

# Public Health Futures Task Force

## Project Update



**Public Health**  
Prevent. Promote. Protect.

### Task Force Members:

Bernardston: Jon Pineo, BOH

Buckland: Jim Bauerlein, BOH

Conway: Dave Chichester, BOH

Charlemont: Rob Lingle, BOH

Deerfield: Carolyn Ness, BOH & BOS

Gill: Randy Crochier, BOH & BOS

Greenfield: Nicole Zabko, Health Director

Montague: Gina McNeely, Health Director

Shutesbury/Eastern Franklin Health District:

Bill Elliott, BOH

FRCOG Regional Health Inspection Program:

Glen Ayers

**Staff Support:** Phoebe Walker, FRCOG, Justeen Hyde, Institute for Community Health, Ted Harvey, FRCOG.

**Meeting 1 (April 2010):** Task Force members reviewed the history of public health collaboration in Franklin County, then went over a list of the requirements of local health departments. Finally, we brainstormed what additional service we would provide for our communities if we could:

- Staff to do more outreach to the public
  - Community health workers
  - Community organizing for public health preparedness
  - Staff to provide educational programs for the public
  - working in collaboration with social service agencies to help townspeople
- More time in BOH meetings for assessing needs of the community, doing some strategic planning for board of health regulations and budgets, and a staff person to gather the data.
- Public Health Nurses
- More time in BOH meetings for setting policies
- More training for BOH members so they can provide active oversight
- Coordinated mutual aid backup system of Board of Health members
- Housing Receivership Program (including funding, a designated Atty. General's representative, a receiver).
- a circuit-riding receivership lawyer
- Wood, smoke, particulate matter education and prevention.
- Mental health services or skills (youth outreach, nutrition, family skills, social work).
- Vulnerable populations outreach and planning
- Credentialing and standards to follow that make it clear what the local board of health's job is.
- Better support to Board of Health: proactively creating agenda, assessing needs of town. Spend part of the meeting on strategic planning, stagger elections.
- Regional solutions to data management for public health -- land registry, well registry, MAVEN, Title 5 information access, etc..

**Field Trip 1 (May 2010):** A number of Task Force members attended a dinner in Westfield hosted by the Working Group on Local Health Regionalization. The dinner featured speakers from a number of different regional health department collaborations across Massachusetts.

**Meeting 2 (July 2010):** Between Meetings 1 and 2, 7 of the 9 participating communities were surveyed about their food inspection and infectious disease reporting practices to get a sense of the strengths and gaps of our current public health system in those two areas.

*Strengths identified:*

- Skilled and dedicated Board of Health members
- Good municipal relationships
- Wide range of public health services reported among the towns
- Some increases in municipal allocation for public health services
- All have designated person responsible for infectious disease reporting and investigation
- Most have access to laboratory services (however, services are 2 hours away)
- All generate some revenue through fees, fines
  - About half have revolving accounts

*Gaps identified:*

- Few people responsible for performing a broad range of public health services
  - Not all have access to appropriate skills to perform services
- Very little to no prevention and wellness programs
  - All reported wanting to provide more prevention services if funding available
- Disease surveillance and investigation often not performed by public health nurse
- No community health assessments
- Little data collected to inform prioritization of community health needs
- No formal evaluation of services
- Limited oversight and quality assurance of public health services

Task Force members also reviewed the 10 Essential Services of Public Health and key health status indicators for Franklin County and found the following areas in need of improvement:

- Higher number of adults reporting days in poor or fair physical health in last 30 days (3.6)
- Higher number of adults reporting days in poor or fair mental health in last 30 days (3.6)
- Higher premature death years
- Lower primary care provider rate per 100,000 (107)
- Lower high school graduation (69%)
- Very high rates of asthma mortality relative to the rest of the state (274%)

These statistics on the health challenges Franklin County faces have direct effects on local boards of health: there is clearly need for more prevention and health education. Members felt that Boards should be addressing asthma issues – perhaps through education, perhaps through pre-rental housing inspections. Some members had seen a large uptick in their animal control responsibilities as well.

In terms of planning for the future of our region, we saw the following changes on the horizon:

- Greater diversity in population -- More linguistic capacity needed to communicate with the public
- More illness, particularly flu strains and more complicated TB cases

- Continuation of demands for emergency preparedness and response
- On-going challenges local and state budgets
- Global warming, including:
  - More mosquito borne disease
  - More tick-borne disease
  - More high heat days (especially hard for elders)
  - More ice storms
  - More flooding

**Meeting 3 (December 2010):** During Meeting 3 we reviewed the pros and cons of the many ways public health services can be shared in Massachusetts, including stand-alone health departments, shared services (inter-municipal agreements, cafeteria services, and districts ), and Comprehensive Health Districts.

