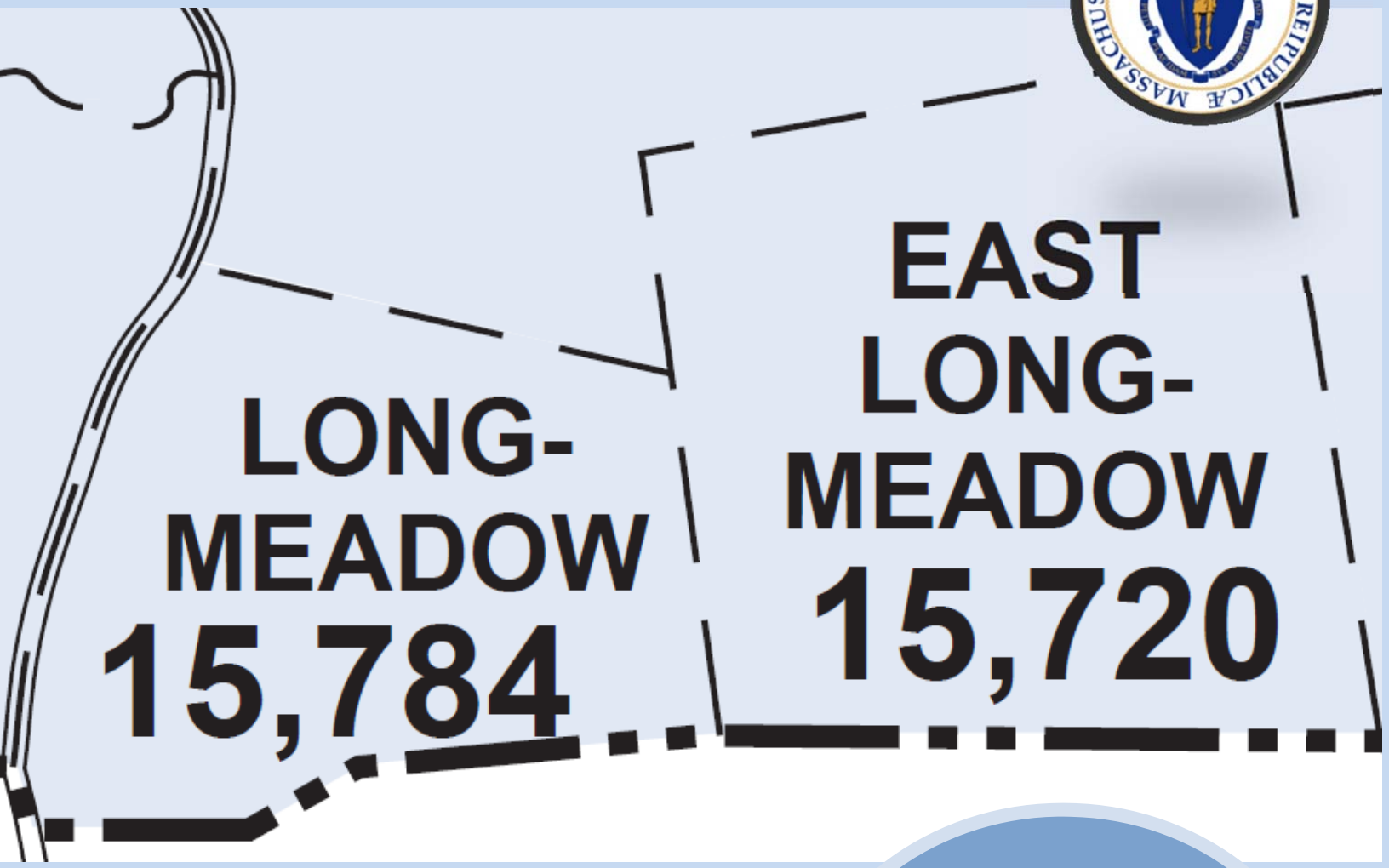
Shared Local Public Health Department Services - Exploratory

Towns of Longmeadow and East Longmeadow

November 28, 2018 DRAFT - UNOFFICIAL



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A Best Practice Smart Guide *for* creating a stronger and more comprehensive system for delivering public health services in a cross-jurisdictional sharing capacity

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Public Health

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Project Overview

Catalyst for Regional Progress
PVPC
Timothy W. Brennan, Executive Director

The present economic climate and the growing needs of the region are drastically shifting the fiscal landscape of cities and towns. Municipal budgets are increasingly tight and local leaders have statutory responsibilities and obligations that require them to perform specific municipal functions to meet local needs. It is for these reasons that communities are constantly investigating new ways to maximize efficiency to meet their legal responsibilities with less and still deliver the level of service that taxpayers expect.

Of the various municipal functions expected from local governments, local public health departments in particular are often under-resourced and operate below capacity just to maintain the most basic requirements and minimum standards of local public health. A combination of dwindling financial resources, shortages of trained staff, and increasing requirements for training and certifications are just some of the many issues facing local public health operations across the Commonwealth which also impact local and regional economic development opportunities. The Towns of East Longmeadow and Longmeadow are two of many Massachusetts communities who are experiencing some of these issues and have joined together with the Pioneer Valley Planning Commission (PVPC) and the Massachusetts Department of Public Health (MDPH) to explore the sharing of public health services and functions across jurisdictions in the hopes of creating a stronger and more comprehensive system for delivering services. Additionally, the Commonwealth of Massachusetts has recognized these concerns impacting towns such as Longmeadow and East Longmeadow and has established a Special Commission on Local and Regional Public Health to assess the effectiveness and the efficiency of municipal and regional public health systems in the Commonwealth and to make recommendations regarding how to strengthen the delivery of public health services and preventatives measures. The exploratory phase of Longmeadow and East Longmeadow could not have been more timely and can learn from the process and status report of the Special Commission as the Towns move forward with this information gathering phase.

An established shared service advisory working group made up of representatives of the Towns of Longmeadow and East Longmeadow drove the exploratory process. Monthly meetings were held in which members of the advisory group were able to share an honest assessment of what they think they do well in their respective communities, where they think they need to improve, and what possible solutions can be explored to make improvements. The overall goal of the exploratory process was centered around creating a more equitable health service delivery system in a shared service arrangement within the current available resources of these communities.

The following objectives were achieved through this exploratory process:

- Establish shared service advisory working group;
- Review and outline the duties and responsibilities of the of the Health Departments, including those both currently addressed and those desired;
- Bring forward information on available health data from community health assessments and environmental health assessments and develop comparative analysis to determine local public health activities to mitigate identified health concerns;
- Assess the workload of the Health Departments to determine similarities and differences in need between the two towns, including identifying potential overlap of duties and efficiencies that can be achieved through cross-jurisdictional sharing of services;
- Provide information about best practices and other service models from comparable communities that are cross-sharing services, if any exist;
- Identify options with cost estimates for shared-service arrangement; and
- Present findings to the Boards' of Health and Town leadership for input and direction.

TOWN PROFILES

Town of Longmeadow

Population: 15,784
Town Budget: $67m
Income Per Capita: $53,767
Median Household Income: $109,117
Tax Rate: Commercial $26.13; Residential $23.62
Land Area: 9.7 sq miles
Land Acreage: 6,126
Residential Land Acreage: 2,675
Commercial Land Acreage: 56
Agricultural Land Acreage: 224
Open/Public Land Acreage: 130
Outdoor Recreational Land Acreage: 346
Undeveloped Land Acreage: 2,307
(source: www.citydata.com and www.census.gov)

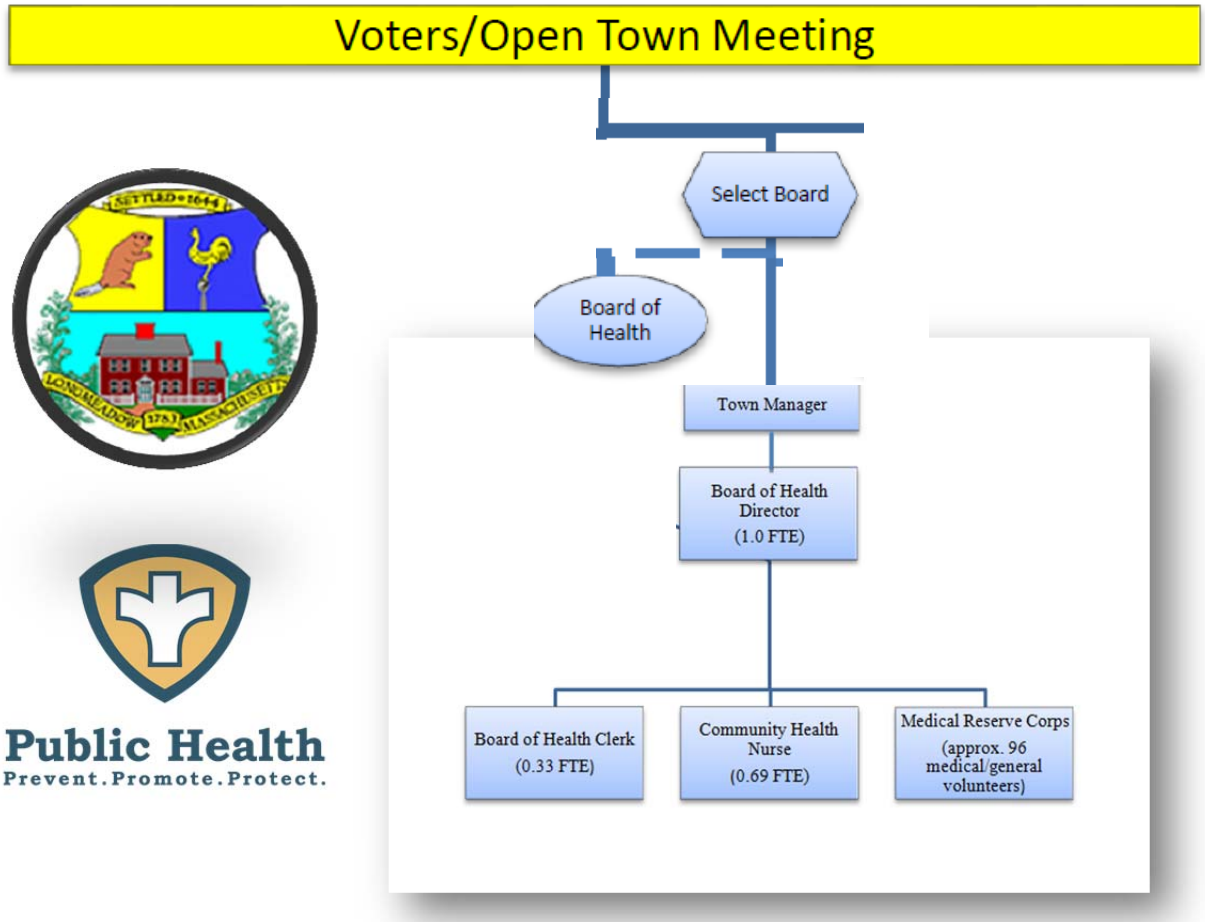
Town of Longmeadow is a residential community located in western Massachusetts in Hampden County at the southern edge of the Connecticut's River within the Pioneer Valley. Its 9.7 square miles is bordered on the east by East Longmeadow, on the west by the Connecticut River and Agawam, on the north by Springfield and on the south by Enfield Connecticut. The total land area of the Town of Longmeadow is 9.7 sq. miles, of which 9.1 square miles is land and .5 square miles is water. Longmeadow's population of 15,784 people consists of 5,741 households, with an average population density of 1,749 people per square mile.

