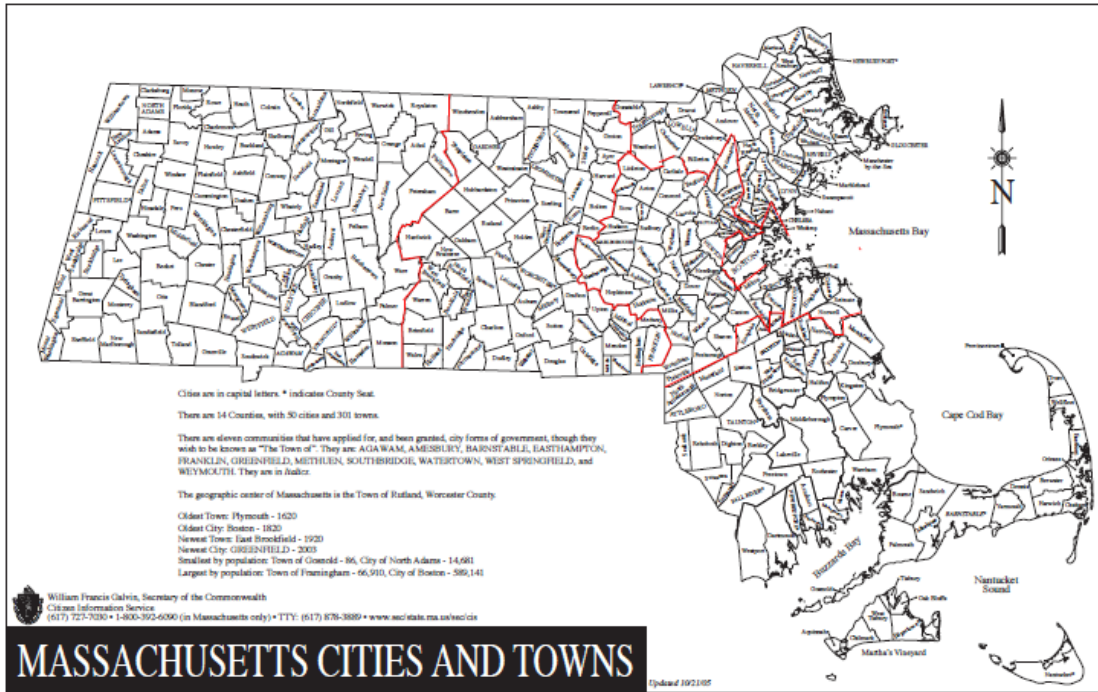
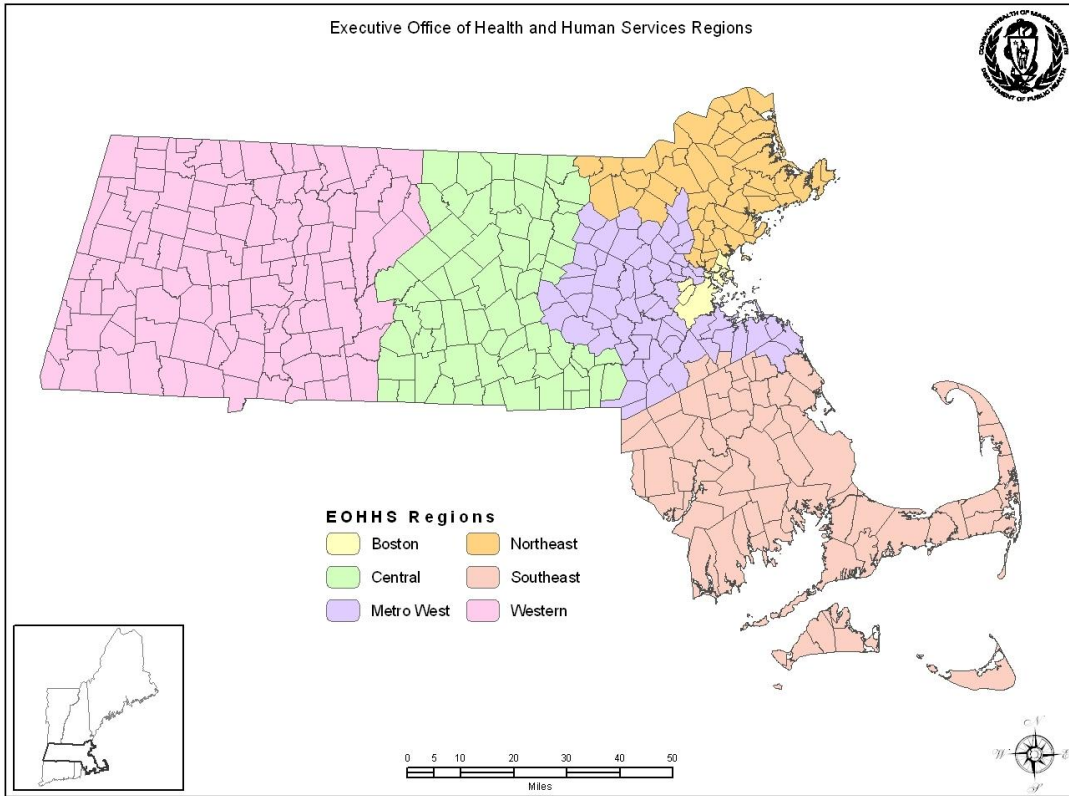
MAVEN:

