INTRODUCTION

The Center for Sharing Public Health Services visited the Shared Services Learning Community site in Central Massachusetts on September 9–10, 2014. This *Site Visit Report* documents the activities from the site visit as well as some of the Center's observations.

The report includes a lengthy *Background* section for those not familiar with the partnership. For those familiar with the partnership, go directly to the *Observations* section, which starts on page 4.

BACKGROUND

About the Center

The Center for Sharing Public Health Services helps communities learn how to work across jurisdictional boundaries to deliver essential public health services. The Center serves as a national resource on cross-jurisdictional sharing (CJS), building the evidence and producing and disseminating tools, methods and models to assist public health agencies and policymakers as they consider and adopt CJS approaches.

Building Evidence: One way the Center builds evidence is by working closely with a Shared Services Learning Community (SSLC), made up of demonstration projects in several states that encompass a diverse spectrum of CJS initiatives, from small-scale initiatives to full consolidation of health departments. The Center provides technical assistance and a forum that allows these communities to share lessons learned with each other and the Center. In return, the SSLC acts as a learning laboratory by providing real world experiences that the Center collects and analyzes and shares with the nation.

Producing and disseminating tools, methods and models: The experiences of the SSLC, along with other research and expert opinions, provide the knowledge and insight the Center needs to provide tools and assistance to any community or group of communities considering CJS arrangements.

The Center for Sharing Public Health Services is a national initiative managed by the Kansas Health Institute with support from the Robert Wood Johnson Foundation.

About The Area

Massachusetts has approximately 350 local public health departments, most of which have their own independently elected boards of health. The state mandates they deliver a relatively narrow band of specified services, mostly related to environmental health. Many other traditional public health services are not mandated by the state and, therefore, are not provided by health departments. Private organizations often provide some public health functions, resulting in a system that is fragmented.

The Massachusetts Department of Public Health (MDPH) used the vast majority of its National Public Health Improvement Initiative funds (award under the federal Affordable Care Act) for District Incentive Grants (DIGs). The DIG effort was built on previous work by the Massachusetts Public Health Regionalization Project, a multi-disciplinary effort that has been in existence for approximately 10 years.

MDPH awarded DIGs through a competitive process to groups of cities and towns working to share public health staff and services with the goal of improving the scope and quality of local public health services for their combined populations. The grants are intended to address gaps in capacity in order to guard the public's health through programs like food protection, code enforcement, and disease prevention, and by encouraging policies and programs aimed at smoking, obesity, health disparities, underage drinking and other health threats. The then-nascent Central Massachusetts Regional Public Health Alliance received one of the five District Incentive Grants, and the RWJF award has enabled the Alliance to move forward in its development.

About the CJS Project

Derek Brindisi, director of Worcester's Division of Public Health, is leading this effort, which is working cooperatively to create and sustain a viable, cost-effective and labor-efficient regional public health district.

The alliance is managed by the City of Worcester's Division of Public Health, which provides services to partner municipalities. Worcester has a population of 182,544, of which 20.1 percent live below federal poverty level. Six other towns make up the alliance: Grafton, population 17,765; Holden, population 17,346; Leicester, population 10,471; Millbury, population 13,261; Shrewsbury, population 31,640; and West Boylston, population 7,481. There is considerable disparity in size and available resources among the municipalities in the alliance.

SITE VISIT

Participants

The following members of the host team participated in the site visit:

- Derek Brindisi, Director, City of Worcester – Division of Public Health (Project Director)
- Erin Cathcart, Accreditation Coordinator, City of Worcester – Division of Public Health
- Karyn Clark, Chief of Community Health, City of Worcester – Division of Public Health
- Kerry Clark, Chief of Environmental Health and Response, City of Worcester – Division of Public Health
- Megan DeNubila, Prevention Specialist, City of Worcester – Division of Public Health
- Michael Hirsh, MD, Medical Director, City of Worcester – Division of Public Health
- Chris Montiverdi, Deputy Director, City of Worcester – Division of Public Health
- Laura Overton, Program Manager, Center for Public Health Practice, City of Worcester – Division of Public Health

Other people attending the City of Worcester – Division of Public Health staff meeting included:

- Paige Bik, Regional Community Health Coordinator, City of Worcester – Division of Public Health
- Colleen Bolen, Health and Medical Preparedness Coordinator, City of Worcester – Division of Public Health