Governance Structure and Operations

The Town operates under the open town meeting form of government with a five-member Select Board and an appointed Town Manager. Under this form of government, an annual Town Meeting, open to all residents, is essentially the legislative body for the town, and decides three (3) major items:

- Set the salaries of elected officials
- Vote to appropriate money for town operations
- Vote on the town's local regulations

All town residents are eligible to vote on all matters.



The Select Board consists of elected officials with an appointed strong Town Manager who supervises town employees and administers town operations. The Select Board and the Town Manager jointly serve as the town's excutive officers.

The five-member Board of Health in Longmeadow has been in operation for over three decades. The Board is appointed by the Select Board for a three-year term and is the government body specifically charged with promogating regulations that are enforced by the Health Department under supervision of the Town Manager. This includes preserving, protecting, and promoting the public health, safety, and well-being of the residents of the town. They do this by enforcing town by-laws and state and federal laws and regulations relating to public heath and environmental issues that impact local health. Typically, their functions primarily constitute state-mandated inspectional services and surveillance for communicable diseases. However, the Health Department is committed to prevention and wellness, therefore they also provide an array of other services such as public education on relevant community public health issues and clinical health services such as T.B. testing, adult immunizations, and occupational vaccinations for town employees.

The Health Department functions include but are not limited to:

- Addressing the health concerns of town residents
- Administering state health laws
- Adopting town health regulations and protocols

- Conducting inspections
- Developing and enforcing tobacco related policies
- Enforcing sanitary codes and regulations
- Enforcing state regulations regarding Title V: Septic Tanks and Home Sewers
- Issuing permits for various food establishments, businesses, and institutions
- Recording, reporting, and following up on communicable diseases within the community
- Sponsoring flu clinics and a rabies clinic each year
- Administering immunizations throughout the year
- Serving as a resource for the town for health promotion activities and technical assistance

Budget and Personnel

The Board of Health Department has a full time Director, a part-time Clerk, and a part-time Public Health Nurse. Their operating budget of approximatley $155,680.99 sustains the salaries of these personnel and other operating expenses relied upon to meet needs of the departments. The following is a budget breakdown of the department during the last three years and the expected expenses going into FY19:

	FY 2016 Actual	FY 2017 Budget	FY 2017 Actual	FY 2018 Requested	FY 2019 Requested
Personnel Services		(Rev. Budget)		(Rev. Budget)	
Community Health Nurse	40360.19	42960.00	41902.74	44583.14	46691.01
Director	78,704.56	80184.00	80151.22	83348.22	85071.12
Clerical	13,163.10	13479.00	13511.23	13695.01	13968.86
Subtotal	**132,247.35**	**136,623.00**	**135,565.19**	**141,626.37**	**145,530.99**
Expenses: Operating		(Town Mtng.)		(Town Mtng.)	
Employee Training	593.53	800.00	688.24	850.00	875.00
Prof & Tech - Inspection	0.00	500.00	500.00	500.00	3000.00
Office Supplies	695.10	800.00	471.52	850.00	850.00
Vaccinations	512.41	550.00	1819.88	525.00	525.00
Other Expense	3251.72	3800.00	3641.73	4300.00	4300.00
Dues & Memberships	543.00	500.00	493.00	600.00	600.00
Petty Cash	0.00	0.00	0.00	0.00	0.00
Subtotal	**5595.76**	**6950.00**	**7614.37**	**7625.00**	**10150.00**
TOTAL EXPENSES BOARD OF HEALTH	**137,843.11**	**143,573.00**	**143,179.56**	**149,251.37**	**155,680.99**

Existing Operating Functions of the Board of Health Department

State and/or local regulations mandate the licensing and inspection of facilities. The following activities were conducted by the Board of Health within the last three years:

Longmeadow Board of Health Licensing and Inspectional Services

# Licenses Issued	2015	2016	2017
Bakery	4	4	4
Food Service	47	41	46
Catering	0	1	1
Frozen Dessert	2	3	3
Methyl Alcohol	7	7	7
Milk	42	42	42
Retail Food	9	11	8
Temporary Food Svc.	43	49	38
Mobil Push Cart	0	1	3
Health Clubs	1	1	1
Tanning Establishments	0	0	0
Outdoor Dining	5	5	6
Tobacco Retailers	13	13	8
Residential Kitchens	5	4	4
Handicapped Park. Per.	7	4	6
Swimming Pools	17	17	17
Camps	24	20	21
Septic Sys. Installer	2	4	2
Septic Sys.Cleaning/ Hauling	3	4	4
Wells	1	0	0
Total #Licenses:	**232**	**231**	**221**

#Inspections Performed	2015	2016	2017
Food Service	176	194	183
Health Clubs	0	0	0
Outdoor Dining	14	12	10
Camps	70	63	78
Swimming Pools	42	51	48
Septic System Abandoned	2	2	3
Septic Sys. Inspection	2	3	3
Septic Sys. Install/Repair In	6	7	8
Wells	0	0	0
Elder Abuse	4	4	3
Housing	18	22	26
Nuisances, Misc.	15	14	17
School Safety	12	12	12
Total # Inspections:	**361**	**384**	**391**

The following is a listing of communicable disease reports received and investigated by the Board of Health Department as mandated by the Massachusetts Public Health regulations:

Infectious Disease Reporting, Surveillance and Control

Reportable Diseases:	Cases reported in: 2015	2016	2017
Camphylobacter	3	0	5
Chickenpox	2	1	0
C. Diff	0	0	0
Dengue	0	0	0
Giardiasi	0	0	0
Haehophilis Influenzae	1	0	1
Human Granlulocytic Anaplasmosis	0	0	3
Influenza (not subtyped)	2	9	15
Influenza A	0	0	0
Hepatitis A	0	0	0
Hepatitis B	3	2	3
Hepatitis C	7	9	8
Listeriosis	1	0	0
Lyme Disease	23	15	17
Pertussis	1	0	13
Salmonella	1	4	0
Shigellosis	0	0	0
Latent TB	0	2	2
Legionellosis	0	0	0
Group A Streptococcus (invasive)	3	4	1
Group B Streptococcus	1	0	1
Mumps	0	0	0
Entervirus Norovirus	0	2	0
Ehrilichiosis	0	0	1
Total	**48**	**48**	**70**

Beyond these activities, other Board of Health functions and special projects worked on by the department include:

- The Board of Health promulgated new local body-art regulations. Significant progress was made on drafting local Board of Health regulations on mandatory recycling, tanning facilities, and bees; adoption of these regulations is anticipated in early 2019;
- Revalidated provider status with Medicare effective for five years;
- Initiated successful legal actions to abate severe code violation at two extremely distressed residences in Longmeadow;
- Submitted two grants with funding notification scheduled for winter 2018:
    1. a federal MRC grant to do a full scale exercise of the town emergency sheltering capabilities, and
    2. a state grant to study possible sharing or regionalization of public health services;
- Emergency Preparedness: Federal mandates require that the Longmeadow Board of Health participate in the Hampden County Health Coalition (HCHC) which meets monthly at the Pioneer Valley Planning Commission and the Coalition provides drills, trainings and monthly planning activities for the purpose of coordinating regional response to health and other emergencies;
- The Longmeadow Medical Reserve Corps (MRC) Unit: The MRC Unit is housed at the Board of Health. The Unit continues in its multi-year plan to build capacity through volunteer recruitment and training, and to support the Board of Health in the performance of routine and emergency public health functions; and
- The Public Health Nurse is based in the same building as the Council on Aging and the Town Child-Care Center which allows for strong ability to assist in medical emergencies within the building, train staff, provide educational programs, and serve as the Camp Nurse for the Town-operated summer camp.

Challenges and Opportunities

The Town of Longmeadow's current Board of Health structure has existed for over three decades. The existing Health Director has built the department and has been responsible for the strong reputation it has in town between its local government and the community. The Health Director regularly consults with the Select Board and Town Manager to maintain communications. The Health Director strongly feels that the local government understands the role of the Board of Health Department and acknowledges its jurisdiction. Within its limited capacity, the department does its best to keep up with its responsibilities, despite the escalating demands and pressures that have made the work in the department more difficult and complex. With retirement of the Health Director on the horizon, the Health Director wants to ensure there is a succession plan that will not only maintain the capacity she has developed over the years, but also to create new opportunities that will establish a much stronger and more comprehensive system for delivering public health services. The current challenges and opportunities include:

- Staff capacity is limited (1 Health Director, 1 part-time Public Health Nurse, 1 part-time Clerk, no Health Inspectors) to what they can achieve beyond their day-to-day mandates;
- Enforcement of the Housing Code has spread the department thin. These enforcements continue to increase as the population continues to age and limited family/individual support systems exist;
- A lot is expected from the Health Director and the department, and very little time is available for administrative related work and other preventative activities outside of their mandates;
- Budget resources are limited;
- The Health Director is looking to retire in a few years which raises the question about how the town will sustain the public health services currently provided as well as respond to the changing public health landscape, including population demographics, chronic and emerging diseases, and new Commonwealth mandates.

Town of East Longmeadow

Population: 15,720
Town Budget: $55m
Income Per Capita: $39,282
Median Household Income: $99,707
Tax Rate: Commercial $20.72; Residential $20.72
Land Area: 13 sq miles
Land Acreage: 8,325
Residential Land Acreage: 3,196
Commercial Land Acreage: 185
Agricultural Land Acreage: 481
Open/Public Land Acreage: 197
Outdoor Recreational Land Acreage: 300
Undeveloped Land Acreage: 3,576
(source: www.citydata.com and www.census.gov)

East Longmeadow is both suburban and rural in character located in western Massachusetts in Hampden County. Half of its developed land is in residential use with a mix of primarily single-family homes and an abundance of open space and woodland. Its 13 square miles is bordered on the west by Longmeadow, on the east by Hampden, on the north by Springfield and on the south by Enfield Connecticut. East Longmeadow's population of 15,720 people consists of 5,933 households, with an average population density of 1,087 people per square mile.