http://www.mass.gov/?pageID=eohhs2terminal&L=6&L0=Home&L1=Provider&L2=Reporting+to+the+State&L3=Diseases+%26+Conditions&L4=Reportable+Diseases%2C+Surveillance+and+Isolation+%26+Quarantine+Requirements&L5=Office+of+Integrated+Surveillance+and+Information+Services&sid=Eeohhs2&b=terminalcontent&f=dph_cdc_p_isis_maven&csid=Eeohhs2

MassCHIP:

<http://www.mass.gov/?pageID=eohhs2subtopic&L=4&L0=Home&L1=Researcher&L2=Community+Health+and+Safety&L3=MassCHIP&sid=Eeohhs2>

Appendix B – Executive Office of Health and Human Services Regional Map



Appendix C: Workforce Qualifications (page 1 of 3)

Position Title (see Page 2 for definitions)		Environmental Health Professional (EHP)		Head Local Health Agency (HLHA)		Head Regional/District Health Agency (HRHA)	Public Health Nurse (PHN)
		Option 1	Option 2	If responsible for performing environmental health activities and functions	If <u>not</u> responsible for performing environmental health activities and functions		
Qualifications, by type (Education, Experience, Training)							
Education	Degree	Bachelor's degree from an accredited institution that includes at least 30 semester hours/45 quarter hours in basic science	Associate's degree from an accredited institution that includes at least 30 semester hours/45 quarter hours in basic science	Bachelor's degree from an accredited institution that includes at least 30 semester hours/45 quarter hours in basic science		Advanced degree in public health or a related field, If responsible for performing environmental health activities and functions, must also meet Option 1 requirements for EHP	Graduation from an accredited school of nursing; BSN strongly preferred
	Credential	MA Registered Sanitarian (RS) or NEHA Registered Environmental Health Specialist (REHS) credential	Certified Environmental Health Technician (CEHT) credential	MA Registered Sanitarian (RS) or NEHA Registered Environmental Health Specialist (REHS) credential	MA Certified Health Officer (CHO) or other professional certification in leadership, management, or administration (such as National Certified Public Health Administrator, Public or Environmental Health Leadership Institute)	Professional Certification in leadership, management, or administration such as MA Certified Health Officer (CHO), national Certified Public Health Administrator, graduation from a Public/Environmental Health Leadership Institute	MA Registered Nurse (RN)
Experience relevant to the work		Specified by credential	3 - 5 years	five years		five years	3 years
Competency Training Level (see Page 3 and 4 for description and levels)	Awareness	Cross Cutting (XC) 1- 10, Program Area (PA) 4, 5, 9, 16			PA 1-17	PA 1 - 17	XC 1 - 10, PA 1-3,6, 7-8, 10-15, 17
	Performance	PA 1-3,6, 7-8, 10-15, 17		XC 1 - 10, PA 1 - 17	XC 1- 10	XC 1 - 10	PA 4, 5, 9, 16
	Disclaimer	<i>If responsible for carrying out activities in specific Program Areas, required competency level is performance. Otherwise, competency level would be awareness</i>					
Possible additional program specific qualifications and/or substitutions		Certified Food Safety Professional (CFSP), Certified Food Manager, Certified Pool Operator (CPO), Healthy Homes Specialist (HHS), Lead Determination Inspector, Lead Inspector, Septic System Inspector, Soil Evaluator		An advanced degree could be substituted for 2 years of work experience or professional certification in leadership, management, or administration.		An additional advanced degree (e.g. DVM, MD, MPH, MS, MSN) could be substituted for two years of work experience or the leadership credential	American Nurses Credentialing Center (ANCC) certification or certification in Public Health (CPH). An advanced degree (i.e. MS, MSN, MPH) could be substituted for two years of relevant work experience.