Between Meetings 2 and 3 the FRCOG conducted extensive data-gathering to get a comprehensive picture of the amount of work currently being done and the amount of money currently being spent by participating Boards of Health. What we found was very surprising:

The participating towns and the Regional Health Inspection Towns are already spending a half a million dollars a year on a public health system serving only a few thousand more people than some of our large health department neighbors, and providing far fewer services. What are the inefficiencies? Task Force members identified the spending on numerous Board of Health clerks, software, and computers, as one redundant feature, and the payments to BOH members to witness perc tests as another. In addition, all of the part time (and full time) agents paid for by these towns are spending time on the same certifications and trainings, leaving fewer hours for direct inspection work. We spent some time comparing service, square mile, population and budget numbers with the Quabbin Health District, which serves communities very similar to ours with a comprehensive district including all inspections, public health nursing, animal control and plumbing inspection.

<b>Model</b>	<b>Population</b>	<b>Budget</b>
Public Health Futures communities & FRCOG Regional Health Inspection Program (RHIP) communities*	44,927	\$570,862
Above communities, without Greenfield	24,949	\$386,990
RHIP communities plus Conway and Deerfield	16,460	\$323,027
RHIP communities alone	9,901	\$87,596
<i>Quabbin Health District (Belchertown, Ware &amp; Pelham)</i>	<i>25,000</i>	<i>\$242,976</i>
<i>Northampton Health Department</i>	<i>28,528</i>	<i>\$252,000</i>
<i>Amherst Health Department</i>	<i>37,000</i>	<i>\$354,000</i>

Note: budget data not complete for Franklin County towns – probably higher.

\* Ashfield, Bernardston, Buckland, Charlemont, Gill, Hawley, Heath, Monroe

**Meeting 3, cont'd.** Our final activity was to evaluate a number of different options for better using our funds to improve public health. We consider a list of possible shared services, including:

- a food inspection district
- a community sanitation district (housing complaints, housing court, hoarding cases, receivership, pre-rental housing insp, rec camps, pools)
- a Title 5/Septic district
- a public health nursing district
- a combination of any two or more of the above
- a comprehensive public health district like the Quabbin Health District.

In order to evaluate them, we asked the following questions:

- Which choice makes the biggest improvement in the lives of Franklin County residents?
- Which choice is the most efficient? (allows you to share training or equipment or personnel in the way that saves the most money and time)
- Which choice has the highest level of political and financial support? (which allows you to generate revenue)
- Which choice has the least opposition?

The resulting table of criteria is attached at the end of this document.

### **Next Steps:**

After reviewing the data on need, on current expenditures, and on efficiency and capacity to generate revenue and improve lives, the Task Force agreed to submit a planning grant application to DPH to create a two-tiered health district in Franklin County. The district would provide for two levels of membership, and towns could decide which to join.