Governance Structure and Operation

The town recently experienced a shift in its local government structure. Up until 2016, East Longmeadow had an open town meeting form of government, with a three-member Select Board. Under this form of government, the Select Board also served in the role of Fire, Police, and Board of Health Commissioners. The Board of Health at that time only had one 10 hours/week Health Agent. In 2015, a Charter Review Commission was elected to review the form of town government and to write a revised town charter for submission to the voters to review and approve. This passed in 2016 which then transitioned the town governing board from a three-member elected Select Board to a seven-member elected Town Council with an appointed strong Town Manager to administer the chief executive functions of the town. These include but are not limited to:

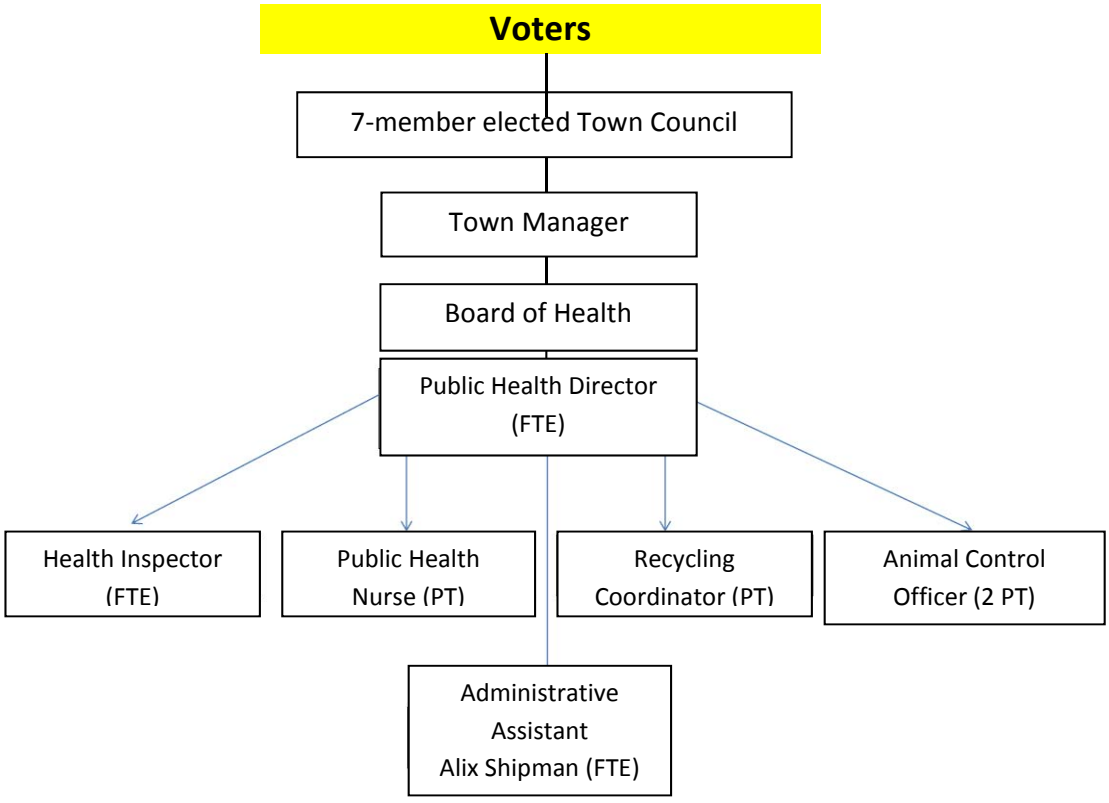
- Appoint, and may suspend or remove, subject to the provisions of the civil service law where applicable and except as otherwise authorized by the charter, all department heads, members of boards, committees, commissions and employees;
- Prepare in conjunction with department heads and boards of the town and present to the Town Council the annual budget for the town; and
- Supervise and direct the administration of all departments, agencies and offices.

This transition completely changed how the local departments, including the health department, functions operate and are managed. Under this new form of government, all registered voters in town are eligible to vote for Town Council who now serve as the town's legislative officers. The three-member Board of Health at East Longmeadow is now appointed by the Town Manager for a three-year term. They are the government body specifically charged with overseeing the activities of the Health Department, and they do so collaboratively with the Town Manager. The role of the Board of Health includes enforcing federal, state, and local laws and creating and enforcing local laws relating to public health and environmental issues within the town. The Board of Health is committed to addressing the public health needs of the community so the residents of East Longmeadow can thrive where they live, work, and play. The department responsibilitites include but are not limited to:

- Addressing the health concerns of town residents;
- Administering state health laws;
- Adopting town health regulations;
- Conducting inspections;
- Developing and enforcing tobacco related policies;
- Enforcing sanitary codes and regulations;
- Enforcing state regulations regarding Title V: Septic Tanks and Home Sewers;
- Issuing permits for various food establishments, businesses, and institutions; and
- Recording, reporting, and following up on communicable diseases within the community.

Public Health
Prevent. Promote. Protect.
East Longmeadow
Health Department

More than just meeting their minimum mandates charged by statute, the Health Department is fully committed to prevention and promoting wellness in the community.



Budget and Personnel

Today, the Health Department has expanded its operational capacity and leveraged other resources in the attempt to not only effectively meet local public health needs but also to promote health and prevention. They have three fulltime employees which include a Health Director, Health Inspector, and an Administrative Assistant. Additionally, they have two part-time employees which include a Public Health Nurse and a Recycling Coordinator. The operating budget of $252,745 sustains the salaries of the personnel at the Health Department with the exception of the Recycling Coordinator who is funded through multiple sources; and other operating expenses relied upon to effectively meet local public health requirements and other needs of the department. Overall, there has been, and continues to be, strong support for the Health Department by its Town Manager and Town Council as proven through the result of its expansion efforts and increase in its budget since FY2016. The following is the operating budget breakdown of the department for the last three years:

FY16

Description	Original Appropriation
DEPT HEAD SALARY/WAGES	63,404.00
COMMUNICATION-POSTAGE	1,150.00
OTR PURCH SRV-OTHER	52,000.00
OFFICE SUPPLIES	3,200.00
TRAVEL-MILEAGE TOLLS &	2,500.00
DUES AND MEMBERSHIPS	350.00
OTHER	1,000.00
TOTAL	**$123,604.00**

FY17

Description	Original Appropriation
FULL TIME SALARY/WAGES	60,549.00
PART TIME SALARY/WAGES	4,437.00
DEPT HEAD SALARY/WAGES	27,405.00
STIPEND	475.00
CLOTHING & BOOTS ALLOW	500.00
STIPENDS	3,500.00
REPAIRS-VEHICLES	850.00
PROF/TECH-MEDICAL	500.00
PROF/TECH-TRAINING SEM	4,800.00
PROF/TECH-ADVERTISING	1,000.00
PROF/TECH-OTHERS	900.00
COMMUNICATION-POSTAGE	1,740.00
OTR PURCH SRV-OTHER	42,500.00
OFFICE SUPPLIES	3,900.00
CLEANING SUPPLIES	150.00
VEH SUPPLY-GASOLINE	150.00
VEH SUPPLY-TIRES	400.00
MEDICAL SUPPLIES	200.00
OTH SUP-UNIFORM/CLOTHI	500.00
OTH SUP-MISC	1,200.00
TRAVEL-MILEAGE TOLLS &	5,350.00
TRAVEL-MEALS & FOOD	420.00
TRAVEL-HOTEL	1,000.00
DUES AND MEMBERSHIPS	700.00
OTHER CHARGES/EXPENSES	3,000.00
TOTAL HEALTH DEPT.	**166,126.00**

FY18

Description	Original Appropriation
FULL TIME SALARY/WAGES	80,777.00
PART TIME SALARY/WAGES	37,862.00
BOARD/COMMITTEE SALARY	3,500.00
DEPT HEAD SALARY/WAGES	58,500.00
STIPEND	350.00
STIPENDS	1,500.00
REPAIRS-VEHICLES	350.00
RENTAL/LEASE OFFICE EQ	1,136.00
PROF/TECH-TRAINING SEM	4,800.00
PROF/TECH-ADVERTISING	900.00
PROF/TECH-OTHERS	700.00
PROF TECH-SOFTWARE SUP	1,100.00
COMMUNICATION-POSTAGE	1,400.00
COMMUNICATION-PRINTING	1,000.00
OTR PURCH SRV-OTHER	48,000.00
OFFICE SUPPLIES	2,600.00
CLEANING SUPPLIES	100.00
VEH SUPPLY-GASOLINE	150.00
MEDICAL SUPPLIES	200.00
OTH SUP-UNIFORM/CLOTHI	1,000.00
OTH SUP-MISC	720.00
TRAVEL-MILEAGE TOLLS &	3,300.00
TRAVEL-MEALS & FOOD	300.00
TRAVEL-HOTEL	1,000.00
DUES AND MEMBERSHIPS	500.00
CAP OUTLAY-FURNITURE	1,000.00
TOTAL HEALTH DEPT.	**252,745.00**

Existing Operating Functions of the Health Department

State and/or local regulations mandate the licensing and inspection of facilities. The following activities were conducted by the Board of Health in 2017:

Permitting

In 2017, the Health Department issued a total of 284 permits, and the total permit revenue was $38,435. 252 total food permits were issued. The breakdown was as follows:

- 81 Food service establishment permits
- 36 Retail food service establishment permits
- 44 Temporary event permits
- 9 Catering permits
- 7 Frozen Dessert permits
- 70 Milk and Cream permits
- 5 Bakery permits
- Additional permits issued include tobacco (17), funeral directors (1), outdoor wood boilers (2), septic (1), camps (4) and pools (7).

Inspections

- **Food:** In 2017, 71 inspections were completed, 26 of those required re-inspections, and 7 establishments required two or more re-inspections.
- **Housing/complaints:** The department responds to a variety of housing concerns. Complaints include items such as tenant concerns of substandard housing conditions, unmaintained yards, trash accumulation, abandoned houses, and a variety of conditions that residents deemed as unsafe. In 2017, the department had 95 complaints and completed 95 inspections, 4 of which were referred to the Attorney General's Receivership program. Based on the results of the inspections, the town sent 46 letters to correct with 46 re-inspections to assess compliance. Of the 46, 11 required two or more re-inspections.

The East Longmeadow Health Department also oversees the Town's Animal Control program and recycling/trash removal. The following is related animal control data for 2017:

Animal Control/Animal Inspector

The Health Department has two Animal Control Officers (ACO's). The ACO position is a 24 hour, 7 day a week position with the primary goal of "Protecting the Health, Safety and Welfare of People and Animals." In 2017, the Animal Control Officers responded to 290 calls of which 12 were bites to humans, 18 were related to wildlife and 36 were strays. Throughout the year, 16 animals needed to be put in quarantine.

Since 2011, the ACO efforts in conjunction with the Town Clerk's office has generated dog licenses and related revenue in the following amount. Licensing statistics are as follows:

- 2011- $16,052 baseline 1,310 dogs licensed
- 2015- $37,222 1,884 dogs licensed
- 2016- $31,863.75 2,048 dogs licensed
- 2017- $30,159 2,106 dogs licensed

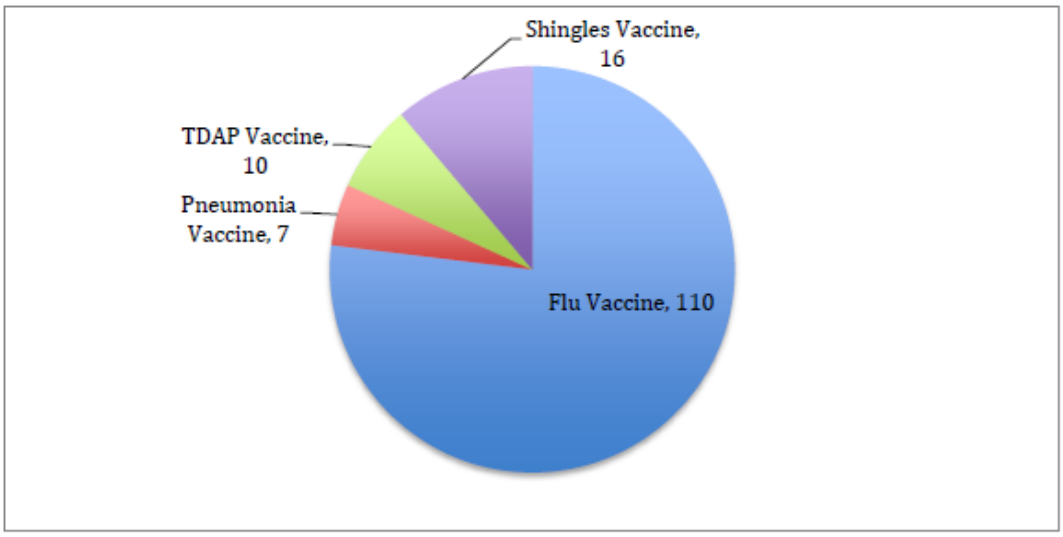
- The Animal Inspector conducted 31 barn inspections, resulting in 26 active barns being identified. These 26 barns housed a variety of horses, ponies, pigs, goats, ducks, and chickens.