Appendix C: Workforce Qualifications (page 2 of 3)

Position	Defined as...
Environmental Health Professional	Health inspectors, sanitarians, code enforcement officers, compliance officers, and environmental health specialists
Head of a Local Health Agency	The administrative head designated by the governing body of a city or town to manage public health services. Titles of administrative heads may vary (e.g., directors, health agents, health officers, or other administrative titles)
Head of a Regional Health District	The administrative head of a regionalized local health staff serving two or more communities. May be the Executive Director or Health Director of a District, or the manager of a regional health collaboration that operates out of a host town, city or agency
Public Health Nurse	A nursing professional with educational preparation in <i>public health and nursing science</i> with a focus on population-level outcomes

Competencies	
Cross Cutting (XC)	Program Area (PA)
1. Advocacy	1. Air Quality
2. Analysis, Problem Solving, and Risk Management	2. Animal Control
3. Communication	3. Body Art
4. Community/Public Health Assessment	4. Disease Case Management
5. Cultural Competence	5. Disease Surveillance, Investigation and Follow-up
6. Emergency Preparedness	6. Drinking Water
7. Health Education	7. Food Protection
8. Leadership	8. Hazardous and Medical/Biologic Waste
9. Legal Issues	9. Health Promotion and Disease Prevention
10. Project Development, Planning, and Management	10. Housing
	11. Nuisance Control and Noisome Trades
	12. Recreational Camps for Children
	13. Recreational Waters
	14. Solid Waste
	15. Tanning Establishments
	16. Vaccine Management
	17. Wastewater Treatment

Appendix C: Workforce Qualifications (page 3 of 3)

Excerpt from MA Competency Report: Local public health agencies in Massachusetts and throughout the U.S. provide a wide range of services to protect the public's health. To ensure more consistency across local public health agencies, in March 2006, the Local Public Health Institute of Massachusetts' Advisory Council established a subcommittee to develop a competency model and set of competencies. Additional support was provided by the Health Resources and Services Administration via the New England Alliance for Public Health Workforce Development and Boston University School of Public Health. The subcommittee needed to identify 1) the work that is done by local public health entities across Massachusetts, 2) those individuals who are doing the work, and 3) the legal and regulatory climate in which they were operating.

The subcommittee drafted a model for local public health competencies, based on specific programs within local public health agencies as well as a set of cross-cutting competencies. The subcommittee established two levels of competency for this model:

- Awareness level (basic information), and
- Performance level (intermediate level of mastery, often involves applying a skill)

The draft competency model and sets were reviewed by a number of representatives from various agencies, organizations, and associations for further review. The most up-to-date version of the report is available on the Local Public Health Institute of MA website at http://www.masslocalinstitute.org/?page_id=192. These competencies will be used to assist with developing and delivering comprehensive training programs for the local public health workforce in Massachusetts.

Levels of Program Area Competency

Awareness (What an individual knows): These attributes represent a basic level of knowledge and understanding. When training is complete, the individual should be able to describe, explain, identify, or recognize public health concepts.

For each program area, AWARENESS level includes:

- Explaining the science, disease mechanisms, and public and environmental health control measures relevant to the specific program area
- Identifying and interpreting applicable laws, regulations, and procedures
- Explaining enforcement activities and due process procedures (licenses, permits, inspections, investigations, re-inspections, correction orders, hearings, fines and penalties, emergency actions such as isolation and quarantine, court options)
- Identifying appropriate inspection or investigation methods, frequencies and processes
- Naming relevant tools and equipment necessary to conduct inspections, investigations, or surveillance activities
- Recognizing agency staff performance standards (i.e. minimum education or credentials to perform the work)
- Describing confidentiality and privacy rights of clients and patients

Performance (What an individual can do): These attributes reflect a higher level of skill or ability. When training is complete, the individual should be able to demonstrate, develop, generate, implement or initiate to effectively contribute to the solution of public health problems.

For each program area, PERFORMANCE level includes:

- Enforcing applicable laws and regulations
- Maintaining records
- Using proper inspection, investigation, and sampling equipment and tools
- Documenting inspection, investigation, and disease surveillance results
- Providing due process until compliance is achieved
- Conducting research, assessing, and analyzing information and data
- Drafting local policies, regulations, and by-laws
- Developing, managing and evaluating all program