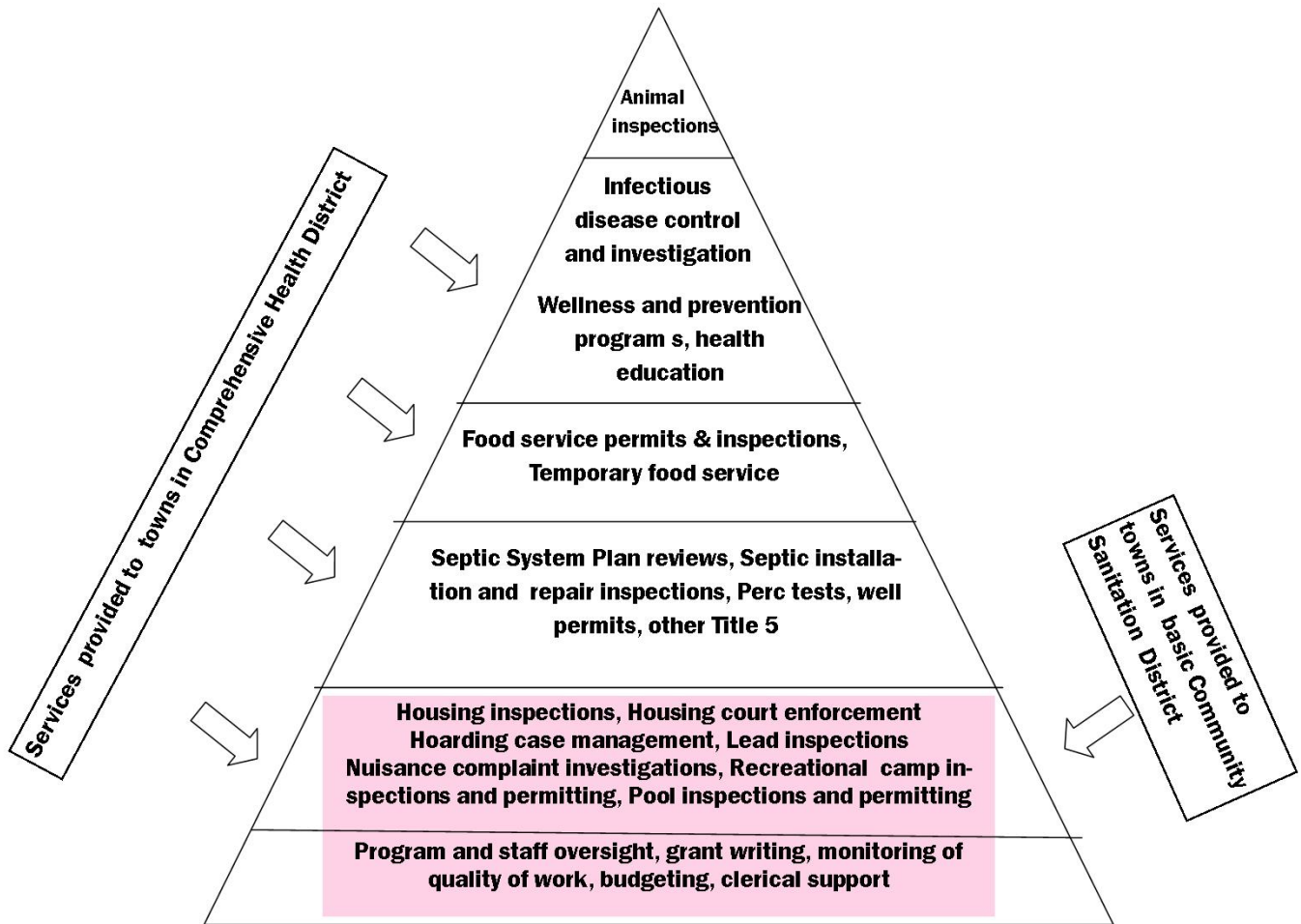
### **Proposed Model for Planning Grant:**

1. The basic level would be access for a participating City or Town to **community sanitation services:**
  - Housing inspections
  - Housing court enforcement
  - Hoarding case management
  - Lead inspections
  - Nuisance complaint investigations
  - Recreational camp inspections and permitting
  - Pool inspections and permitting

These services are some of the most specialized public health services that Boards of Health provide, often calling for significant mental health and mediation skills, and technical training. They are also among the most fraught with conflict and emotions for local officials.

2. The full level of services would be membership in a **comprehensive health district**, including all of the above community sanitation issues as well as:

- Food inspections – both regular and temporary
- Septic work: perc tests, Title 5 inspections & septic plan technical review
- Transfer station permitting
- Public health nursing – immunizations, health and wellness clinics, medication and wound management.
- Infectious disease control and investigation
- Animal inspections



**Proposed two-tier model for Franklin County Health District.**

This is just the barest outline of the Task Force's proposed model. We will spend the next six weeks gathering the information we will need to plan the most effective and efficient program to serve the towns of Franklin County, and reaching out to towns that want to join us. These are the questions we will be asking during the planning process:

#### **Service Questions:**

- What should be the service standards be? Review inspection policies, community outreach, forms used, timelines required, etc. Need to discuss with each BOH.
- Who else should be involved in our planning for this shared service? (i.e. courts, food program at DPH, human service organizations)
- How many and what kind of staff do we need? Come up with job descriptions, interview process, etc.
- What kind of equipment do we need?
- Where & when is a district staff person needed? (i.e. BOH mtgs, office hours, etc.)
- Will we use e-permitting?
- What will be emergency (24/7) coverage?
- How will potential users (i.e. restaurant owners, housing complainants, etc..) find out about the new shared service?

#### **Governance Questions**

- Who gets a vote? Review, modify, and approve template bylaws/operating procedures to cover budget approval process, weights of votes, roles and responsibilities
- What legal model should we use to organize? Need to discuss with BOS members and each BOH
- Who will host the service and what is expected of the host? (Town or FRCOG or separate legal entity)
- What will our shared fee structure be? (need to compare current fees and agree on new ones, including deciding what to base them on)
- What will our other (non-fee) revenue streams be?