Recycling/Trash

- **Trash:** In 2017, the Health Department took over supervision of town trash removal and disposal. In that time the department received 167 complaints by residents, and 48 complaints by the hauler. As a result of hauler complaints, 48 letters were sent to residents. The department maintains frequent communication with the haulers to ensure prompt service to town residents.
- **Recycling**: 2017 is the first year the town has had a recycling coordinator. The recycling coordinator is paid entirely from grant or recycling rebate money to implement, administer, promote, publicize, and monitor the recyclable materials collection. Responsibilities include: Assisting in coordinating recycling events and household hazardous waste collection. This position works with the curbside hauler to identify neighborhoods most in need of education, and applies for recycling grants as they become available. Notable accomplishments in 2017 include textile recycling, working collaboratively with the school department to increase recycling in the schools, and frequent interaction with residents to answer recycling or trash related questions or concerns.

Beyond these activities, other Board of Health functions and special projects worked on by the department include:

- **Reportable Disease Data:** According to the Massachusetts Virtual Epidemiologic Network, the Town of East Longmeadow had 110 confirmed, probable, or suspect cases of communicable disease in 2017. 110 is up 35 cases from last year's 75. Most notably there were 29 cases of Lyme Disease.
- **New Mosquito Program:** During 2017, the Town transitioned its mosquito control program to a mosquito control and surveillance approach. The first West Nile Virus (WNV) positive pool was not found until July 27th. Finally, using targeted control of the department's catch basins, monitoring for population and virus, and frequent updates to residents the Health Department maintained zero incidents of WNV for residents.
- **New Tick Program:** 2017 marked the town’s inaugural season of subsidizing tick testing through its partners at the UMASS lab. As the town’s communicable disease numbers indicated, the department had 29 reported cases of Lyme Disease this year. The program started in July 2017 and while it was only used 6 times, 5 of 6 times were after October 1st. The goal in 2018 is to increase the frequency this program is used in an attempt to bring down the amount of confirmed Lyme Disease cases reported.
- **Vaccination Clinic Data:** In 2017, the Health Department held a vaccination clinic, which made 4 different types of vaccines available. The vaccines offered were Flu, Shingles, TDAP, and Pneumonia. The total vaccines administered at this year’s clinic were 143, just shy of doubling last year's 74. This year the department was able to offer the uninsured/underinsured residents all 4 vaccines free of charge. In total the Town facilitated 110 flu vaccinations, 16 Shingles vaccinations, 10 TDAP, and 7 Pneumonia vaccinations.



Other notable accomplishments during 2017 include:

- Worked with East Longmeadow Community Access Television (ELCAT) to record health segments for residents. Topics include cooking safety, mosquito surveillance, tick testing program, swim safety, and a flu clinic segment.
- Health Department staff participated in a train the trainer workshop in the administration of Narcan.
- Collaborated with the Attorney General's office to participate in the receivership program. The receivership program allowed the Health Department to take further actions on abandoned and blighted properties in town.
- Provided food safety trainings.
- Created an electronic database of all septic complaint files.
- Created and maintained recycling and health department Facebook and Twitter accounts.
- Participated in numerous town wide events such as National Night Out, the Fire Department Open House, and the Taste of East Longmeadow.

Challenges and Opportunities

The Town recently experienced a shift in its local government structure which has brought on new opportunities for capacity growth for its local government functions. The Town underwent a Charter change and transitioned from a Select Board to a Town Council form of government with many changes to how the local department functions operate and are managed. Prior to the transition, the Board of Health use to be managed by the Select Board and staffed by a 10hrs/week Health Agent. Today, the Department is under the leadership of an appointed Board of Health. They now have a fulltime Director and other staff capacity and resources that did not exist before. There is strong support for the Health Department by its Town Manager and Town Council. The current Health Director has been highlighted as the key leader that has helped greatly through the transition and capacity building expansion efforts at the Board of Health. The Director credits the Town Manager and the Board of Health team who

prioritizes public health in the community. Although the Town has experienced growth in the Health Department and has achieved operational efficiency from where they were prior to the Charter changes, challenges are not ignored. These challenges include:

- Lack of town-wide understanding of the role/responsibilities of a Board of Health;
- No Public Health Nursing support for communicable disease management and prevention programming;
- Completing public health prevention work beyond what is federally or state mandated;
- No time/resources to complete a comprehensive community health needs assessment (CHNA) which provides information of the health status of the community residents, inform public health strategies, and improve accountability by tracking the impact of programs and services;
- Need for the development of public health programs and strategies in response to the health needs of town residents.

Core Functions & 10 Essential Services of Public Health Systems

The underlying responsibility of all local health departments is to protect and promote health, and prevent disease, and injury. Public health services are population based which are services focused on improving the health status of the population within a given jurisdiction or public health system. Public health systems are commonly defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction."[1] This concept ensures that all entities' contributions to the health and well-being of the community or state are recognized in assessing the provision of public health services. Examples of public health systems include:

- Healthcare providers;
- Public safety agencies;
- Human service and charity organizations;
- Education and youth development organizations;
- Recreation and arts-related organizations;
- Economic and philanthropic organizations; and
- Environmental agencies and organizations.

10 Essential Public Health Services
Center for Disease Control & Prevention

For public health departments to effectively achieve its focus within its public health system, it is expected for local public health departments to balance three core government public health functions which are nationally recognized practice-focused and evidenced-based standards. These core functions of public health are:

Core Function #1 - ASSESSMENT
ASSESS the health needs of the community. To systematically collect, assemble, and make available information on the public health status of the community, in cooperation with others, including statistics on health status, community health needs, environmental health, epidemiologic, and other studies of health problems.
INVESTIGATE the occurrence of health effects and health hazards in the community. To systematically develop in collaboration with others in the community, more detailed information on the magnitude of a health problem, duration, trends, location, population at risk, and how best to proceed to prevent or control the problem.
ANALYZE the determinants of identified health needs. This is the process of examining etiologic, risk, and contributing factors that precede and contribute to specific health problems or reduced health status in the community. Identifying these factors helps in working with the community in planning intervention efforts for prevention or control.

[1] Center for Disease Control and Prevention. The Public Health System & the 10 Essential Public Health Services https://www.cdc.gov/stltpublichealth/publichealthservices/essentialhealthservices.html

Core Function #2 - POLICY DEVELOPMENT
ADVOCATE for public health, build constituencies, and identify resources in the community. This is the process of generating support among constituent groups that address community health needs and issues, establishing collaborative relationships between a public health agency and the public it serves, the government body it represents, and other health and human-related organizations in the community.
PRIORITIZE among health needs. To facilitate a community process to rank health needs according to their importance, the magnitude, the seriousness of the consequences, economic impact and community readiness or the ability to prevent or control the problem.
PLAN and develop policies to address priority health needs. This is the process by which agencies, working with community constituents and other groups, facilitate the formulated goals and objectives to meet the priority health needs of the community, identify a course of action to achieve the goals and objectives in a way that fosters community involvement and ownership, and is responsive to local needs.

Core Function #3 - ASSURANCE
MANAGE resources and develop organizational structure. To acquire, allocate influence, resources (people, facilities, and equipment) and to encourage or enable them to meet priority community health needs in the best way possible.
IMPLEMENT programs. Work with other organizations, agencies and individuals to assure the implementation of programs in the community that fit community priorities. Work with the community to change community policy and practices.
EVALUATE programs and provide quality assurance. This is a process of continuous inquiry to determine the efficiency and effectiveness of efforts so that corrections can be made to improve activities and outcomes.
INFORM and educate the public. This is the process of informing the community about health problems, the availability of services; gaining the attention of individuals, high-risk groups, and constituents concerning public health issues; and providing health education to help develop beliefs, attitudes, and skills conducive to good individual and community health.

These functions are essential to the maintenance of population-based services within a public health system and set the national minimum standards for local public health departments, recommended by the Public Health Department Accreditation Board (PHAB), in which every resident can expect to have access to in their community. These services include the 10 Essential Public Health Services which are a set of public health activities that all communities should assume:

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; and
10. Research for new insights and innovative solutions to health problems.

Local Public Health should be striving to meet these core functions and essential services to conform with PHAB standards. Unfortunately, many Massachusetts communities, especially small towns, lack capacity to fully provide these minimum set of services within their public health systems or jurisdiction, and conformance to minimum requirements of state mandates is not enough. In the effort to build capacity to adequately meet these standards and achieve national accreditation, many Massachusetts communities such as Longmeadow and East Longmeadow are exploring and/or currently practicing regional/shared-service solutions. The Commonwealth of Massachusetts has also been taking an active role through its Special Commission on Local and Regional Public Health to better understand and take action toward strengthening support to improve services of local public health departments.[2] A summary of the progress on the charge of the Special Commission which includes a description of preliminary recommendations can be found at www.mass.gov/service-details/special-commission-on-local-and-regional-public-health.

[2] Special Commission on Local and Regional Public Health. https://www.mass.gov/service-details/special-commission-on-local-and-regional-public-health.

Exploring Cross-Jurisdictional Sharing Models

The 351 cities and towns in Massachusetts, varying in size and population, are independently organized for the delivery of local public health services. No matter the size however, every city and town is expected to provide state, federally, and locally mandated public health services. The dependence on local funding for public health services has resulted in significant disparities in the availability of public health services. Inconsistency has led to small towns struggling to meet their local health mandates, variability in the qualifications and credentials of Board of Health members and staff, and limited ability to meet standards of national public health accreditation. Communities struggling to meet these gaps are encouraged by the Commonwealth of Massachusetts to explore to the sharing of health services and staff across local health jurisdictions. In most cases it's beneficial to share staff between jurisdictions, but on a practical level, when exploring the concept, there can be a natural hesitation related to existing governance structures, the history between and culture of the jurisdictions, the equitable provision of services, and underlying fiscal arrangements, among other factors.