- Mike Borowiec, Regional Environmental Health Coordinator, City of Worcester – Division of Public Health
- Patricia Bruchmann, Public Health Nurse, City of Worcester – Division of Public Health
- Sandra Early, Public Health Nurse, City of Worcester – Division of Public Health
- Liz Foley, Worcester Regional MRC Coordinator, Division of Public Health
- Tracy Kennedy, Project Coordinator of The Prevention and Wellness Trust Fund, Division of Public Health
- Barbara Mard, Regional Public Health Specialist, Division of Public Health on behalf the Town of West Boylston
- Amanda Major, Community Engagement Organizer, City of Worcester – Division of Public Health
- Seth Peters, Chief of Epidemiology, City of Worcester – Division of Public Health
- Julie Van Arsdalen, Regional Public Health Specialist, Division of Public Health on behalf of Town of Leicester

Community partners that participated included:

- Esther Boama-Nyarko, student at Boston University School of Public Health
- Esther Borer, University of Massachusetts Injury Prevention
- Amy Borg, University of Massachusetts Medical School
- Seth Eckhouse, Boston University School of Public Health
- Leah Gallivan, Edward M. Kennedy Community Health Center
- Tina Grosowsky, Central Massachusetts Tobacco Free Commission Partner
- Heather Lyn Haley, Family Medicine –University of Massachusetts Medical School
- Noreen Johnson-Smith, Family Health Center of Worcester
- Thuha Le, Family Health Center of Worcester
- Jim Leary, University of Massachusetts Medical School
- Stephanie Lemon, University of Massachusetts Medical School
- Yung Phan, Worcester Elder Affairs/Senior Center
- Jose Ramirez, Edward M. Kennedy Community Health Center
- Kim Reckert, UMass Memorial Medical Center
- Kimberly Salmon, Fallon Health
- Clara Savage, Common Pathways
- John O'Brien, Clark University

The following town managers/board members participated:

- Leon Gaumond, West Boylston
- Thomas Gregory, Shrewsbury
- Kristen Las, Shrewsbury
- Kevin Mizikar, Leicester

- Chris Montiverdi, Leicester
- Jim Morin, Millbury
- Bob Spain, Millbury

Visitors from two other Shared Services Learning Community Sites participated in the site visit:

- Cumberland County, Maine CJS
    - Shane Gallagher, City of Portland, Maine
    - Tony Plante, Town of Windham, Maine
- Minnesota System Wide:
    - Lisa Brodsky, Bloomington Public Health
    - Jill Bruns, Kandiyohi-Renville Public Health
    - Bonnie Paulsen, Bloomington Public Health
- Northeast Ohio:
    - Kelly Engelhart, City of Ravenna

Five representatives from the Center for Sharing Public Health Services participated in the site visit:

- Patrick M. Libbey, Co-Director
- Grace Gorenflo, Senior Project Consultant
- Liza Corso, Senior Public Health Advisor for the Office for State, Tribal, Local and Territorial Support at the Centers for Disease Control and Prevention; member of Center's Technical Advisor's Team
- Harold Cox, Associate Dean for Public Health Practice and Associate Professor of Community Health Sciences at Boston University School of Public Health; member of Center's Technical Advisor's Team
- Cheryl Hilvert, Director for the Center for Management Strategies for the International City/County Management Association; member of Center's Technical Advisor's Team

Site Visit Activities

Site visitors went to University of Massachusetts Medical School, and met with community partners for their perspectives on public health and working with the alliance. The next stop was Shrewsbury, where they met with the various Alliance town managers to hear administrative perspectives. The final event of the first day was a reception at Clark University where they met academic partners who collaborate with public health. The following day, the site visitors went to Worcester Public Health Division, where health district staff discussed their perspectives about how the alliance operates.

Observations

Site visits provide a valuable learning opportunity, both for the Center staff and for the participants. There is only so much information the Center can gather from reports or phone calls. Meeting with

people in their actual environment completes the picture and contributes to a better understanding of the project.

Some observations gleaned by the Center as a result of participating in the site visit are listed below.

The alliance comprises a series of contracts between Worcester's Division of Public Health and participating towns.

The Central Massachusetts Regional Public Health Alliance is not a legal entity. The alliance was formed through an intergovernmental agreement that allows Worcester's Division of Public Health to provide services to the other towns in the alliance. Each town receives services under a separate contract with Worcester. The contracts are not standardized but instead include various environmental health and other public health services as needed.

Towns purchase services they are statutorily obligated to provide. In some cases, they also receive additional services beyond the terms of their contracts for which they are not paying.

Each town has its own board of health. Worcester leadership meets with these boards of health individually, resulting in six bilateral relationships. There is a regional public health council to which council members have been assigned, but there has not been much engagement at a collective level. Therefore, rather than having an oversight body that provides guidance and leadership, the alliance is primarily about transactional relationships right now.

Environmental health service provision has been standardized throughout the region.