The Center for Sharing Public Health Services defines cross-jurisdictional sharing as the deliberate exercise of public authority to enable collaboration across jurisdictional boundaries to deliver essential municipal services.[3] There are circumstances in local government that create a favorable opportunity for cross-jurisdictional sharing services and costs among two (2) or more government bodies. Often, those moments are anticipated and present an opportunity to plan, such as in the current case for Longmeadow and East Longmeadow that has started this exploratory process. Mainly, timing is considered to be the most critical factor when municipalities are looking at the possibility of sharing municipal services. These opportune moments include when:

- a vacancy occurs in a town position;
- outside funding for a program is terminated, or another fiscal need arises;
- an opportunity to enhance service efficiency arises;
- a new position is created or a new service or program is initiated;
- a major purchase of equipment or vehicles is under consideration;
- a major building construction project is planned; or
- outside incentives are offered.

In the circumstances for Longmeadow and East Longmeadow, both communities have reached a fitting moment to share local public health resources as the Longmeadow Public Health Director plans for retirement in the near future which will result in a vacancy. Simultaneously, East Longmeadow's new

[3] Center for Sharing Public Health Services. Rethinking Boundaries for Better Health. https://phsharing.org/.

government structure, growing energy, expansion, and town-wide support of their local Health Department allows them flexibility to be creative in how they leverage resources and offer services to ensure a greater local public health system. Both communities identify the need to maintain and expand their respective levels of service to keep up with the demand and growing health challenges of the communities. The willingness of both municipalities to be creative and explore sharing resources is a positive first step forward. In the exploratory phase, there are some underlying questions that typically need to be addressed to assist the Towns with their decision in supporting the idea of a shared service arrangement. These questions are:

1. What would the governance structure look like?
2. What are the equitable means as far as allocating salaries, benefits, and other costs between the two (2) municipalities?
3. Who is responsible?

Governance and Equity

Sharing services between municipalities especially public health related services has a long history in Massachusetts primarily because the legal means to organize, reach an agreement, or share costs to meet needs exists.[4] There are several state laws and statutes that provide Massachusetts cities and towns with the authority to share or regionalize municipal services. These statutes include: Intermunicipal Agreements and Massachusetts General Law Chapter 40, Section 4A; and Special Legislation.[5] On the subject of public health, legislation does exist under MGL Chapter 111, Section 27A[6] to specifically allow two or more communities create public health districts.

Inter-municipal Agreement (IMA): IMAs are the most commonly used form of contracts in shared service projects between municipalities and host agencies. It allows two or more governmental units to enter into an agreement to perform jointly services that a single municipality is authorized by law to do on its own. Shared service agreements under IMA take several forms:

1) a municipality as the lead and provides defined services to one or more municipalities for an agreed-upon price;
2) a municipality provides specific services to another municipality on an as-needed-basis for a fee;
3) a Regional Planning Agency (RPA), Council of Governments (COG), or other regional service organization as the host agency and provides services to participating municipalities under a fee-for-service contract.

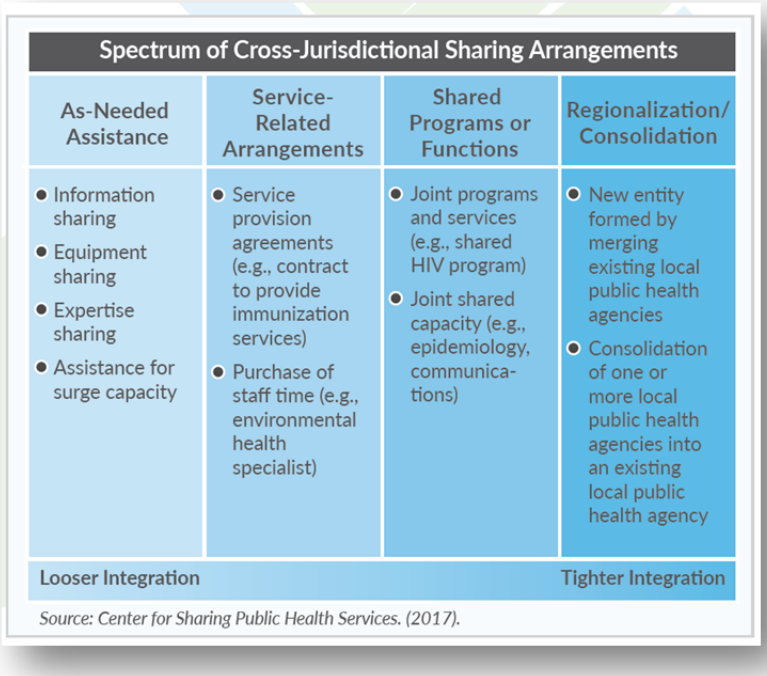
The distinguishing factor in these types of arrangements is that one entity is ultimately responsible for the service being provided. Although the governance and costs are shared with other participating municipalities through the provisions of the applicable contract, the "lead" community or "host agency" bears ultimate responsibility for the provision of services. It's up to the communities to decide and agree who that lead or host agency will be best

[4] Boston University School of Public Health. MA Public Health Regionalization Project. http://www.bu.edu/regionalization/.
[5] Regionalization: A guide for sharing public services in Massachusetts. Laws that allow for regionalization. http://www.regionalbestpractices.org/.
[6] Section 27A: Appointment of health officer by two or more towns; duties; compensation; joint committee. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section27A.

fitted to take on the responsibilities.
Special Legislation: Under this act, municipal officials may draft and seek approval of special legislation allowing for the creation of new regional entities or district. Such legislation must be introduced by a state legislator and passed by the Massachusetts Legislature.
MGL Chapter 111, Section 27A: Under this legislation, two or more municipalities may form a health district to provide services. The personnel employed by the districts are overseen by an established joint-committee between the participating communities. The joint committee can be made up of the boards of health combined or an appointed representative of the respective boards of health of each community.

Cross-Jurisdictional Sharing Spectrum

The Center for Sharing Public Health Services have organized the different sharing arrangements into four main types - reflected in the spectrum below.[7] For each of these arrangement types, the governance model, financial structure, and decision-making process can be different. Generally, the level of service integration increases, the level of jurisdictional autonomy decreases, and implementation becomes more complex, as can governance, when practicing any of these arrangement types. If implemented correctly, each type of arrangement can achieve gains in effectiveness and efficiency. As noted earlier, there are many established health districts that are implementing best practice sharing models across Massachusetts. An important factor however, is that there is no one-size fits all approach. When the Towns move forward with implementing a shared service arrangement on a pilot scale level, changes can be made in areas where the communities see fit to ensure optimization of services for their defined regional jurisdiction.



[7] Center for Sharing Public Health Services. Spectrum of Cross Jurisdictional Sharing Arrangements. www.phsharing.org

As-Needed Assistance: On the left side of the spectrum there is 'as-needed assistance', where one jurisdiction collaborates with other jurisdictions on an as-needed basis. These arrangements are informal and customary, as well as sporadic in nature. Some examples of as-needed assistance include:

- Information sharing (e.g., notifying adjacent other local health jurisdictions of a rise in pertussis cases)
- Expertise sharing (e.g., access to an epidemiologist, an inspected, and other professional staff)
- Equipment sharing (e.g., generators when needed)
- Assistance for surge capacity (e.g., providing additional nurses to an adjacent health jurisdiction)

Service-Related Arrangements: Unlike as-needed assistance, 'service-related arrangements' involve regular and predictable sharing, usually formalized through contracts. Some examples of service-related arrangements include:

- Service provision agreements (e.g., contract to provide immunization services)
- Purchase of staff time (e.g., purchasing the services of an environmental health specialist)
- Interstate compacts (e.g., interstate Health Care Compact to improve policies within states)

Shared Programs or Functions: If all entities contribute resources and have a formal role in decisions about how and when to deliver services, then the arrangement is a 'shared program or function'. Some examples include:

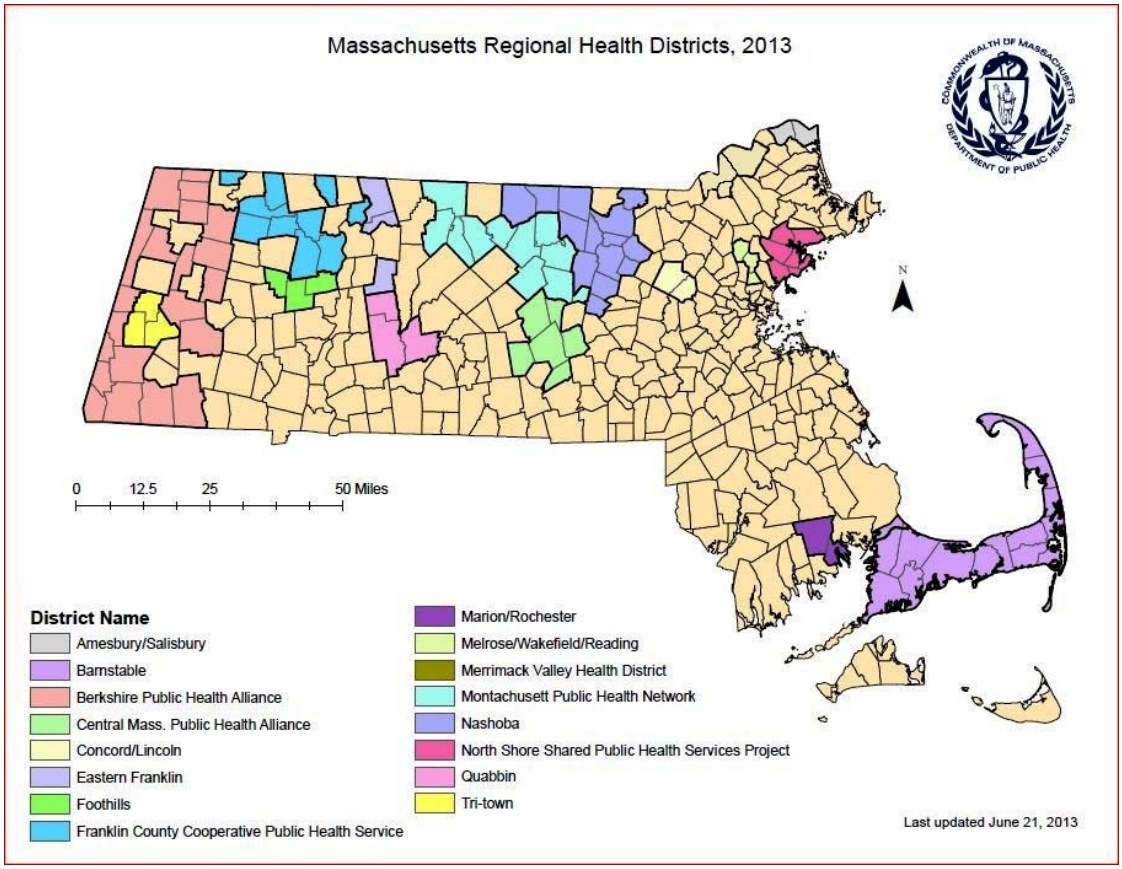
- Joint programs and services (e.g., shared stake in a regional HIV program)
- Joint shared capacity (e.g., shared oversight of a Health Agent, or Inspector)
- Joint ownership of assets/procurement (e.g., multiple health jurisdictions contract to purchase large capital expenses)

Regionalization/Consolidation: On the right side of the spectrum is 'regionalization/consolidation', where multiple jurisdictions are served by a single governmental entity that delivers all services and formally assumes the risks, costs, and decision-making across the jurisdictions involved. Some examples include:

- Merger (i.e., one local public health agency acquires one or more other agencies into itself)
- Consolidation (i.e., two or more local public health agencies combine to create a new agency)
- Regionalization (i.e., creation of a special district or a new entity to service a geographic area)

Best Practice Models and Service Types

In Massachusetts, there are 16 examples of shared services or regional health districts reflecting different models and arrangement types described on the cross-jurisdictional sharing arrangement spectrum. In Western Massachusetts alone, there are six (6) health district examples.[8] The map below produced by the MA Public Health Regionalization Project mirrors the public health districts in Massachusetts. Each of these shared service health districts demonstrates the different arrangements that may be pursued contingent on the limitations of what's available for Longmeadow and East Longmeadow.



Some examples of health districts in Western Massachusetts with different arrangement types include:

Berkshire Public Health Alliance[9]

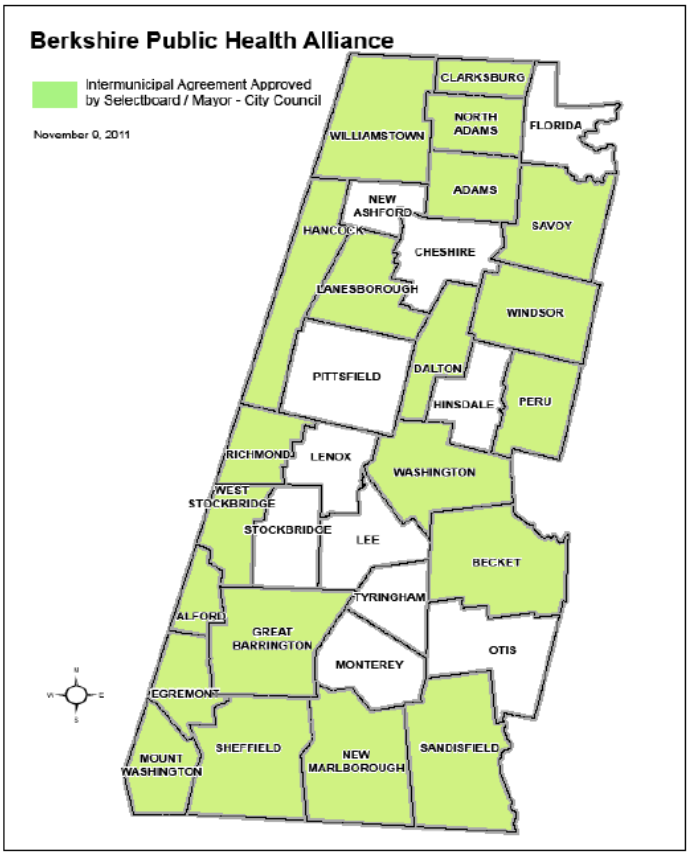
The Berkshire Public Health Alliance is a collaboration that started with 22 Berkshire Communities who have signed an Inter-Municipal Agreement to provide professional public health services and programs for the member communities. On the spectrum, this is categorized under the 'shared programs or functions' arrangement type. The mission of the Alliance is to improve the delivery of public health services and thereby improve the overall health and well-being of Berkshire County residents. The Alliance was established in the fall of 2011 by the 22 Berkshire municipalities of Adams, Alford, Becket,

[8] Maps of Regional Health Districts in Massachusetts. www.bu.edu/regionalization/digs/maps/

[9] Berkshire Regional Planning Commission. Berkshire Public Health Alliance. http://berkshireplanning.org/initiatives/berkshire-public-health-alliance.

Clarksburg, Dalton, Egremont, Florida, Great Barrington, Hancock, Lanesborough, Mt. Washington, New Marlborough, North Adams, Peru, Richmond, Sandisfield, Savoy, Sheffield, Washington, West Stockbridge, Williamstown, and Windsor. The towns of Pittsfield and Cheshire have now joined the BPHA. The Berkshire Regional Planning Commission (BRPC) serves as the Host Agency (fiduciary agent) for the alliance. Initial Alliance efforts concentrated on providing inspectional services and public health nursing services to member municipalities. Today, services available through the Alliance include:

- **Public Health Nursing Services -** The Public Health Nursing provides wellness programming, flu clinics, disease screenings and disease investigations for those who are challenged by location, mobility, and income. The nurses are promoting the wellbeing of the community and creating partnership to prevent disease, reducing the effects of chronic diseases, lowering premature death rates and improving quality of life for many. In addition the nurse monitor the MAVEN (Massachusetts Virtual Epidemiologic Network) reporting that municipalities are required to conduct.
- **Public Health Inspectional Services -** Health Inspectors work under the direction of the municipal Boards of Health to provide technical services. These services are all those required of Boards of Health, including Title V (on-site septic) inspections, food establishment inspections, camp inspections, swimming pool inspections and housing inspections.
- **Opioid Abuse Prevention Center -** With funding support provided by the Massachusetts Department of Public Health, the Berkshire Opioid Abuse Prevention Collaborative will develop and implement local policies, practices, systems and environmental changes to prevent the misuse or abuse of opioids, prevent or reduce unintentional deaths and non-fatal hospital events associated with opioid poisonings and increase the capacity of municipalities to deal with the growing problem.



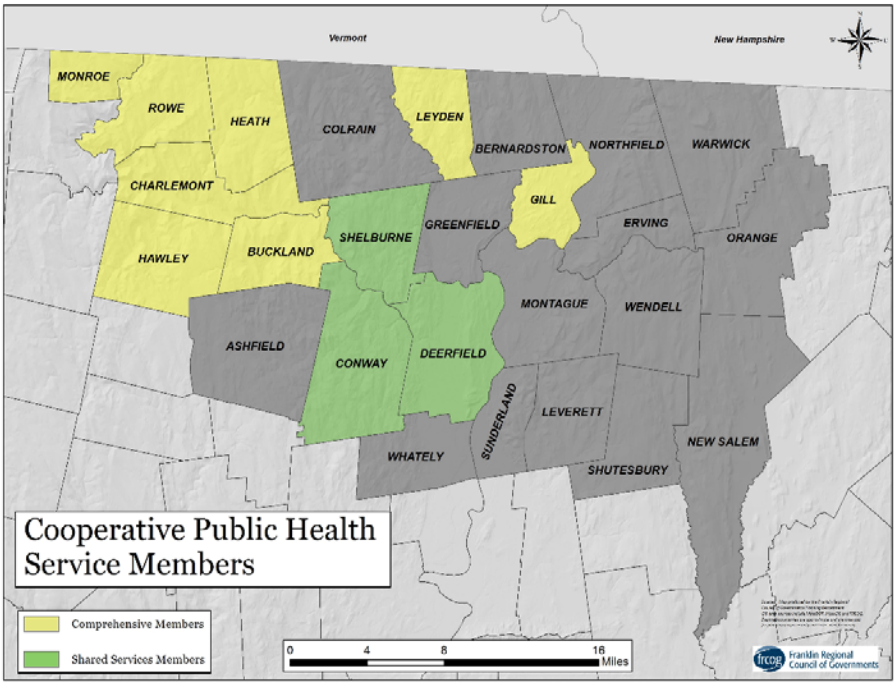
Tri-Town Health Department[10]

The Tri-Town Health Department is overseen by a collaboration of board members from the Towns of Lee, Lenox, and Stockbridge. The Tri-Town model on the spectrum is categorized under the 'regionalization/consolidation' arrangement type. Established in 1929, the department delivers an array of programs and services to the participating communities to meet the standards to promote, protect, and sustain public health for its communities. There staff capacity includes:

- Public Health Director / Reg. Sanitarian
- Office Manager / Health Educator
- 2 Health Inspector's / one of which is also an Enforcement Officer
- 2 Animal Control Inspectors

Cooperative Public Health Services[11]

The Cooperative Public Health Service is a regional health district serving eleven Towns in Franklin County. This arrangement type of this model on the spectrum is a 'service-related arrangement' type. The Franklin Regional Council of Governments (FRCOG) operates the cooperative as the Host Agency (fiduciary agent). The cooperative works to improve the public's health through environmental health inspections, code enforcement, education, wellness, and special programs.



[10] Town of Lee. Tri-Town Health Department. https://www.lee.ma.us/tri-town-health-department.
[11] Franklin Regional Council of Governments (FRCOG). Cooperative Public Health Services. https://frcog.org/program-services/cooperative-public-health-services/.

The Boards of Health of the Towns of Buckland, Charlemont, Gill, Hawley, Heath, Leyden, Rowe, and Monroe share a regional Health Agent through the district. The same towns, plus Conway, Deerfield, and Shelburne, share a public health nursing program as well. The services offered through the cooperative include:

- **Public Health Nursing Program -** Oversight of state-mandated infectious disease surveillance, reporting and case monitoring, including assistance to residents and local agencies regarding the prevention and spread of disease and to assure appropriate treatment. Coordination of blood pressure, blood glucose, and other preventative and diagnostic health screenings. Coordination of community vaccination clinics providing seasonal flu, pneumonia and tetanus/diphtheria. Oversight of mercury thermometer and sharps disposal and container exchange. The public health nursing program also provides skin testing for residents and town employees at risk for Tuberculosis.
- **Public Health Inspection Services -** Health Inspectors provide technical services required, including Title V (on-site septic) inspections, food establishment inspections, camp inspections, swimming pool inspections and housing inspections.

Overall

Clearly, there is no one-size-fits-all solution. Each of these models, although different, share the same desired purpose - to create a stronger and more comprehensive system for delivering public health services in a cross-jurisdictional sharing capacity. These shared staffing approaches have proven to be helpful in filling gaps, or in some cases, enabling the provision of services that would not have been otherwise feasible. Some of the major benefits realized include but are not limited to:

- More effective planning and response for common infections like influenza, or rare, tropical diseases like Zika and Ebola;
- Qualification for grant funding that may not have been available to an individual health department on its own, whether due to the smaller population served or a lack of in-house capacity and resources;
- Addition of call-in assistance lines and other services that would not otherwise be economical;
- Dependable backup coverage and coordinated scheduling for skilled positions; and
- Regular communication among the parties has brought both the opportunity to address challenges as they've been encountered and a path to continue improving services as the contractual arrangements grow and evolve.

Recommendations / Proposed Solutions

As people travel across jurisdictions, public health challenges also travel, whether stemming from food poisoning, substance abuse, environmental exposures, or communicable diseases. Rather than take an insular approach to addressing just the issues in one singular area, local public health officials have considered, and in some cases implemented, partnerships as an effective means of containing existing and potential problems, expanding organizational capacity, and effectively managing public health expenditures. In this report, we learned that such cross-jurisdictional sharing arrangements generally take one of four forms, or a combination thereof: (1) as-needed assistance; (2) service-related arrangements; (3) shared programs or functions; and (4) regionalization/consolidation. All of these arrangements require decisions regarding maintaining in-house staffing expertise for the range of essential local public health roles relative to sharing staff among multiple jurisdictions or contracting for staffing services with other entities. In this report, we also learned of state and national recommendations to adequately meet public health essential services within a public health system or jurisdiction. With these factors in mind, this section reflects identified approaches to building a stronger health presence going forward within the budget limitations of the two towns.