As a result of the work of the alliance, some environmental health services have been standardized across the cities. Training has been provided to all environmental health staff, thus enabling them to work in any town. Generally, however, staff works in just work one or two jurisdictions.

Staff are ambivalent about the changes

Before the alliance, each town provided their own environmental health services with a small staff of one or two. Once towns contracted for services through the alliance, many released some of their own public health staff, who were then hired by Worcester and reassigned back to the towns. For these staff, much of the public health infrastructure in their towns remains intact, and it's unclear whether they should report to town officials or leadership in the City of Worcester – Division of Public Health. Some staff continue to strongly identify with their town, as opposed to having more of a regional identify. There also is some concern that town residents don't feel that staff are working for their town, even when they are situated in a town building. Along these lines, it was observed that staffing under the alliance may have gone much more smoothly if the staff hired were completely new to the area, and did not come from one of the participating towns.

The standardization of policies and protocols has meant that there is a change in how staff does their work. Some staff expressed concern that they now need to spend more time on paperwork.

One benefit is overall better staff coverage for absences.

Lessons Learned

As a result of participating in this site visit, the Center staff came away with several insights that could be used in other sharing work.

Tactically expanding engagement among the cities in the alliance could strengthen a regional public health identity.

Building ownership of the alliance among town managers could help them see the alliance as more than a contractual agreement for predetermined services. One way to do this could be to work collectively with town managers on individual issues they are concerned about.

Engage other organizations in the alliance.

Any alliance likely could benefit from the involvement of community partners, like academia and nonprofits. Not only will their involvement expand engagement, but they also could bring valuable assets to the alliance. Other organizations that provide public health services in the region also could participate in the alliance.

Change management and communications plans could alleviate staff concerns.

People often become concerned when they try to anticipate the consequences of change. Deliberately attending to change and its effects through good communication and meaningful engagement of staff members can help in the acceptance of change.

Worcester should be aware it may be underwriting services is other towns.

Some towns may be getting public health benefits that are not spelled out in their contracts. Worcester may eventually need to consider if they are underwriting those additional services. The City of Worcester – Division of Public Health is in the process of doing a cost study that may help in this area.

The alliance should continue to work on its shared identity.

The alliance has a logo and has been using it on their paperwork. It may help to expand awareness of the alliance by using it more widely and publicly.

SELECTED COMMENTS AND QUOTES FROM THE SITE VISIT AND FOLLOW-UP EVALUATIONS

Shortly after the visit, the Center sent out an electronic evaluation. The comments below came from the site team and the site visitors via the evaluations.

I believe that most people found the site visit informative in terms of the status of this project as well as the obstacles that may exist to its continued long term viability.

It was interesting hearing from some of the other observers about the organizational challenges to regionalization in their communities

Credible information// we are all working in the same direction to achieve our goals. Hesitation in the beginning, but in the long run each individual community has open the doors to programs and experiences they would not have been able to manage with their current budget.

The nationwide interest in developing cross-jurisdictional health alliances.

I learned the struggles that others share in regionalizing, such as creating and selling "buy-in" from outside communities and local health departments. It was evident that others shared the same struggle of overcoming the individualistic mindset of "my town" which prevents people from seeing the overall benefits of regionalization.

As a continuation of the SSLC in San Diego and our own meetings that there needs to be transparency about goals and expectations of the respective parties going into a CJS arrangement; that having individuals involved who are committed to the success of the effort is important (pretty self-evident, really); that more work should be done up front to identify possible disconnects in policy or practice and iron those out; and that incremental, trust-building steps are likely to be more acceptable and more successful but take sustained effort, and patience, over time, and may prove difficult as individuals continue to move in and out of roles among the jurisdictions participating in the CJS arrangement.

Hearing from some of the people "on the ground" about the day-to-day realities. It didn't really change the overall view of what the Central Mass alliance has accomplished, but was a reminder that the overall success has not been without its challenges and problems.

Getting to know the fiscal piece but a reminder of how different Public Health is structured across the country.

I appreciated the hospitality of the hosts as well as the opportunity to attend this visit as a part of the TAT team. I feel that this project, while an honest attempt to expand public health services and providing some service sharing, is really more of a “contract service” project and could benefit through some advice from the Center as to ways to better involve participants, develop ownership and role responsibilities, and address some of what appears to be simple “business related” needs of the host team.

One of the biggest "take-aways" came from discussion toward the end of the site visit, about how to influence elected and senior appointed decision-makers. Because they deal with a broad range of public policy issues and, more likely than not, public health is not chief among them, just taking the "educate, educate, educate" approach when they're already inundated with information is not a high percentage play. Finding ways to show the public health angle of issues they already care about is more likely to translate into broader support and generate positive outcomes for their communities.