The following chart is a side-by-side comparison of the existing available resources within the two communities:

Budget Information	Longmeadow (Budget)	Hours	Benefits	East Longmeadow (Budget)	Hours	Benefits
FY19 Municipal Appropriations for Public Health Budgets	**$155,681.00**			**$267,927.10**		
Public Health Director	FTE / $85,071	40/hrs a week	Full	FTE / $73,500	37.5	Full
Clerical/Admin Assistant	PT / $10,000	10/hrs a week	Full	FTE / $39,917	37.5	Full
Public Health Nurse	PT / $46,491.01	27.5/hrs a week	Full	$10,000	$30/hr for MAVEN reporting as needed	None
Health Inspector	None			$44,144.00	37.5	Full
Recycling Coordinator	Not in budget control of Dept.			$19,760 Revolving Account		
Animal Control Officer	Not in budget control of Dept.			$27,375.00		None
Animal Inspector	Not in budget control of Dept.			$1,500.00		
SWAP (Senior Work Abatement Program)	Volunteer	100/hrs a year	None	Volunteer	150/hrs a year	None
Board of Health Members	Volunteers		None	$3,500		None
Pell Grant	Intern	250/hrs academic year, 10hrs/week	None			
Expense/Operating	$10,150.00			$69,390.00		

NOTE: East Longmeadow employees are unionized and Longmeadow employees are not.

Option #1 - Public Health District under M.G.L Chapter 111, Section 27A

Adopt M.G.L. Chapter 111, Section 27A to establish a health district for the purpose of employing a health director and necessary assistants and clerks to perform related duties and receive such compensation determined by the joint committee or 'alliance' - a committee made up of representatives from the public health boards of both towns. The alliance annually would elect a chairperson and a secretary and would determine the relative amount of service to be performed in each participating municipality of the district. The personnel employed by the district would be overseen under the alliance. The treasurer of one of the municipalities of the district, designated by the alliance, would be treasurer of the health district and give to the district a bond with a surety company authorized to transact business in the Commonwealth as surety, for the faithful performance of his/her duties as treasurer of the district, in such sum and upon such conditions as the alliance may require. The individual municipalities will still retain its own autonomous Board of Health and ability to set local policies and procedures. Any participating community of the district may withdraw by majority vote of its legislative body.

Perceived Pros:

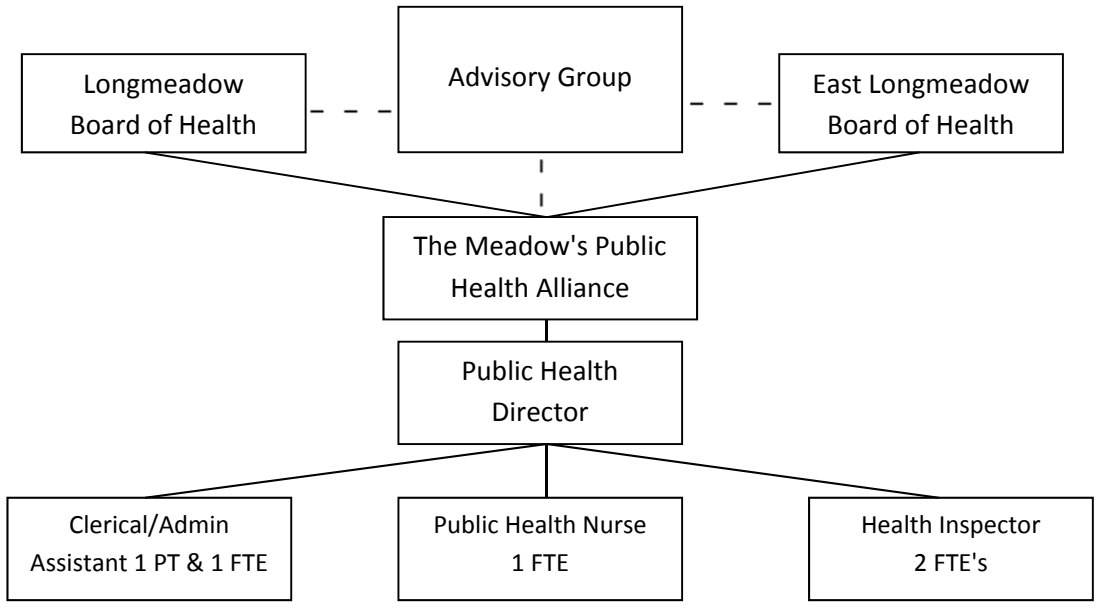
- The statute is very prescriptive and specific and maps out a process to follow to create the new regional public health district.
- Oversight of personnel shifts to an established Alliance between communities who would have primary management responsibilities of the positions.
- The Alliance will bear the responsibilities for the provision of the services.
- Both communities as service receiving municipalities of the health district share the overall responsibility. No community is designated as the lead agency.
- Both communities maintain local control and retain its own autonomous Board of health and ability to set local policies and procedures.
- Through the Alliance, both communities will sustain position of existing highly qualified Director who can oversee operations and handle the administrative component of the departments. Which means:
- Longmeadow will have ability to separate roles of Health inspector and administrative duties into two separate positions, instead of its current 2 in 1. Which means:
- Both communities will have their own dedicated full-time Health Inspectors who can provide greater coverage and back-up to one another when necessary.
- Through the Alliance, both communities will sustain a fulltime position of a highly qualified Public Health Nurse. Longmeadow will continue to have 27.5hrs a week, and East Longmeadow will gain 10hrs a week - something they never had before - affording East Longmeadow , at a minimum, the opportunity to provide immunizations and decrease influenza.
- Districts created according to this statute are difficult to dissolve; a vote of the town meeting is required to do so.

Perceived Cons:

- The process of creating the new district is intensive, including the requirement of votes at Town Meeting to create and staff the health district.
- This approach requires the creation of a comprehensive health district and does not allow the flexibility of more limited shared service arrangements.
- The municipalities will minimize local control on daily oversight of the personnel.

The financial considerations below do not include a possible lead community administrative fee and benefit costs.

Budget Information	Total Allocation	Longmeadow (Budget)	Hours/Week	East Longmeadow (Budget)	Hours/Week
Public Health Director (Shared)	1 FTE $73,500	$36,750	18.75	$36,750	18.75
Clerical/Admin Assistant	1 PT & 1 FTE $59,917	PT / $20,000	19	$39,917	37.5
Public Health Nurse (Shared)	1 FTE $62,000	$45,260	27.5	$16,740	10
Health Inspector	2 FTEs $106,000	$53,000	37.5	$53,000	37.5
Benefits					
Operating/Expense	$10,000			Identify expense for these services	
TOTAL	**$311,417**	**$154,960**		**$146,407**	



Option #2 - Public Health Cooperative under an agreed upon Inter-Municipal Agreement (IMA)

Under this option with an established IMA, it's recommended for the two municipalities to institute a shared service partnership arrangement in which one of the two communities becomes the lead municipality and provides services to the other. It is recommended for East Longmeadow to become the lead community in anticipation of the departure of the Health Director in Longmeadow. East Longmeadow currently has an existing operational capacity to step in and meet gaps, and abilities to leverage resources to support health department activities. Through this arrangement, East Longmeadow would provide agreed upon services needed to the Town of Longmeadow, specifically services of a Health Director, Public Health Nurse, and Health Inspector. An IMA would include all the terms and conditions necessary to define the municipality's relationship and satisfy statutory requirements. East Longmeadow, as the lead community, would have primary fiduciary responsibility and shared costs would be fully funded in its annual budget on the basis of an agreed upon allocation formula. East Longmeadow would be responsible for administrative, budgetary, and human resources responsibility of managing the shared service arrangement and would be the formal employer of all the shared staff included in the arrangement (Health Director, Public Health Nurse, and Health Inspector) and would be responsible for the provision of compensation and benefits. The Town of Longmeadow would reimburse East Longmeadow for the staff time dedicated to its public health needs. Longmeadow would only be responsible for hiring/overseeing its own clerical support. Longmeadow would still retain its own autonomous board of health and ability to set local policies and procedures. Each individual jurisdiction also would have the option to alter, expand, or discontinue its involvement as agreements come up for annual reauthorization. An advisory board may be established between the two Boards of Health for transparency and communication purposes as well as to cross-collaborate for goal and priority setting for services being implemented in their communities. Besides creating a stronger and much more comprehensive system for delivering public health services, some of the perceived pros and cons of this arrangement include:

Perceived Pros:

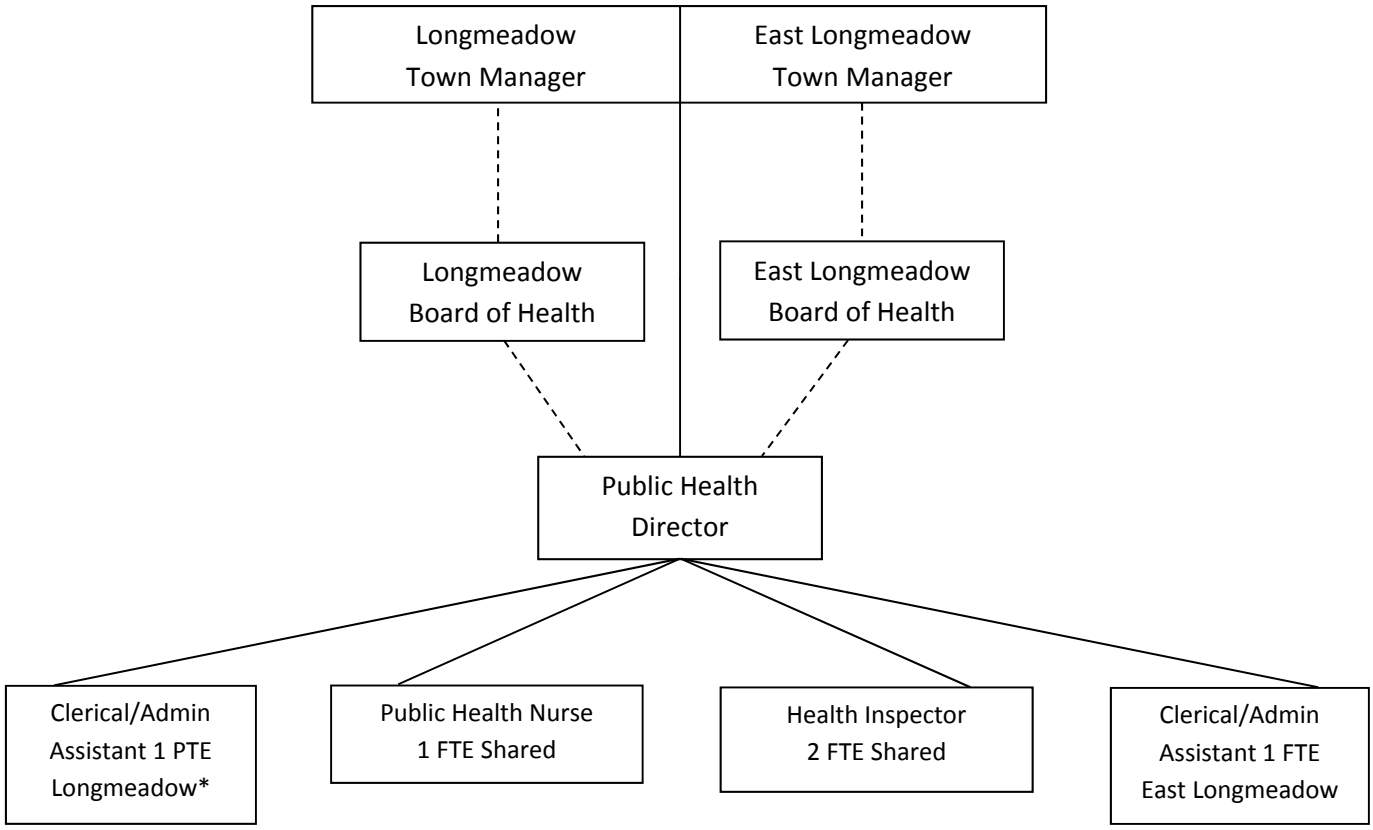
- Public Health sharing arrangements created through IMAs can be as comprehensive or limited as the parties prefer.
- Agreements can be negotiated by Town Managers and ratified by Boards of Health/Boards of Selectmen and are not required to be confirmed at Town Meeting.
- Both communities will sustain position of existing highly qualified Director who can oversee operations and handle the administrative component of the departments. Which means;
- Longmeadow will have ability to separate roles of health inspector and administrative duties into two separate positions, instead of its current 2 in 1. Which means;
- Both communities will have their own dedicated fulltime Health Inspectors who can provide greater coverage and back-up when necessary.
- Both communities will jointly sustain a fulltime position of one highly qualified Public Health Nurse. Longmeadow currently employs a part time nurse and East Longmeadow has no nurse on staff. This position will allow Longmeadow to maintain current services while also providing East Longmeadow the opportunity to increase nursing services.
- Both communities maintain local control and retain their own autonomous Board of Health and ability to set local policies and procedures. "Lead" community will have primary management responsibility.
- "Lead" community may increase revenue by charging an administrative fee to the service receiving municipality.
- The service receiving municipality will only have to be responsible for paying a fee-for-service to the "lead" community.

Perceived Cons:

- The "lead" community will bear the responsibilities for the provision of the services.
- The "non-lead" community will minimize local control on daily oversight of the health director, public health nurse, and health inspector.
- "Lead" community will have primary management responsibility and shared position would be fully funded in its annual budget.
- Benefit costs could have long-term cost implication as pertaining to worker's compensation, unemployment, health insurance, and retirement.
- IMA-based districts include opt-out clauses that can lead to dissolving the relationship more easily (some communities may prefer this and see it as an advantage).

The financial considerations below do not include a possible lead community administrative fee and benefit costs.

Budget Information	Salary	Longmeadow (Budget)	Hours/Week	East Longmeadow (Budget)	Hours/Week
Public Health Director (Shared)	1 FTE $73,500	$36,750	18.75	$36,750	18.75
Public Health Nurse (Shared)	1 FTE $62,000	$31,000	18.75	$31,000	18.75
Health Inspector	2 FTE	$53,000	37.5	$53,000	37.5
Benefits					
TOTAL		**$120,750**		**$120,750**	



——— Direct
- - - - - - - - - Advisory
* General direction of Town Manager under supervision of Public Health Director

Summary and Results of Observation

The Boards of Health and the Public Health Departments of both communities have been carrying out the responsibilities concerning local health and doing what they can within their limitations. The task has been fairly manageable for some time, however the communities recognize and agree on the challenges facing local public health departments, and are committed to identifying solutions that will maintain and/or improve capacity, and create new opportunities that will establish a much stronger and more comprehensive system for delivering public health services as recommended by the Public Health Accreditation Board.[12] Two options have been presented that have potential to allow the towns to build capacity and improve health outcomes in their communities. Although there is no "one-size-fits-all" solution to public health departments achieving these goals, whichever option the towns decide to pursue, gaps will be filled that have not been otherwise feasible in the absence of the partnered approach, and services will be enhanced. In the context of this analysis, the following are our overall observations:

- Currently, East Longmeadow does not have a public health nurse. Instituting one of the two options will allow the town to have at least 10 hours a week of services from a professional public health nurse to coordinate (at a minimum) immunizations throughout the year. The town of East Longmeadow also seems to have a high population of young children and elders which could benefit from a public health nurse. Moreover, East Longmeadow has a higher rate of influenza than Longmeadow which can be mitigated by the presence of a public health nurse who can organize public information and flu clinics. If there were any form of breakouts, having available a public health nurse to dispense vaccinations as needed would be helpful.
- Longmeadow has gotten by with having the health director and health inspector as a combined position, leaving the health director responsible for all inspections and administrative duties of the department and with little time to organize critical health promotion activities. Any one of the two options will make available to the town both a health inspector and a health director as separate positions for roughly the same cost, as well as increase access to inspectional and health promotional services with little cost.
- The proposed options will make available two full-time health inspectors, one for each community, allowing Longmeadow to have a dedicated inspector not worrying about the administrative functions of the department. Additionally, the two inspectors can collaborate and assist each other as-needed. For example, should one be on leave or at training, the other can provide coverage.
- All these positions will provide dependable backup coverage, and coordinated scheduling for skilled positions and stronger administrative oversight. Regular communication between the communities and staff will bring both the opportunity to address challenges as they've been encountered, and a path to continue improving services as the contractual arrangement and services grow and evolve.
- Skilled and credentialed employees are critical. One of the shared service arrangements can provide longer term sustainability to maintain professional staff resulting in increased performance.

[12] Public Health Accreditation Board. http://www.phaboard.org/.

- Each town has an administrative staff positon under the direction of the respective Health Directors. The Longmeadow position is currently supplemented by volunteers and interns from local colleges. It is assumed that this practice will continue.
- In both of the options presented, the towns will maintain their respective Boards of Health. These Boards will continue to provide guidance critical to policy making and adjudication, recognizing that although community needs are the same, priorities differ between the two towns. The operation of the department will be determined by the Director as determined by the Town Managers. The Boards of Health will assist with setting priorities for the Director.
- Chronic diseases pose the biggest health challenges for communities, families, and individuals. Having adequate staff such as the options propose can address the immediate inspectional and public health needs and also institute preventive and health promotion activities to ensure a healthy community. A healthy community is critical for a strong vibrant and economically successful community.
- There is limited to no community based health assessment in either of the municipalities and there is a shared desire to create one. Upon implementing a shared service solution there is a shared desire to engage in a comprehensive community level health needs assessment which is one step toward achieving accreditation, and also positions the communities to compete strongly for grants and other funding.
- Conforming to minimum requirements of state mandates is not enough to adequately meet PHAB standards. It should be a goal for every community, such as Longmeadow and East Longmeadow, to strive toward national accreditation. The towns can move in that direction through a shared service/partnership arrangement between the towns and build capacity to reach accreditation.
- Longmeadow and East Longmeadow are not alone. The Commonwealth of Massachusetts recognize local public health challenges and currently has a special commission conducting a comprehensive review of local and regional public health to assess the effectiveness and the efficiency of municipal and regional public health systems and to make recommendations regarding how to strengthen the delivery of public health services and preventative measures. Longmeadow and East Longmeadow currently are one step ahead of any recommendations that may come out of the Commission recommendations. It's anticipated that the Commission will include in the recommendations standards for the delivery of comprehensive public health services. Longmeadow and East Longmeadow are ahead of the game by exploring and moving towards strengthening its public health capacity through shared services.
- There is a shared desire to possibly implement a pilot shared service partnership arrangement through a cooperative effort in phases with the later intent to expand and establish a public health district.

A final important observation for the municipalities to continue to research is how spending on public health systems can sometimes result in important population health gains which previous studies have suggested that these gains can financially impact the communities. A comprehensive community level health needs assessment will allow the two communities to take a closer look into this within their jurisdictions and better plan and prepare for improving health outcomes which can in-turn positively impact town spending and local economic development.

Next Steps

The following chart reflects the next steps beyond the exploratory process and into implementation. The next steps encompass four key components:

- **Decide -** The municipalities will decide which shared-service model they will to implement as a pilot for delivering public health services.
- **Establish -** The municipalities will develop an agreed upon Inter-Municipal Agreement (IMA) that will determine the overall parameters of the partnership agreement between the two municipalities for shared services.
- **Sustain -** The municipalities will leverage existing resources to sustain the agreed upon partnership arrangement for services. These resources include a combination of state resources and local funding allocations.
- **Implement -** Upon securing funding and signing the IMA, the municipalities will proceed with executing the services under the agreement.

Action	Lead	When
Organize a joint-Board of Health meeting between the two towns to receive presentation of exploratory report.	Municipalities & PVPC	No later than December 2018
Come to an agreement to implement an identified pilot shared model.	Municipalities	December 2018
Apply for Efficiency & Regionalization (E&R) Grant • One-time 'start-up' costs to supplement pilot model for FY20. • Include in grant budget to do community level health needs assessment.	East Longmeadow, PVPC to assist write grant	January 15 - February 15, 2019
Request from PVPC for DLTA resources for ongoing technical assistance.	Municipalities	January, 2019
Include shared allocation in town budgets to sustain shared service arrangement not covered in E&R grant.	Municipalities	November, 2018 - February, 2019 (budget process)
Develop an Inter-Municipal Agreement.	PVPC	March, 2019
Implement shared-service partnership arrangement.	Municipalities	July 1, 2019

Relevant Sources

Berkshire Regional Planning Commission. Berkshire Public Health Alliance. http://berkshireplanning.org/initiatives/berkshire-public-health-alliance.

Boston University School of Public Health. MA Public Health Regionalization Project. http://www.bu.edu/regionalization/.

Center for Disease Control and Prevention. The Public Health System & the 10 Essential Public Health Services https://www.cdc.gov/stltpublichealth/publichealthservices/essentialhealthservices.html

Center for Sharing Public Health Services. Rethinking Boundaries for Better Health. https://phsharing.org/.

Center for Sharing Public Health Services. Spectrum of Cross Jurisdictional Sharing Arrangements. www.phsharing.org.

Franklin Regional Council of Governments (FRCOG). Cooperative Public Health Services. https://frcog.org/program-services/cooperative-public-health-services/.

Maps of Regional Health Districts in Massachusetts. www.bu.edu/regionalization/digs/maps/.

Massachusetts Department of Public Health. https://www.mass.gov/orgs/department-of-public-health

Mass General Laws. Section 27A: Appointment of health officer by two or more towns; duties; compensation; joint committee. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section27A.

Public Health Accreditation Board. http://www.phaboard.org/.

Public Health Institute of Western Massachusetts. https://www.publichealthwm.org/

Special Commission on Local and Regional Public Health. https://www.mass.gov/service-details/special-commission-on-local-and-regional-public-health

Regionalization: A guide for sharing public services in Massachusetts. Laws that allow for regionalization. http://www.regionalbestpractices.org/.

Town of Lee. Tri-Town Health Department. https://www.lee.ma.us/tri-town-health-department.